Multidisciplinary Team (MDT) Working Charter

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Multidisciplinary Team (MDT) Working Charter

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&

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Foreword

There has been a significant increase in multidisciplinary team (MDT) working in the last 20 years. For many they are a major clinical commitment and there is therefore a responsibility to make them as effective as possible. There is no doubt that they have had a significant impact on referral and access to specialist care and one of the main drivers of improvement in cancer services over this time period.

Whilst it is acknowledged that the multidisciplinary team meeting (MDM) is only a part of the pathway for the delivery of excellent care, it nevertheless represents a key opportunity to facilitate expert diagnostic opinion, apply evidence based treatment decisions, for education for multidisciplinary team members, to audit clinical outcomes and consider patients for access to high quality clinical trials and research.

The significant investment in specialist cancer services that has occurred makes it the responsibility of all MDTs to review their organisational structure and performance. This excellent document describes the fundamental governance structure for MDT meetings and the attributes of a well functioning cancer team. Peer review led by Health Inspectorate Wales, in partnership with the Cancer Networks, will be the process by which the structure and performance will be externally reviewed and reported to Health Boards and Welsh Government.

I recommend that all cancer teams in Wales read this document and take time away for the routine business of MDT meetings and patient care to undertake self-appraisal of the teams’ performance and agree goals with the Cancer Network Teams to achieve continuous improvement in service quality.

Dr Chris Jones
Deputy Chief medical Officer Welsh Government
Chair: Cancer Implementation Group
The Characteristics of an Effective MDT
Introduction & Aims

This document sets out the characteristics of an effective MDT.

Each MDT is encouraged to:
- Look at the characteristics and see how your MDT(s) compares with them
- Initiate discussions within the MDT(s) about what actions can be taken to make the team and meetings more effective

In conjunction with this, a DVD has been produced in England by the National Cancer Action Team about MDT working and it is advised that all MDTs should use it as the focus of a dedicated business meeting assigned to the form and function of each MDT. MDT working is a very important component in the management of cancer and will be an important focus for Peer Review. The MDT meeting (MDM) forms a pivotal place for key treatment and management decisions to be made, although it must be remembered that the vast majority of care is delivered by site-specific clinical teams. It is an opportunity for recording and validating clinical data, agreeing factual information on which treatment decisions are made and communicating this to all levels of care. It is also a great place for professional networking and education.

The Network core team cannot fill gaps in key MDT roles, mandate practices or monitor all meetings but can advise Health Boards to report service gaps and be receptive to concerns within teams that should trigger Peer Review.

Effective MDT working should result in:
- The treatment and care being considered by professionals with the specialist knowledge and skills in the relevant aspects of the specific cancer type, where necessary issuing supplementary reports based on greater expertise or, more commonly, on access to better clinical information not available at the time of the original report
- An opportunity to take on board opinions from a wide multi-disciplinary professional group
- Good communication between primary, secondary and tertiary care
- Good data collection to aid all secondary uses of data
- Continuity of care, when care can be delivered by different individuals or providers
- Adherence to national and local clinical guidelines
- Good working relationships between all team members from within the organisation and across organisational boundaries
- Opportunities for education and professional development for core and extended team members
- Opportunities for patients to be offered entry into high quality and relevant clinical trials.

The key features of a functioning MDT are set out in summary below. The main body of this MDT Working Charter document describes these in greater detail. It must be emphasised however that MDT working is evolving and it is for teams and their supporting Cancer Services departments to reassure their own Health Board that the service they are delivering is excellent. This must however be supported by evidence of performance against nationally agreed indicators and measures.
MDTs should have dedicated time not just to give access for all cancer patients to specialist oncological opinions, but to consider how the team works together, to develop a ‘charter’ that is signed up to by individual members and to develop metrics that reflect the effectiveness of the MDT though clinical audit and performance measures. Attendance at meetings should be recorded on a register for both audit and governance.

Organisations should provide adequate facilities for participation in MDT meetings (MDMs). The MDT rooms should have dual projection capabilities for the presentation of clinical information and recording of clinical discussions that can be seen and validated by all, access to PACS (Picture Archiving Communication System) and presentation of pathology images, where these images are felt necessary (which are not in the majority of cases), access to video-conferencing (VC) facilities and it is recommended that Teams use the Canisc MDM module preferably in ‘live mode’ within the meeting or at least ‘administratively’. Whilst this module is not perfect and important decisions on its development are awaited from NWIS, it allows a consistent system and way of working for preparing, presenting and the recording of clinical information for patient outcome reporting and communication with other teams (e.g., other local/regional MDTs, other service user clinical teams, tertiary care, primary care, third sector etc).

The key to an effective MDT is in the preparation. As much clinical information as possible should be recorded onto the MDM module (or other system) before the meeting, including radiology and pathology reports (this should be the initial reports and supplementary review reports), information on co-morbidities, performance status, patient wishes and anything else known about the patient that will contribute to enabling discussion and decisions by the MDT.

The MDT itself needs to be well led and well organised. The Chair and/or Lead of the meeting should ensure that:

i. There should be agreement about how many cases can be reasonably discussed. If longer or more frequent meetings are required these need to be negotiated with the relevant Health Boards.
ii. It should be an exception that patients are not presented by someone who knows the case well. For many patients this will be the one time their case is subject to specialist multi-disciplinary review and they deserve to have an advocate who understands as much about the individual case as possible.
iii. The timings of cases eg, early/late, new/follow up, diagnostic/treatment decisions etc should be such that specialists only attend for the cases that they can contribute to or are interested in (the time for this preparation and meeting activity is direct clinical care (DCC)). This should be considered valuable for CPD/SPA merits.
iv. Discussions should be focused, polite and inclusive of all MDT members. Frequently, specialist nurses and Allied Health Professionals provide specific information about the patient that are highly pertinent to treatment decisions and should, where necessary, be positively engaged by the Chair.

The role of the MDT is to agree the clinical facts through multidisciplinary specialist review, bringing together all clinical and diagnostic information and advise the clinical team delivering the care on evidence based treatment options and clinical trials, even if these are not available locally. Whilst strong individual and consensus views should be recorded, it is the individual consultant and his/her
team that has direct clinical responsibility for the care of the patient. Where recommendations are not followed, these issues should be addressed through clinical audit and treatment pathway meetings. Where care is frequently given against the recommendations of the MDT, this should be escalated to the Clinical and Medical Directors of the Health Boards and the Network.

(vi) The MDT is a clinical meeting and discussions should be focused on clinical care but it is also an opportunity to validate clinical information e.g., agree clinical stage at diagnosis, assign a key worker (although this will often happen or change outside of the MDT meeting) and document care plans. Systems should be developed where core data is agreed and recorded and information gaps completed. There should also be a system in place to highlight where significant changes have occurred to original diagnostic reports, especially radiology and pathology, after specialist multi-disciplinary review.

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The MDT Characteristics

The Characteristics of an effective MDT as well as a section on Peer Review are described in the document as follows:

1. The Team
   a. Membership
   b. Attendance
   c. Leadership
   d. Team Working & Culture
   e. Personal Development & Training

2. Meeting Infrastructure
   a. Meeting Venue
   b. Technology & Equipment

3. Meeting Organisation & Logistics
   a. Scheduling of Meetings
   b. Preparation prior to Meetings
   c. Organisation and administration during Meetings
   d. Processes and co-ordinator post Meetings

4. Patient-Centred Decision Making
   a. Who gets discussed at Meeting?
   b. Patient centred care (including Key Worker)
   c. Clinical decision making process

5. MDT Governance
   a. Organisation support
   b. Data collection, analysis and audit
   c. Clinical Governance

6. Peer Review
1. The Team

1.a Membership

1.a.1 Any clinician managing cancer patients should be a member of the appropriate cancer MDT. Where patients are managed by a clinician who is not an MDT member, local processes should be in place to ensure that their care and management is discussed by the MDT.

1.a.2 All relevant professionals/disciplines for core and extended members, are represented within the team. These should broadly be in accordance with the National Standards for Cancer Services in Wales, although it is recognised that these were sometimes applied in a one size fits all irrespective of the views of the local service. Each MDT will be registered with a unique MDT identifier code issued by the National Reference Data Service.

1.a.3 All core members should have a nominated deputy in place to cover planned and where possible unplanned absences. Advanced notice of absence should be given by the core member so that cover is organised, where possible.

1.a.4 All members have the level of expertise and specialisation required by the MDT. Where there is no relevant measure or accreditation for a role the issue of clinical competence is for the relevant professional body or the Health Board to determine.

1.a.5 The MDT Co-ordinator is recognised as a core member of the team. They should be positioned within the meeting where they can hear and see everything.

1.b Attendance

1.b.1 MDT core and extended members have dedicated time included in their job plans to prepare for, travel to (if required) and attend MDT meetings. The amount of time should be negotiated locally to reflect workload and varies according to cancer type and discipline.

1.b.2 Core members should be present for the discussion of all cases where their input is required. It will be for the Chair to decide whether there is adequate representation of professions/disciplines at a meeting to make recommendations to form a treatment plan about any/all patients and the action to take if not.

1.b.3 It is the responsibility of the clinician or member of the clinical team who has met the patient and who has listed the patient for discussion, to present the patients case at the meeting. The presentation of the case must be adequately prepared prior to the meeting to ensure all relevant clinical information is available. Audits should be performed to determine why patients listed are not discussed and the reasons why. If problems are identified these should be addressed and re-audited.

1.b.4 The Chair is responsible for raising concerns about non-attendance of particular members (including deputies) and escalating concerns if regular non-attendance is impacting on the quality of the MDT working.
Frequent non-attendance should be addressed during job plan reviews and/or during the appraisal processes.

1.b.5 A register of attendance should be maintained for each MDT. MDT attendance is monitored as part of the National Standards for Cancer Services in Wales and is an integral part of site specific Peer Review assessments.

1.b.6 Extended team members and non-team members need only attend for the cases that are relevant to them.

1.b.7 Individuals observing the MDT should be introduced by the Chair prior to the start of the MDT and their details included on the attendance list.

1.c Leadership

1.c.1 There is an identified MDT Lead Clinician and Chair of the MDT with a nominated deputy to cover when necessary. The Leader/Chair do not need to be the same person.

Chair

1.c.2 The MDT Chair is responsible for the organisation and the smooth running of the MDT meeting.

1.c.3 The Chair has the skills in the following areas:

- Meeting management
- Listening and good communication skills
- Interpersonal relations
- Managing disruptive personalities & conflict
- Negotiating
- Facilitating consensual clinical decision-making
- Time management.

1.c.4 It is the responsibility of the Chair to:

- Agree the MDT list with the MDT Co-ordinator
- Agree to Urgent cases being added to the MDT List after the MDT deadline and to notify the MDT Co-ordinator
- Ensure all relevant cases are discussed and prioritised as necessary
- Ensure all relevant team members are included in the discussion
- Ensure discussions are focused and relevant
- Promotes evidence-based and patient centred recommendations and ensures that eligibility for relevant clinical trials is considered
- Ensure the meeting runs to time, where possible
- Ensure that each patient discussed has a clear discussion and treatment plan recorded before the next patient is discussed
- Ensure that all necessary clinical data items are recorded with cases not continuing until the annotated discussion has been validated
- Ensure there are agreed processes whereby recommendations within the treatment plan are clearly documented, recorded and fed back to the patient, GP and the clinical team within the locally agreed timeframe
- Ensure that the presenting clinician is delegated with the responsibility for carrying out any actions post MDT meeting.
1.c.5 The MDT Lead (who may also be the Chair) has a wider remit not just confined to MDT meetings. It is the responsibility of the Lead to:

- Agree with the team issues around governance, eg, setting clear team objectives, purpose for the team, what is expected of members etc
- Ensure that other professionals/disciplines within the organisation have an understanding of the role of the MDT and why it is so important within the cancer care environment
- Negotiate for funding and/or resources required for the MDT
- Ensure that any issues of concern that impact on the safety of MDT recommendations are escalated accordingly
- Work with the MDT Co-ordinator and Cancer Services and/or the core Network team to complete and monitor the Cancer Standard returns in the required format. See link to the National Standards Database [http://nww.cscg-csm.wales.nhs.uk/login.cfm](http://nww.cscg-csm.wales.nhs.uk/login.cfm)
- Ensure that at agreed intervals (eg, 1-4 times per year) separate business meetings are organised to discuss MDT business including patient pathway development, service improvement, research and audit.

1.d Team Working & Culture

1.d.1 Every member has clearly defined roles and responsibilities within the team which they have agreed to and are included in their job plans. Appendix 1 provides an example of the role of the Pathologist and Appendix 2 provides an example of the role of the Radiologist within the MDT.

1.d.2 The team has agreed what is acceptable team behaviour/etiquette including:

- Mutual trust and respect between all team members
- An equal voice for all team members allowing all opinions to be valued
- Resolution of conflict between team members
- To encourage constructive discussion/debate
- The ability to request and provide clarification if anything is unclear.

1.d.3 Every member plays a role in sharing learning and best practice with peers.

1.e Personal Development & Training

1.e.1 All members recognise the need for continued learning and development. Individual members need to be supported to gain the necessary knowledge and skills for their roles and responsibilities within the MDT and for their professional role. Support must be available from the team and the organisation and members should take up relevant CPD opportunities.

1.e.2 Networking opportunities are important to share learning and experiences with other MDTs within the same Health Board, Network or beyond.

1.e.3 Access to training opportunities are required to support the members role within the MDT in areas such as:

- Leadership skills
- Chairing skills
- Communication skills including listening, presenting and if relevant writing
- Time management
- Confidence and assertiveness
- Use of IT equipment including video-conferencing
- Knowledge of anatomy, oncology, radiology and pathology, for members of the MDT not expert in these areas.

2. Meeting Infrastructure

2.a Meeting Venue

2.a.1 Dedicated MDT rooms should be available in a suitable, quiet location to ensure confidential discussions.

2.a.2 The MDT room should be suitable in size and layout to accommodate all MDT members. All members should have a seat, should be able to hear discussions taking place and be able to view all presented data.

2.b Technology & Equipment

2.b.1 Meeting rooms where MDTs take place should have:

- Dual projection screens and projectors (allows projection of radiology/pathology and validation of MDT discussion and management plan recorded)
- Access to the appropriate equipment for projecting and viewing radiology images including retrospective images
- Access to the appropriate equipment for projecting and viewing specimen biopsies/resections and accessing retrospective pathology reports
- Access to Canisc or another database to enable documentation of the MDT discussion and management plan in real-time
- Video-conferencing equipment to see and speak to members who are off site, allowing information and images to be shared across all sites. See link for tips and advice on successful video-conferencing - http://howis.wales.nhs.uk/sites3/Documents/983/Tips%20and%20advice%20on%20effective%20vc%20updated%20May%202012.pdf
- Access to local IT technical support and NHS Wales Informatics Service Multimedia Helpdesk contact numbers should any problems arise with IT systems and/or Video-conferencing equipment before or during the meeting, as the quality of the MDT decision making is seriously affected when equipment failure occurs. See link for contacting NWIS helpdesk - http://howis.wales.nhs.uk/sites3/Documents/983/Contacting%20NWIS%20Videoconference%20Helpdesk%20Nov%202010.pdf
- The use of decision making aids and clinical pathways should be agreed by the MDT in it’s operational policy, and then be available for use in the MDT

2.b.2 There is commitment from all organisations to provide technology and equipment, including video conferencing, that is of good quality, reliable and of the minimum network wide specification, taking into account issues such as:

- Standards of data transfer
- Image and audio quality
- Bandwidth – speed for loading images, real-time data entry
- Inter-hospital compatibility including cross-site compatibility.
3. Meeting Organisation & Logistics

3.a Scheduling of Meetings

3.a.1 MDT meetings should take place regularly. See links to MDTs held within South Wales and North Wales.
South Wales Cancer Network Directory of Cancer Services
North Wales Cancer Network - MDT

3.a.2 MDT meetings should be held during core hours where possible, and set up so that they do not clash with any clinical commitments. Where possible out-patient clinics should follow MDT meetings.

3.b Preparation prior to Meetings

3.b.1 Processes should be in place to ensure that all patients diagnosed with a new primary cancer have their cases discussed by the relevant MDT. Each MDT should clearly state what and when cases can be re-discussed by the MDT ie, disease recurrence/progression etc.

3.b.2 A locally agreed cut-off time for patients to be listed onto the MDT should be adhered to by all team members. Flexibility must be given for urgent cases that need to be added to the list. The Chair of the MDT should authorise the cases prior to the patients being listed.

3.b.3 The MDT patient list should be organised in consultation with core team members prior to each meeting eg, if the pathologist has to leave the meeting early then the list should be organised to deal with all cases requiring the pathologists input first.

3.b.4 The MDT patient list is circulated prior to the meeting to all core team members.

3.b.5 All clinically relevant information relating to each patient being discussed at MDT should be collated and available at the MDT meeting, wherever possible. Information should include all diagnostic information (pathology and radiology), clinical information including treatment already undertaken, significant co-morbidities, and clinical history. It is important that data items collected are part of the All Wales Datasets and are regularly recorded and validated by the MDT team.

3.b.6 Team members are aware of the necessary clinical information required for each patient to be presented and discussed at MDT.
3.c Organisation and Administration During MDT Meetings

3.c.1 It is clear who is presenting the patient for discussion and the reason for discussion.

3.c.2 There is access to all relevant clinical information at the meeting including patient notes and/or electronic record, past and present test results/images/samples and appointment dates. Access to the local PAS system (and those of LHBs whose patients are discussed), radiology and pathology systems should also be available.

3.c.3 An electronic patient record should be used to capture the management plan and discussion during the meeting which should include the rationale for the decision and any uncertainties or disagreements about the management plan. A proforma should be used where the electronic record is not available.

3.c.4 All core cancer data items are collected and agreed during the MDT meeting and completed in real time, where feasible. Some MDTs will wish to collect as much of the data items prior to the meeting to save time but it is the function of the MDT to check that these are correct.

3.c.5 All mobile phones are turned off or on silent during the meeting. If phone calls need to be taken during the meeting the person taking the call should leave the room to minimise disruption to the meeting.

3.c.6 There is effective and timely chairing and co-ordination throughout the meeting.

3.d Processes and Co-ordination Post Meeting

3.d.1 Ensure processes are in place:

- For communicating MDT recommendations to patients, GPs, and clinical teams within a timely manner eg, patient clinics following the MDT or the next day, where feasible, GP letters, Minutes of the MDT meeting
- To ensure a copy of the MDT recommendations is placed in the patient’s notes (paper or electronic)
- To ensure that patient’s information needs are assessed and met
- To ensure outcomes agreed at the meeting are implemented
- To ensure the MDT is notified of any significant changes made to their recommended treatment plan. It is the responsibility of the clinician responsible for the care of the patient to update the MDT
- To manage patient referrals made between other MDTs (this includes referrals to MDTs in a different provider)
- To track patients through their pathway to ensure that any tests, treatments or appointments are carried out in a timely manner ie, within cancer waiting times targets, where applicable.

3.d.2 Complete data items from cancer datasets if this has not already been done within the meeting.
4. Patient-Centred Decision Making

4.a Who gets discussed at the Meeting?

4.a.1 Local processes should be in place to ensure that all newly diagnosed cancer patients are discussed at the local MDT meeting.

4.a.2 Processes should be in place for all relevant patients to be listed onto the appropriate network MDT for discussion.

4.a.3 Specified referral criteria should be in place so it is clear when to send a case to a MDT for discussion. All teams should have clear guidance as to:

- Which patients should be discussed
- The reason for discussion by the MDT
- What information has to be available to aid the MDT discussion
- When to refer a patient onto another MDT (for example, from local to network).

4.a.4 There is local agreement about if and when patients with advanced or recurrent disease should be re-discussed at the MDT.

4.a.5 A clinician can bring private patient cases to the MDT for discussion provided there is time within the meeting. Any reimbursement arrangements are for local determination.

4.b Patient-Centred Care

4.b.1 Patients are aware of the MDT, its purpose, who attends and when it meets. Patients should be informed that their case is being or has been discussed and are given the outcome within a timely manner.

4.b.2 The patients’ view, preferences and holistic needs are presented by a member of the MDT who has met the patient, or if unable to do so, ensure that an appropriate colleague/member of that specialty team are fully briefed and able to present the case for discussion.

4.b.3 A member of the MDT is responsible for identifying or notifying the MDT of the patients key worker. This should be recorded onto Canisc.

4.b.4 A member of the MDT is responsible for ensuring that the patients information needs have been, or will be addressed/assessed.

4.b.5 Patients are given information consistent with their wishes, on their cancer, their diagnosis and treatment options. This should include therapies that may be available by referral to other MDTs, sufficient to make a well informed decision on their treatment and care.

4.c Clinical Decision Making Process

The role of the MDT is to support clinicians and patients to agree the most appropriate care plan. It is however the responsibility of the clinician supervising the case to deliver the most appropriate treatment, which should be in light of the recommendations of the MDT.
4.c.1 An agreed dataset of information is provided at the MDT meeting which should include diagnostic information (pathology and radiology), all clinical information (co-morbidities, psychosocial and specialist palliative care needs), the patients history, views and preferences, where possible. The combined information will allow the MDT to make an informed treatment recommendation. It is important that all data items collected locally are in existing datasets and are within the NHS Data Dictionary which aligns consistent data definitions and codes.

4.c.2 MDTs consider all clinically appropriate treatment options for a patient even those they cannot offer or provide locally.

4.c.3 MDTs have access to a list of all current and relevant clinical trials. Patients suitability for clinical trials should be part of the decision making process. A clinical trials co-ordinator or research nurse should attend MDT meetings, where feasible and applicable.

4.c.4 All Wales standard treatment protocols are in place and used whenever appropriate.

4.c.5 A patients demographic profile and co-morbidities are always considered.

4.c.6 A patients psychosocial, supportive and palliative care needs are always considered.

4.c.7 A patients view, preferences and needs should inform the decision-making process where possible.

4.c.8 MDT discussions should result in clear recommendations leading to an appropriate treatment plan. These recommendations are:

- Evidence based (in line with NICE and/or Cancer Network Guidelines)
- Patient-centred
- In line with standard treatment protocols unless there is a good reason against this, which should then be documented. The majority of patients’ treatment should be protocol driven and should not necessarily require a prolonged discussion.

4.c.9 MDT recommendations are only as good as the information available to base decisions on. If there are concerns that key data is missing this should be documented and discussed in a subsequent meeting.

4.c.10 It is clear who will communicate the MDTs recommendations to the patient, GP and clinical team.

5. MDT Governance

5.a Organisation Support

5.a.1 There is organisational support for MDT meetings and MDT membership demonstrated via:

- The recognition that MDTs are the accepted model by which to deliver safe and high quality cancer care
Adequate funding and resources in terms of people, time, equipment and facilities for MDT meetings to operate effectively.

5.a.2 Health Boards monitor all MDTs annual assessments of compliance within the National Cancer Standards and act on all issues of concern.

5.b **Data Collection, Analysis and Audit of Outcomes**

5.b.1 Every MDT has an MDT co-ordinator to assist the MDT in its data collection processes relating to the MDT.

5.b.2 Key information that directly affects treatment decisions (such as staging, performance status, co-morbidities, treatment plan) is collected at the MDT.

5.b.3 All dataset data items are populated prior to or during the MDT meeting where possible. If this is not possible this can take place shortly after the meetings.

5.b.4 Data collected during MDT meetings is analysed and fed back to MDTs to support learning.

5.b.5 The MDT takes part in internal and external audits of process, outcomes and reviews of audit data.

5.b.7 MDTs consider and act on clinical outcome data as it becomes available for example, through peer review, clinical group meetings etc.

5.b.8 MDTs complete surveys regarding MDT working. Action is taken by MDTs to implement changes as required.

5.b.9 The MDT Working Charter has fallen short of mandating the use of the Canisc MDM Module. It is strongly advised however that if this system is not used, alternative systems are put in place so that clinical decisions and the data on which they are made, are displayed to the whole MDT, that data is validated in real time and that all data is subsequently entered into Canisc against the unique MDT identifier code. A Canisc Team Set up form is required to be completed for all MDTs who use the MDM module, see Appendix 3.

5.b.10 MDTs will be visited by a member of the Network Information Team. An MDT criteria checklist, see Appendix 4, will be completed to record MDT functionality which will be used for feedback to MDTs and to Health Board Cancer Services. The completed MDT criteria checklist will also be used to aid the Site Specific Peer Review process.

5.c **Clinical Governance**

5.c.1 The purpose of the MDT and its expected outcomes are clearly defined. The role of the MDT is an advisory one. However, different views should be recorded and treatment given in the light of consensus opinion from the appropriate specialist team.

If any member of the MDT has concerns over the behaviour or practice of any other member of the MDT, this should be reported to the MDT Lead and/or the appropriate Health Board Manager(s).

5.c.2 There are agreed operational policies and guidelines/protocols for:
- How the MDT operates and discusses the way it operates ie through regular business meetings
- The role of local and tertiary MDTs where these exist
- Who are core members and extended members
- The roles of core members
- How members should work together
- Documentation of agreed patient pathways
- How changes in clinical practice are to be managed
- Procedures for communication post MDT meeting eg, to patients, GPs and other multi-disciplinary members.

The Abertawe Bro Morgannwg University Health Board agreed to permit access to their draft MDT operational policy as a sample template for use by other multidisciplinary teams:


5.c.3 MDT operational policies and guidelines/protocols are reviewed annually.

5.c.4 There are procedures in place to:
- Record the MDT recommendations versus the actual treatment given. The MDT should be notified if their treatment recommendations are not adopted and the reason for this. Wherever possible this should be done before the treatment is undertaken
- Regular audits should be undertaken to ensure agreed clinical pathways are being followed
- Ensure that the MDT is alerted to any serious treatment complications and adverse/unexpected events or death in treatment.

5.c.5 The MDT are able to monitor MDT activity.

5.c.6 It is recommended that MDTs produce an annual report which outlines MDT activities and audits. This can also be used to aid the Site Specific Peer Review process.

5.c.7 The MDT shares good practice and discusses local problem areas with MDTs within its own Health Board/Network.

5.c.8 The MDT has representation on the National and Network Advisory Groups for its cancer site and a representative attends the meetings or sends a deputy.

5.c.9 Significant discrepancies in pathology, radiology or clinical findings identified at local or network MDMs should be recorded and fed back for review in pathology or radiology discrepancy meetings. Supplementary reports must be issued either by the primary reporting pathologist/radiologist or the MDT pathologist/radiologist. For radiology this may be done by adding a chapter to the initial report or creating a new 'RADIS MDT' report. See appendix 1&2.

5.c.10 The MDT annually assesses its own effectiveness and performance and where possible benchmarks itself against similar MDTs making use of the Site Specific Peer Review processes. The results of the assessment are acted on by the MDT and Health Board.
6. Peer Review

The Peer Review process for cancer services, led by the Health Inspectorate Wales working in partnership with the Cancer Networks in North and South Wales, was launched in 2012 and will focus on the quality assurance measures required to improve both the quality and safety of cancer services within the revised structures of NHS Wales. The process will facilitate sustainable improvements in the delivery of high quality cancer services through links to the governance and accountability framework for each Health Board and NHS Trust. This will also be an important development in supporting the monitoring of the ‘Standards for Health Services’ introduced in April 2010 to provide a clear framework against which the quality, safety and overall effectiveness of the services are judged for all organisations.

In Wales, the Peer Review framework will comprise of three levels:

1. Internally validated self-assessments
2. Externally verified self-assessments
3. Peer Review selected visits

The broad aims of Peer Review are to ensure the safe provision of services through improvements in the quality and effectiveness of cancer care, and to ensure that it makes the best use of clinical time, may be used in any service and upholds the following key principles:

- A clinically led approach
- National consistency in delivery
- A focus on improvement
- A focus on systems and services within and across organisations in a network to ensure coordination of patient care
- A focus on coordination of patient pathways
- Peer on peer review
- Integration with other review systems
- Patient and Carer involvement
- Greater focus on self assessments and internal quality assurance
- A targeted and proportionate visit program
- Better use of resources
- Responsiveness to NHS changes
- Greater emphasis on outcomes

The Peer Review process also takes into account Performance Measures, Cancer Delivery Plan, Cancer Standards, National Audits, Clinical and Quality Indicators as decided by the relevant Cancer National Specialist Advisory Group site specific cancer teams, and any National Institute for Health & Clinical Excellence guidance/standards. For further information on Cancer Services Peer Review, see link: 
The Role of the Pathologist at MDT

The Pathologist is a core member of the MDT team. Pathology plays a key role in the diagnosis, staging, management and research of cancer. The Pathologist or their deputy should have the level of expertise and specialisation required by the MDT.

Pathology input to the MDT can consist of one or more of the following:
- Verbal confirmation of pathology reports already provided by another pathologist but not reviewed by the MDT pathologist.
- Demonstration of the pathology findings.
- Review of the pathology with a confirmatory or supplementary report to the MDT.
- Discussion of the pathology report, differential diagnosis and significance for patient management, clinical trials or research.

The degree of pathology input required at the MDT should be decided by local agreement with the Chair and other core members, and should be recognised in the Pathologists job plan.

Within the MDT different patient groups may need different input from the Pathologist depending on tumour type, clinical setting and specialist nature of the MDT. Organisation of the MDT should reflect the different input needs.

The Pathologist should be aware of the reason for discussion at MDT and tailor the input required to the MDT requirements.

If an additional or specialist opinion is provided by the MDT pathologist it is their responsibility to convey that opinion in a supplementary pathology report that accompanies the primary report. This can be done directly by the MDT Pathologist or via the primary reporting pathologist, according to local arrangements.

Second and/or specialist review of pathology is an important means of ensuring a consistent quality of pathology reports and for access to specialist opinions. Review for MDT is also a significant source of additional workload for Consultant Pathologists. The Pathologist should initiate discussions on the organisation of the MDT that would facilitate pathology review and maximise the benefit of second opinions.

The Pathologist also provides an educational role at MDT by:
- Promoting awareness of aetiological and prognostic factors
- Discussing differential diagnosis
- Promoting appropriate requests for investigations and provision of adequate clinical history

The Pathologist and the pathology report play a key role in the selection of patients for clinical trials and research.

Dr Kenneth May
Consultant Histopathologist
Cardiff & Vale University Health Board

Dr James Harrison
Consultant Histopathologist
Aneurin Bevan Health Board

30 November 2012
The Role of the Radiologist at an MDT

- The Radiologist is a core member of the MDT. Radiology plays a key role in the diagnosis, staging, management and research into cancer. The Radiologist also provides an educational role at the MDM by discussing differential diagnosis and advising appropriate further investigations.

- There should be a lead Radiologist and ideally a deputy for each cancer subsite.

- The lead Radiologist/deputy should have the level of expertise and specialisation required by the MDM.

- The lead Radiologist/deputy for the MDM should perform and report the majority of imaging for that cancer subsite. Radiology reports should include sufficient detail to enable a radiological TNM (or other) stage to be assessed when performed as a staging scan. The conclusion should contain a radiological TNM stage. For PET-CT the Radiologist should be able to display the images and demonstrate the salient features.

- The lead Radiologist/deputy should review the images prior to the MDM.

- The lead Radiologist/deputy should attend the MDM regularly (>90%) .

- If, following the MDM, there is a significant discrepancy in the interpretation of the radiology with respect to staging, extent of disease etc, a supplementary report should be issued. The supplementary report could either be a formal “RADIS MDT” report with the creation of a separate Radis and PACS visit or a second chapter to the last radiology visit. Both options should clearly state “supplementary report following MDM discussion on xx/xx/xxxx”.

- Radiologists should have dedicated time in their job plans to account for preparation time and attendance at the MDM.

Dr Mark Robinson
Consultant Radiologist
Aneurin Bevan Health Board

Dr Rhian Rhys
Consultant Radiologist
Cwm Taf Health Board

29 April 2014

References

1 - Objective 7.5, Generic Cancer Standards, Cancer NSAG
2 - Objective 4.1, Generic Cancer Standards, Cancer NSAG
Canisc Request Form for Multidisciplinary Team Set Up or Amendment

**Team Members**

Please complete each item for *all* team members and their nominated cover. (There must always be an MDM coordinator and someone to deputise in their absence).

**Note:** all team members who do not already have a Canisc account, but require Canisc access, will additionally require a New User Form completed.

<table>
<thead>
<tr>
<th>Full Name</th>
<th>Canisc User Name</th>
<th>GMC No (Clinicians only)</th>
<th>Organisation (representing for MDT)</th>
<th>Start Date at organisation</th>
<th>Speciality</th>
<th>MDT Membership Type (Healthcare Professional Type)</th>
<th>Role in Team (eg Histopathology, Radiology)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MDM coordinator</td>
<td>MDM coordinator</td>
</tr>
</tbody>
</table>

**Team Details**

<table>
<thead>
<tr>
<th>Team Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team Specialty</td>
</tr>
<tr>
<td>Start Date</td>
</tr>
<tr>
<td>Organisation where the MDT is held</td>
</tr>
<tr>
<td>If Network or Supra-Network MDT, other organisations involved</td>
</tr>
</tbody>
</table>

**MDM Meeting (‘Clinic’) Setup**

<table>
<thead>
<tr>
<th>Clinic Title/Description (max 40 characters)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic Code (max 10 characters)</td>
</tr>
<tr>
<td>Type of MDT Local/Network/Supra-Network</td>
</tr>
<tr>
<td>Start Date of MDM</td>
</tr>
<tr>
<td>Lead Clinician</td>
</tr>
</tbody>
</table>
Day of the week meeting held
Weeks of month held
Start Time of meeting
End Time of meeting
Location

Team Document Header and Footer

Note that the MDM meeting (‘clinic’) will be set up with the following Rules, unless otherwise stated:

<table>
<thead>
<tr>
<th>Rule</th>
<th>Default</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slot Size</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Slot Size (new patients)</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Default patient/slot</td>
<td>3</td>
</tr>
<tr>
<td>Default overbooks/slot</td>
<td>0</td>
</tr>
<tr>
<td>Max new patients</td>
<td>30</td>
</tr>
<tr>
<td>Max old patients</td>
<td>30</td>
</tr>
<tr>
<td>Max patient slots used</td>
<td>30</td>
</tr>
<tr>
<td>Max overbooks per meeting</td>
<td>0</td>
</tr>
</tbody>
</table>

Signature of Canisc Trainer/MDT Lead/ MDT Co-ordinator……………………………………………………………….. Date ………………………………

On completion of this form, please return to the Canisc Team at the relevant Cancer Network Office.
# MDT Criteria Checklist

## MDT Charter Criteria

<table>
<thead>
<tr>
<th>Membership</th>
<th>Y/N</th>
<th>Additional Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core professionals/disciplines (or nominated cover) are represented within the team</td>
<td></td>
<td>(assess via register of attendance &amp; operational guidelines - core MDT members)</td>
</tr>
<tr>
<td>MDT co-ordinator recognised as a core member of the team (acknowledged, respected &amp; included)</td>
<td></td>
<td>personal observation during meeting</td>
</tr>
</tbody>
</table>

## Attendance

| A register of attendance is in place                                       |     | copy of register of attendance required                                              |
| Core members (nominated cover) are present for discussion of their own patients |     | assess via register of attendance + MDM List                                        |

## Leadership

| MDT Chair qualities:                                                      |     | personal observation during meeting                                                  |
| Excellent Communication skills (focuses discussions; clear articulation of decisions) |     |                                                                                     |
| Effective leadership qualities (firm/fair/calm)                           |     | personal observation during meeting                                                  |
| Enforces good clinical decision making & case management                 |     | personal observation during meeting                                                  |
| Good time keeper (meeting starts & ends on time)                          |     | personal observation during meeting                                                  |
| Ensures all relevant cases are prioritised and discussed                 |     | assess via MDM list + ? Check with MDT lead                                        |

## Team Working & Culture

<p>| Constructive discussion &amp; 'healthy' debate is encouraged amongst team members |     | personal observation during meeting                                                  |
| Mutual respect, courtesy and consideration between members                |     | personal observation during meeting                                                  |</p>
<table>
<thead>
<tr>
<th><strong>Meeting Infrastructure</strong></th>
<th><strong>Criteria Guidelines</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Meeting Venue</strong></td>
<td></td>
</tr>
<tr>
<td>Dedicated ‘quiet’ meeting room available (confidentiality needs to be observed)</td>
<td>assessment of venue &amp; location prior to meeting</td>
</tr>
<tr>
<td>Adequate space &amp; seating to accommodate all team members</td>
<td>personal observation during meeting + check with team members</td>
</tr>
<tr>
<td>Comfortable room temperature</td>
<td>personal observation during meeting + check with team members</td>
</tr>
<tr>
<td>Good acoustics (all members able to hear discussions)</td>
<td>personal observation during meeting + check with team members</td>
</tr>
<tr>
<td>Room layout allows all team members to view images, histopathology etc</td>
<td>personal observation during meeting + check with team members</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Technology &amp; Equipment</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully functioning video-conferencing facilities (good quality sound &amp; images)</td>
<td>assessment of equipment prior to meeting; personal observation during meeting + check with team members</td>
</tr>
<tr>
<td>Fully functioning equipment to view radiology and histopathology images (high quality images)</td>
<td>personal observation during meeting + check with radiologist/histopathologist</td>
</tr>
<tr>
<td>Adequate Computer facilities to enable live data collection (if appropriate)</td>
<td>assessment of equipment prior to meeting; personal observation during meeting + check MDT co-ordinator</td>
</tr>
<tr>
<td>IT support readily available or easily accessible</td>
<td>personal observation during meeting + check with MDT co-ordinator</td>
</tr>
<tr>
<td>Video-conferencing etiquette (volume set to mute unless actively presenting or discussing cases)</td>
<td>personal observation during meeting + check with MDT lead if any guidelines in place</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td>Is the Canisc MDM module used live within the meeting?</td>
<td>If Y selected, please ensure that the MDT has completed a copy of the Canisc MDM Questionnaire</td>
</tr>
<tr>
<td>If Y selected, please ensure that the MDT has completed a copy of the Canisc MDM Questionnaire</td>
<td>Canisc MDT questionnaire to be completed 6 months post ‘Go live’</td>
</tr>
<tr>
<td>Is the Canisc MDM module used administratively?</td>
<td>If Y selected, please give reasons why the MDT is using administratively &amp; not live within the meeting</td>
</tr>
</tbody>
</table>

### Meeting Organisation & Logistics

<table>
<thead>
<tr>
<th>Patients listed for discussion have been authorised by the MDT chair and follow MDT guidelines</th>
<th>check processes with MDT co-ordinator + MDT lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDT patient list has been circulated to all team members in a timely fashion prior to the meeting</td>
<td>check processes with MDT co-ordinator + check with team members</td>
</tr>
<tr>
<td>Reason for patient discussion is clearly documented</td>
<td>personal observation during meeting</td>
</tr>
<tr>
<td>All relevant clinical information is available for all patients listed for discussion</td>
<td>personal observation during meeting</td>
</tr>
<tr>
<td>Key information including staging, performance status, co-morbidities &amp; treatment plan is captured in the MDT</td>
<td>personal observation during meeting</td>
</tr>
<tr>
<td>All actions/outcomes/MDT recommendations are clearly documented during the meeting</td>
<td>personal observation during meeting</td>
</tr>
</tbody>
</table>