ABS ASSOCIATION OF BREAST SURGERY

BSBR BRITISH SOCIETY OF BREAST RADIOLOGY

ASSOCIATION OF BREAST PATHOLOGY

UKBCG

# Improving the Efficiency of Breast Multidisciplinary Team Meetings:

## A Toolkit for Breast Services

# Appendix 2: Proposal to transform MDTMs

In 2017 the Cancer Transformation Board and Department of Health asked Professor Martin Gore to lead a project whose aim was to transform the working of cancer MDTMs to make them more effective in the light of increasing demands on the service.

The plan was for the reforms to be within the framework set by the recommendations set out in the 2017 Cancer Research UK Report January 2017.

### Aim of MDTM reform

MDTMs to operate more effectively in relation to:

- time
- human resource
- data collection
- decision-making
- audit and bench marking to facilitate improvements in outcomes

### Principles of the new transformed MDTMs

1. Only patients requiring true multidisciplinary input are to be discussed
2. Patients on predetermined agreed algorithms will be recorded and not discussed
3. The time all members of the MDT in general and radiologists and pathologists in particular, spend on MDTMs is to be reduced

### MDTM functioning

1. The MDTM is the forum for a clinician to seek multi-disciplinary/professional advice and input about patient management including investigation, treatment, follow up, ethical and social matters, comorbidities and practical problems
2. The MDTM must not be used as an 'x-ray meeting' or 'pathology meeting'; images and histopathology are not 'to be reviewed' at MDTMs. Separate or sequential meetings must be set aside for such activity
3. Accountability for any intervention remains with the clinician responsible for that intervention
4. MDTM decisions are guidance for the responsible treating clinician
5. Each MDTM will have 2 lists: the first would contain the names of patients who do not require discussion because all their data has been reviewed and is available. These patients will be placed on a pre-agreed, recognised treatment algorithm/pathway. The second list consists of patients who require discussion multi-disciplinary/professional discussion

# Appendix 2: Proposal to transform MDTMs

6. Patients who are not discussed but who are recorded at the MDTM will have their data, treatment and outcome regularly audited for compliance to mandatory dataset collection requirements (local and national)
7. Regular audit will evaluate the acceptability of individual clinician practice in relation to standards of care as determined by MDTM protocols and national guidance
8. The length of MDTMs should have clear limits
9. The time radiologists and pathologists spend in and preparing for, MDTMs must be regularly reviewed. All members of the MDT should engage in ways of reducing the pressure on colleagues in imaging and pathology.
10. Changes in working practice within Departments of Imaging and Pathology need to be explored including making use of resources in a network not simply within an individual Trust, digital pathology, remote reporting etc
11. MDTM processes should be part of a Trust's cancer data collection systems

**Data and Audit**

1. Audit of MDT outcomes and MDTM processes and data will be central to the assurance of standards and mandatory.
2. Audits will be frequent and repetitive in subject matter; frequent data collection lessens the burden reporting as it is less burdensome to collate data for a quarter than a 12-month period. Repeating audits will allow real time assessment of improvements or deteriorations in performance and outcomes within MDTs.
3. Some audit subjects will be compulsory because they will facilitate learning between Alliances, Cancer Centres/Units and MDTs within the same Cancer Centre/Unit.
4. It will necessary to make sure that the processes adopted by and the data generated from the transformed MDTMs are aligned to the requirements of the newly formed Data Coordination Board which has replaced the Standardisation Committee for Care Information at NHS Digital.
5. There is a clear need to transform cancer surgical coding. The new MDTMs will not do this but the systems adopted and data collected will inform future debates on the developments of new systems or the creation of sub-categories within the current systems such as SNOWMED or OPCS.

**Advantages of the reformed working arrangements for MDTMs**

1. Improve patient outcomes by making audit easier and bench marking automatic and potentially in real time
2. Improved effectiveness of the time all members of the MDT in general and radiologists and pathologists in particular, spend on MDTMs
3. Clarification of individual clinician responsibility
4. Clarity of standards of care across England