

Supporting Data: 5

Multidisciplinary team working

Contents

<u>Multidisciplinary team-working (MDT) defined</u>	3
<u>1. Is the concept well-accepted by doctors?</u>	4
<u>2. Patient-planning MDTs</u>	5
2.1 Prevalence	5
2.2 Membership	6
2.2.1 The main members by type of cancer	6
2.2.2 Other members, by type of cancer	7
2.2.3 Attendance	8
2.3 Are all patients discussed?	8
2.3.1 Types of patient discussed	8
2.3.2 Numbers discussed	9
2.3.3 Patients not discussed because their consultants do not attend MDTs	9
2.4 Purpose of MDT	11
2.5 Processes	12
2.5.1 How often meetings are held	12
2.5.2 Administrative support	13
2.5.3 Records	13
2.5.3.1 Written statement of purpose	13
2.5.3.2 Minutes	14
2.5.4 When MDTs occur and how long they take	14
2.5.5 Case study: tele-medicine	15
2.6 Is the nursing viewpoint reflected?	16
<u>3. Joint clinics</u>	17
3.1 Prevalence	17
3.2 Are all patients seen?	18
<u>References</u>	18

Multidisciplinary team-working (MDT) defined

Interviewees during CHI/AC visits described different types of MDT, especially:

- *patient-planning MDT*: a regular meeting to review patients (usually via case notes);
- *joint clinic*: joint or parallel clinics held between, eg, the lead surgeon for a particular type of cancer and the nominated non-surgical oncologist, or between the lead surgeon and clinical nurse specialist; and
- *general meetings*: general education/ audit meetings, often consisting mainly of the consultants within a particular discipline and their medical trainees, where 'interesting' or complex cases are reviewed, and the patients discussed are often not solely cancer patients.

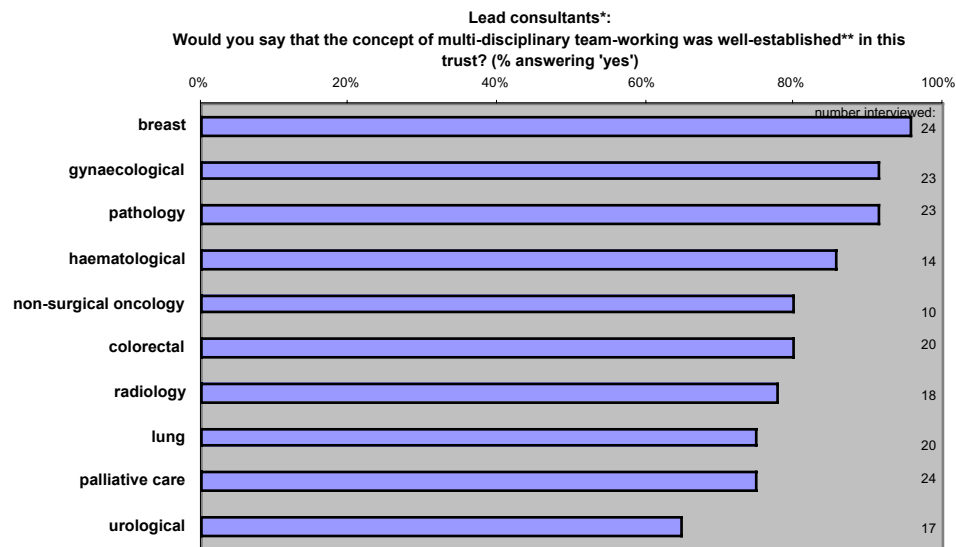
The English Manual of Cancer Services Standards defines the objectives of multidisciplinary team-working as:

- "To ensure that designated specialists work effectively together in teams so that decisions regarding all aspects of diagnosis, treatment and care of individual patients and decisions regarding the team's operational policies are multidisciplinary decisions.
- To ensure that care is given according to recognised guidelines (including guidelines for onward referrals) with appropriate information being collected to inform clinical decision making and to support clinical governance /audit.
- To ensure that mechanisms are in place to support entry of eligible patients into clinical trials, subject to patients giving fully informed consent." (p.9)¹

Calman-Hine report: 'Multi-disciplinary consultation and management are essential' (p.11).²

1 Is the concept well-accepted by doctors?

Figure 1
The views of lead cancer consultants about whether the concept of MDT is well-established



*clinical director or department head for non-surgical oncology; clinical director or cancer lead for radiology and pathology
** well-established for the cancer type in question, or generally-speaking by non-surgical oncologists, pathologists and radiologists

Individual non-surgical oncologists were also asked this question: 30 of 36 said 'yes'.

Source: CHI/AC site visits: 19 trusts/hospitals within nine networks (one network per English region and one in Wales, winter 2000/01)

Table 1
The views of lead consultants about whether MDT arrangements are an effective use of time

<i>'Do you have any views about the relative benefits of MDT meetings, when set against the time costs for those involved in the meetings?'</i>	<i>benefits outweigh time</i>	<i>benefits do NOT outweigh time</i>	<i>mixed answers</i>
acute trust lead cancer doctors	14	1	4
breast cancer lead consultant	20		1
colorectal	6		6
urological	9	1	2
palliative	18	1	
pathology	16	2	
radiology	20	2	

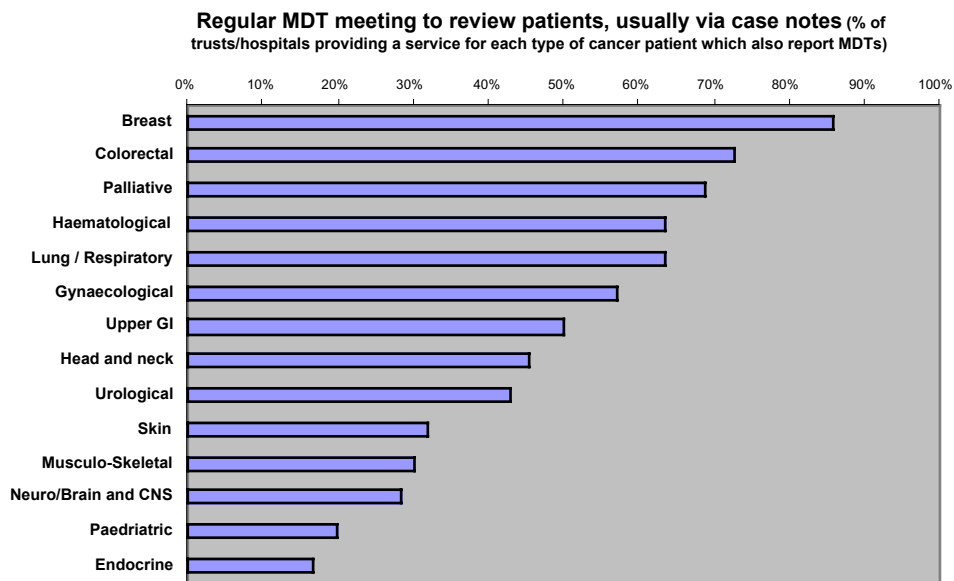
Source: CHI/AC interviews within nine networks (one network per English region and one in Wales, winter 2000/01)

2 Patient-planning MDTs

2.1 Prevalence

Figure 2

The percentage of trusts/hospitals that report regular patient-planning MDTs, by type of cancer



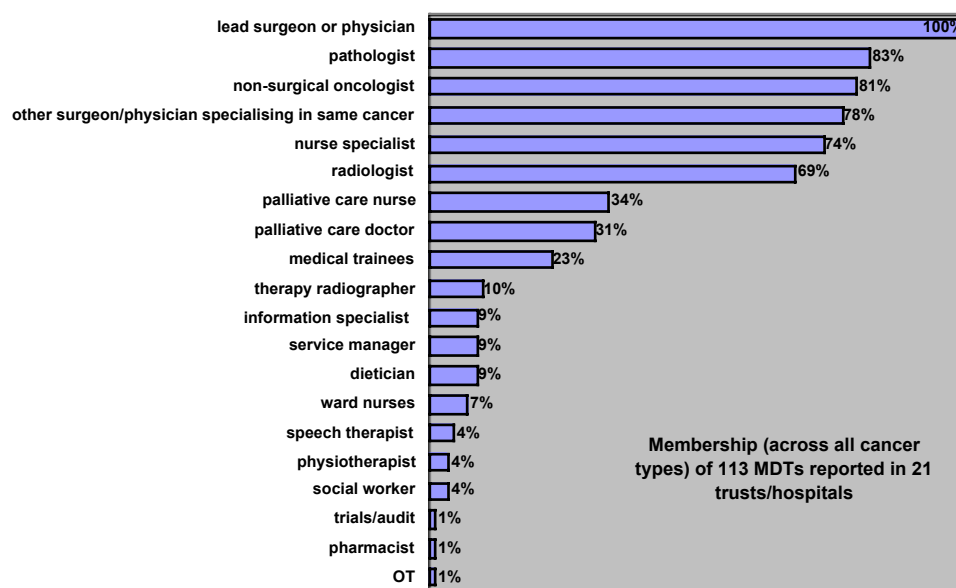
Note: one network did not return this form, but interviews suggest that MDT is under-developed in several key types of cancer.

Source: CHI/AC site visits: 22 trusts/hospitals within nine networks (one network per English region and one in Wales, winter 2000/01)

2.2 Membership

Figure 3

The membership of patient-planning MDTs, across all cancer types



Note: Nominated membership does not necessarily mean that these people are able to attend all meetings.

Source: CHI/AC site visits: 21 trusts/hospitals within nine networks (one network per English region and one in Wales, winter 2000/01)

2.2.1 The main members by type of cancer

Table 2

The main members of patient-planning MDTs, by type of cancer

For trusts/hospitals reporting that a regular meeting to review patients is held, the number reporting that these people are nominated to attend:

	<i>lead surgeon or physician</i>	<i>other surgeons specialising</i>	<i>non-surgical oncologist</i>	<i>nurse specialist</i>	<i>pathologist</i>	<i>radiologist</i>	<i>palliative care nurse</i>	<i>palliative care doctor</i>
All cancer types	113	88	91	84	94	78	38	35
Breast	18	13	18	18	18	18	4	3
Colorectal	15	13	14	14	12	11	6	6
Gynaecological	13	10	10	7	12	10	5	2
Haematological	11	10	6	8	10	7	3	2
Head/Neck	9	7	8	6	6	7	3	3
Lung	15	10	14	11	10	13	6	5
Palliative	5	4	3	7	2	2	8	7
Skin	8	5	3	2	5	0	0	0
Upper GI	11	10	9	6	11	7	3	6
Urological	8	6	6	5	8	3	0	1

Source: CHI/AC site visits: 21 trusts/hospitals within nine networks (one network per English region and one in Wales, winter 2000/01)

By definition, a clinical nurse specialist (CNS) can only attend an MDT if there is a nurse in-post. The above table could thus reflect either a lack of posts and/or that some existing CNSs are not nominated to attend. The following table excludes lack of posts as a factor:

Table 3
Whether CNSs regularly attend MDT meetings

<i>'Do you regularly attend MDT meetings?'</i>	<i>yes</i>	<i>no</i>	<i>unsure</i>	<i>partly*</i>
breast cancer CNS	20	0	0	1
colorectal	19	2	0	0
gynaecological	5	2	0	0
haematological	3	1	0	2
lung	16	1	0	0
urological	7	5	0	1
palliative [attending tumour-specific MDTs]	14	6	1	0

* In these cases, the responses were partly yes and partly no.

Source: CHI/AC interviews within nine networks (one network per English region and one in Wales, winter 2000/01)

2.2.2 Other members, by type of cancer

Table 4
Other members of patient-planning MDTs, by type of cancer, listed by those completing our forms

	<i>medical trainees</i>	<i>therapy radio-grapher</i>	<i>dietician</i>	<i>info. specialist</i>	<i>service manager</i>	<i>ward nurses</i>	<i>speech therapist</i>	<i>physio-therapist</i>	<i>social worker</i>
All cancer types	26	11	10	10	10	8	5	4	4
Breast	3	6		3	2				
Colorectal	4	1	2	1	2	1			
Gynaecological	3			1	1	1			
Haematological	3		2	1	1	2		1	
Head/neck	4		4	1		1	4	1	
Lung / Respiratory	3	2		1	1	1		1	
Musculo-Skeletal	1	1				1	1		1
Palliative	1			2	1				2
Skin					1			1	1
Upper GI	2	1	2		1				
Urological	2					1			

Source: CHI/AC site visits: 18 trusts/hospitals within nine networks (one network per English region and one in Wales, winter 2000/01)

Interviewed gynaecological ward sisters: ‘Do any of the ward nurses attend gynaecological cancer multidisciplinary team meetings?’:

- ‘yes’ = 2;
- ‘no’ = 13.

2.2.3 Attendance

Table 5
Attendance at a weekly breast cancer MDT over a six-month period in 2000, at one trust

<i>Member</i>	<i>Meetings attended (%)</i>
Lead clinician	85%
Second designated surgeon	100%
Pathologist	100%
Radiologist	100%
Non-surgical oncologist	75%
Clinical nurse specialist	100%

Meetings missed due to annual leave or other clinical commitments.

Source: extracted from data provided by a CHI/AC study site

2.3 Are all patients discussed?

2.3.1 Types of patient discussed

Table 6
Which types of patients are discussed at MDTs

<i>What proportion of new referrals are usually reviewed?</i>	<i>Number of MDTs</i>	<i>%</i>
1. all new referrals	14	35%
2. difficult/problematic cases only	3	8%
3. likely cancers only	7	18%
4. diagnosed cancers only	15	38%
5. potentially curative only	1	3%

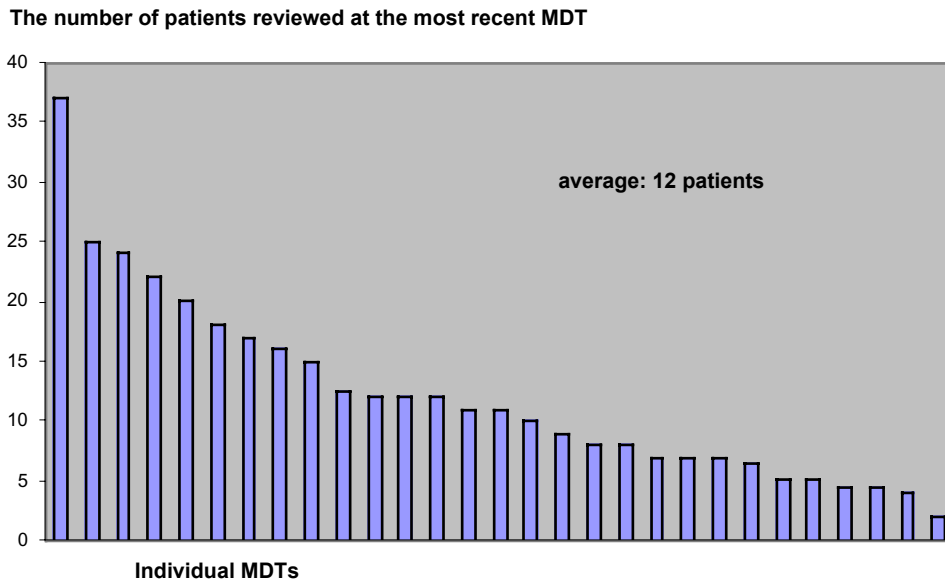
<i>Whether ongoing cases are reviewed:</i>	<i>Number of MDTs</i>	<i>%</i>
1. All active cases	11	32%
2. difficult/problematic cases only	22	65%
3. Ongoing cases are not reviewed	1	3%

Combined results from MDTs for the different types of cancer; not all MDTs completed every section of the checklists.

Source: CHI/AC checklists from 46 MDTs from 20 hospitals/trusts within nine networks (one network per English region and one in Wales, winter 2000/01)

2.3.2 Numbers discussed

Figure 4
The number of patients discussed at MDTs

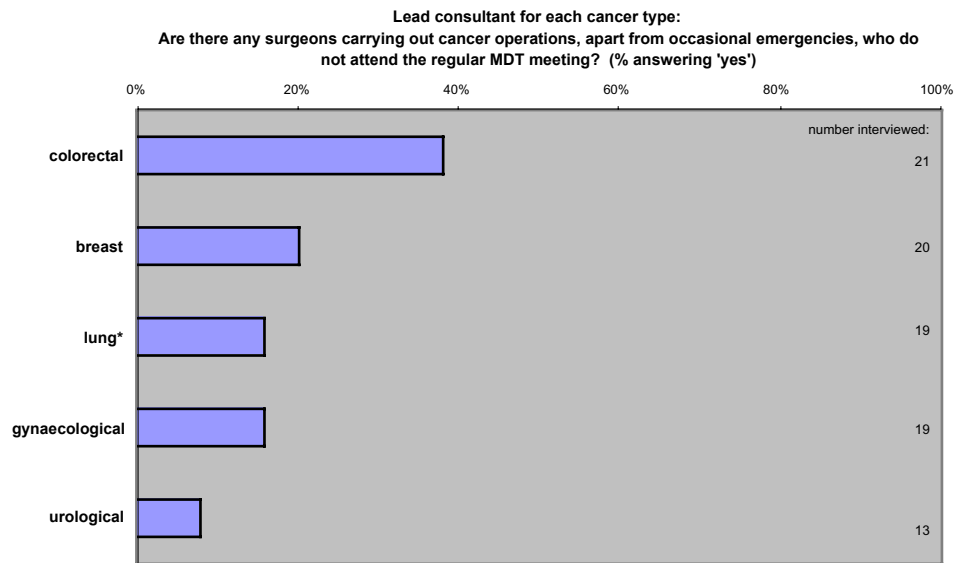


Combined results from MDTs for the different types of cancer.

Source: CHI/AC checklists from 46 MDTs from 20 hospitals/trusts within nine networks (one network per English region and one in Wales, winter 2000/01)

2.3.3 Patients not discussed because their consultants do not attend MDTs

Figure 5
The percentage of lead consultants stating that there are surgeons (or physicians) managing cancer patients that do not attend MDTs



*lung cancer physicians were asked: 'any physicians managing patients'

Source: CHI/AC site visits: 21 trusts/hospitals within nine networks (one network per English region and one in Wales, winter 2000/01)

Table 7
Whether the patients of doctors that do not attend MDTs are still discussed at the MDT

<i>Where 100% specialisation has not been achieved, are the more 'occasional' or generalists' cases coming to the MDT for discussion?</i>	<i>yes</i>	<i>no</i>	<i>unsure</i>	<i>partly</i>
Acute trust lead doctors	5	4	1	2
<i>Where there are patients whose doctor does not attend the MDT, is there a mechanism for reviewing their cases via the MDT meeting?</i>	<i>yes</i>	<i>no</i>	<i>unsure</i>	<i>partly</i>
Breast cancer designated lead doctor	3	0	0	2
Colorectal	4	3	0	1
Gynaecological	1	1	0	1
Urological	2	0	0	3
Lung	2	1	1	0

Source: CHI/AC interviews within nine networks (one network per English region and one in Wales, winter 2000/01)

CASE STUDIES:

One visited trust reported that there are eight surgeons carrying out colorectal cancer operations, but that only four attended the MDT.

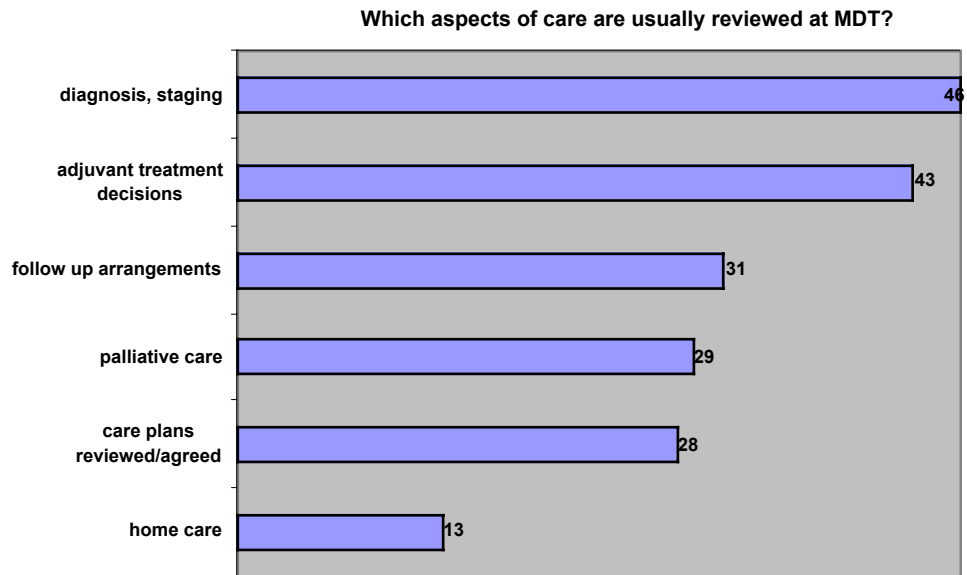
A second visited trust with two main hospitals reported that:

- at one of the hospitals there are two main colorectal cancer surgeons, but only one attends the MDT; the trust estimated that about one-quarter of cases were therefore not discussed at an MDT in this hospital; they also calculated that about one-third of patients are admitted as emergencies, and are therefore not discussed pre-operatively at an MDT; and
- at the second hospital, no MDT arrangements yet exist for colorectal cancer patients.

2.4 Purpose of MDT

Figure 6

Which aspects of care are usually reviewed in MDT meetings?



Combined results from MDTs for the different types of cancer.

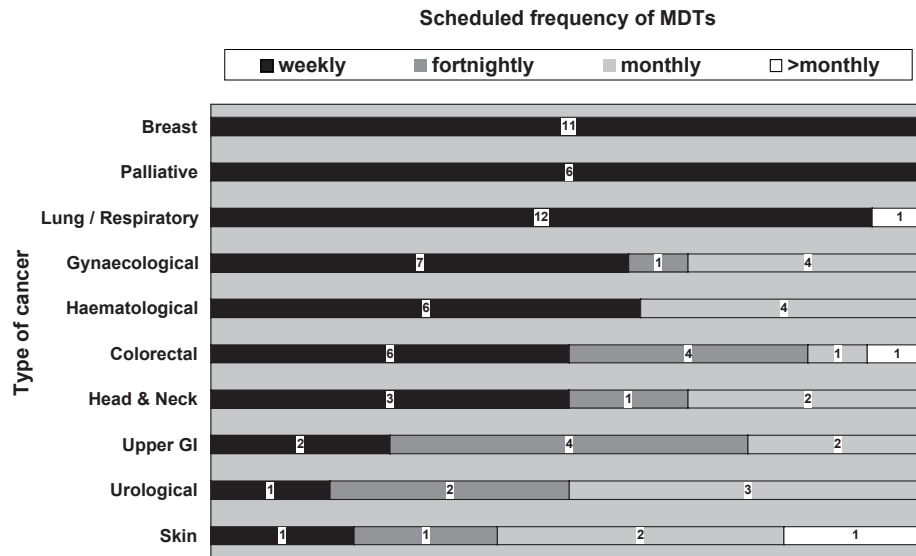
Source: CHI/AC checklists from 46 MDTs from 20 hospitals/trusts within nine networks (one network per English region and one in Wales, winter 2000/01)

2.5 Processes

2.5.1 How often meetings are held

Figure 7

The scheduled frequency of patients planning MDTs



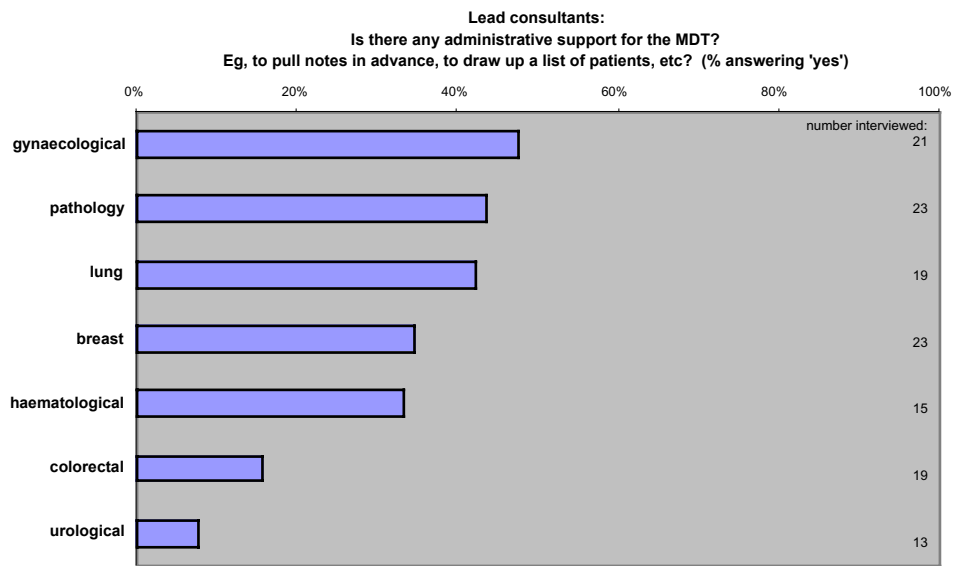
Note: a different number of trusts provided information for each type of cancer. The numbers printed on each bar are the actual number of responses. However the bars have been drawn to a percentage scale to allow for ease of comparison.

Source: CHI/AC site visits: 18 trusts/hospitals within nine networks (one network per English region and one in Wales, winter 2000/01)

2.5.2 Administrative support

Figure 8

Whether there is administrative support available for patient-planning MDTs



Source: CHI/AC site visits: 23 trusts/hospitals within nine networks (one network per English region and one in Wales, winter 2000/01)

2.5.3 Records

2.5.3.1 Written statement of purpose

Table 8

Statements of MDT purpose

Is there a written statement of the agreed purpose? of each MDT	yes	no	unsure	partly
--	-----	----	--------	--------

Acute trust lead cancer doctors	4	13	1	3
---------------------------------	---	----	---	---

Source: CHI/AC interviews within nine networks (one network per English region and one in Wales, winter 2000/01)

2.5.3.2 Minutes

Table 9
Whether minutes are taken at MDT meetings

	<i>A regular meeting to review patients is held (usually via case notes)</i>	<i>Minutes are kept</i>	
Lung / Respiratory	14	8	57%
Colorectal	16	9	56%
Breast	18	10	56%
Neuro/Brain and CNS	4	2	50%
Upper GI	11	5	45%
Gynaecological	12	5	42%
Palliative	11	4	36%
Haematological	14	5	36%
Musculo-Skeletal	3	1	33%
Head and neck	10	3	30%
Urological	9	2	22%
Skin	7	1	14%
Endocrine	2	0	0%
Paediatric	2	0	0%

Source: CHI/AC site visits: 18 trusts/hospitals within nine networks (one network per English region and one in Wales, winter 2000/01)

2.5.4 When MDTs occur and how long they take

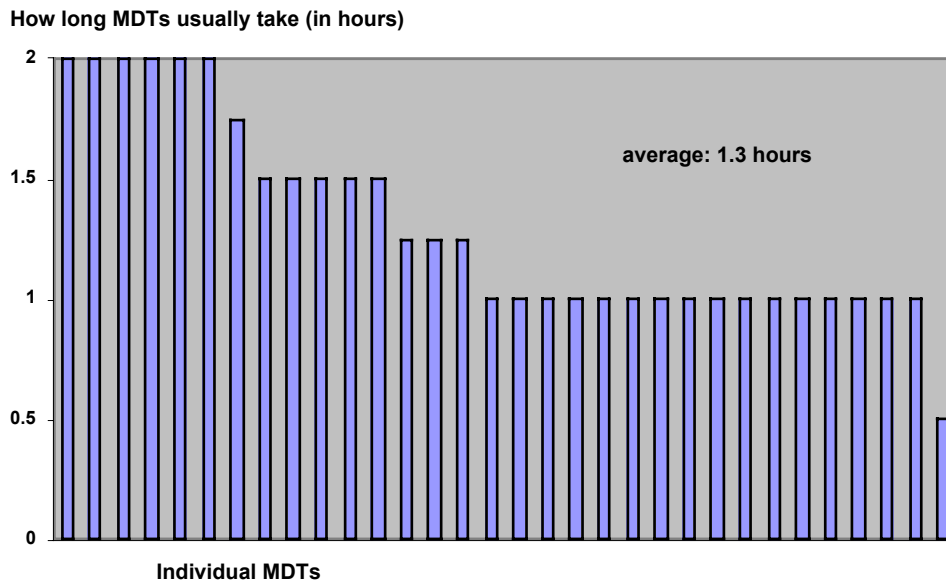
Table 10
Time of day that MDTs take place

<i>Time of day that MDTs usually take place</i>	<i>Number of MDTs</i>	<i>%</i>
1. Meeting is entirely within normal hours	3	9%
2. During lunchtime	17	52%
3. Partly or wholly outside normal hours	13	39%

Combined results from MDTs for the different types of cancer.

Source: CHI/AC checklists from 46 MDTs from 20 hospitals/trusts within nine networks (one network per English region and one in Wales, winter 2000/01)

Figure 9
How long MDTs take



Combined results from MDTs for the different types of cancer.

Source: CHI/AC checklists from 46 MDTs from 20 hospitals/trusts within nine networks (one network per English region and one in Wales, winter 2000/01)

2.5.5 Case study: tele-medicine

Within Ceredigion and Mid Wales NHS Trust, a tele-medicine link has been established at Bronglais Hospital to enable the visiting oncologist to attend all MDT meetings without leaving the cancer centre. Bronglais Hospital is located 2.25 hours drive from the designated cancer centre. Key elements of the service are:

- A tele-medicine link including access to diagnostic information online
- One booked session for MDTs

Outcomes are:

- Oncologist is able to attend all MDTs
- Co-ordinated care for patients
- Better communication and fewer delays for patients

The oncology service provided by the cancer centre includes outreach clinics to Bronglais and one other location in the area on a fortnightly basis. The oncologist does not specialise as patient numbers are low. No time is available for the oncologist to attend MDTs for all specialties.

To overcome this, Bronglais have installed a tele-medicine link which includes making diagnostic information available online. They have a booked session with the oncologist and MDT team members for each specialty attend in succession to meet with the oncologist to discuss patient treatment.

No audit of improvements to outcomes or waiting times has been undertaken. However, the oncologist reported that with the link up he can attend MDT meetings at Bronglais, but cannot attend meetings at two nearer cancer units due to time constraints. The tele-medicine equipment was purchased using charitable funds, and the trust has funded the additional oncology session each week.

2.6 Is the nursing viewpoint reflected?

Table 11
Whether cancer clinical nurse specialists feel that the nursing viewpoint is reflected in MDT meetings

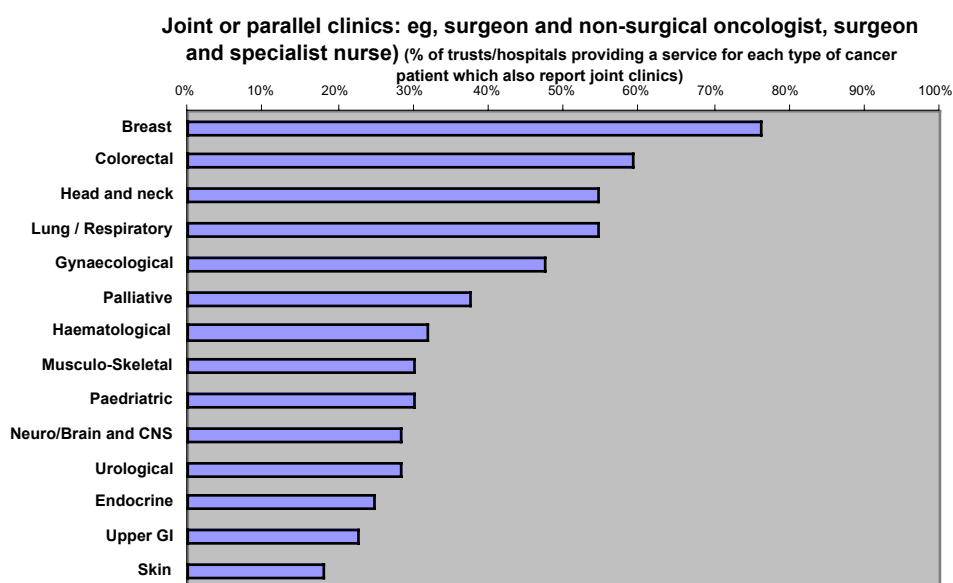
<i>Are you normally satisfied with the outcome of the meetings (eg, you think the treatment plans reflect the necessary nursing input?)</i>	<i>yes</i>	<i>no</i>	<i>unsure</i>	<i>partly</i>
breast cancer CNS	18	1	0	1
colorectal	14	4	0	1
gynaecological	3	0	0	3
haematological	3	0	0	0
lung	11	0	0	1
urological	6	1	1	1
palliative [attending tumour-specific MDTs]	17	2	2	0

Source: CHI/AC interviews within nine networks (one network per English region and one in Wales, winter 2000/01)

3 Joint clinics

3.1 Prevalence

Figure 10
The percentage of trusts/hospitals that report joint or parallel clinics, by type of cancer



Source: CHI/AC site visits: 19 trusts/hospitals within nine networks (one network per English region and one in Wales, winter 2000/01)

Table 12
Variation between trusts/hospitals in the number of regularly-scheduled joint clinics between surgeons and non-surgical oncologists

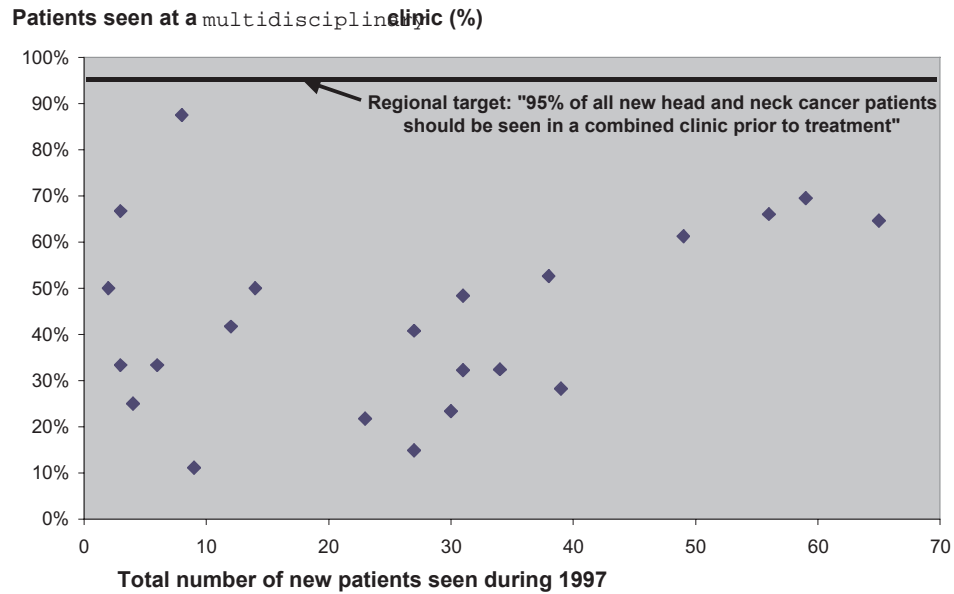
<i>Number of joint clinics within each trust/hospital</i>	<i>Number of replies</i>
0	3
1	2
2	1
3	0
4	3
5	5
6	1

Source: CHI/AC site visits: 15 trusts/hospitals within nine networks (one network per English region and one in Wales, winter 2000/01)

3.2 Are all patients seen?

Figure 11

Patients seen at a multidisciplinary clinic prior to treatment commencing – example for patients diagnosed with head and neck cancers in 1997 at hospitals within one region



Note: Each point represents the average for one hospital trust. N = 591 patients diagnosed in 1997.

Source: Drawn from data in South and West Regional Cancer Organisation Head and Neck Tumour Panel (1999)³

References

- ¹ NHS Executive, 'Manual of Cancer Services Standards', DOH, London, 2000.
- ² Expert Advisory Group on Cancer to the Chief Medical Officers of England and Wales, *A policy framework for commissioning cancer services [The Calman/Hine report]*, DOH, London, 1995.
- ³ South and West Regional Cancer Organisation head and Neck Tumour Panel, *South and West Head and Neck Audit Report*, South and West Cancer Intelligence Unit, Winchester, 1999.