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

Section 6: Attendance/Scheduling

RECOMMENDATION:

The number of MDTMs per week, their length and timing, their format, the number of cases to be discussed, and those expected to attend should all be determined locally according to the needs and resources of the individual breast service

The local requirements will be determined by a number of factors which will include the size of breast service, the setting (large teaching hospital versus smaller district general hospital), and the number of staff in each discipline participating in the breast MDTM.

The following should be taken into account when planning local needs:

Meeting duration

Careful planning is required to ensure that the duration of the MDTM is appropriate for the anticipated number and complexity of cases to be discussed.

The chair of the MDTM has a key role in ensuring that the MDTM proceeds at an appropriate pace to finish at the scheduled time by keeping the meeting focused and prioritising cases for more detailed discussion.

There is no ideal MDTM time duration but there is evidence that the quality of MDT decision-making is affected by fatigue due to sequential case review over, often prolonged, periods of time[1].

For this reason, MDTMs of long duration should be avoided. Options to achieve this include:

- The introduction of multiple shorter MDTMs
- Streamlining or the introduction of a pre-MDTM triage meeting to reduce caseload
- Scheduling a short (10 minutes) break within a longer meeting if that is the only feasible option[1]
- Scheduling the attendance of participants by discipline to relevant sections of the MDTM

Breast MDTM attendance and quoracy requirements

The core membership requirements for breast MDTs and their defined roles and responsibilities have been defined and regularly updated in UK cancer guidance[2].

Core membership

- 2 designated breast surgeons
- 2 imaging specialists
- 2 histopathologists
- 2 clinical nurse specialists

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- 1 clinical oncologist
- 1 medical oncologist (where the responsibility for chemotherapy is not undertaken by the clinical oncology core member)
- 1 MDT coordinator

Current guidance states that all core members are required to show a personal commitment to attending the MDTM. They are required to attend two thirds (66%) of MDTMs.

- A 'quorate breast MDTM' has been defined, where at least the following should be in attendance:
- 2 designated breast surgeons,
- 1 imaging specialist,
- 1 histopathologist,
- 1 breast nurse specialist,
- 1 clinical oncologist (+/- 1 medical oncologist),
- 1 MDT coordinator.

There is increasing acceptance that precise definitions of 'quoracy' and membership attendance targets are unrealistic. In modern practice they restrict more flexible MDTM working arrangements and as a result they have already been abandoned by many breast MDTs. At a MDTM Streamlining Roundtable event hosted by the Department of Health in April 2019 it was confirmed that attendance and quoracy targets are no longer actively monitored. This allows local MDTs the opportunity to consider the use of more flexible MDTM working arrangements.

Examples of flexible scheduling and attendance at MDTMs:

Staggered attendance of disciplines and individuals within the same MDTM

The 2019 *Survey of breast multidisciplinary team clinicians regarding MDTMs* confirmed that the majority of clinicians in all disciplines involved in breast care see benefit in discussing the care of breast patients at key points in their pathway. However, it also suggested that individual disciplines feel that they may not need to be present for all types of case discussion.

Example: Derby-Burton MDTM (Mark Sibbering)

Dividing the MDTM into defined timetabled sections with differing disciplinary attendance requirements has facilitated individuals being able to contribute to relevant case discussions without having to sit through the entire MDTM.

The MDTM is divided as follows:

a) Metastatic

b) Oncology discussion (including diagnostic cases identified for neoadjuvant treatment)

c) Post-operative

d) Diagnostic core biopsies

e) Non-oncology discussion (mainly imaging cases e.g. MRI scans, CT staging)

Oncologists only attend for a) b) c)

Pathologists only attend for b) c) d)

Radiologists, surgeons and nurses are present throughout the meeting, but different individuals are usually timetabled to attend different sections.

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Splitting a large weekly MDTM into two smaller MDTMs: Timetabling attendance of clinicians

In moderate to large breast services a single weekly MDTM is likely to require a very long meeting where large numbers of cases are discussed. This will usually require a large number of clinicians to attend many of whom will not significantly contribute to the meeting. In addition, cases that miss the MDTM deadline, due to results not being available, have to wait a further full week to be discussed which may delay clinical pathways.

Example: Leicester MDTM (Kelly Lambert)

A large teaching hospital with a breast cancer caseload of over 1000 new cases per annum split their once weekly MDTM into two shorter MDTMs a few days apart (Monday and Thursday).

Clinicians and administrative staff were scheduled to attend one of the shorter MDTMs each week. This was a major challenge in terms of reconfiguration of the service and job planning.

However, the change has facilitated a major improvement through a reduction of MDTM caseload at each MDTM, increased attendance from each discipline without increasing the weekly MDTM time of individuals, allowing more flexibility to discuss cases at different points in the week when results are available and so better performance against cancer targets.

Uniform practice is ensured by the MDT lead attending their 'designated' MDT and half of the 'non-designated' MDT meetings and by cross cover of clinicians across the two parts of the MDTM.

The MDT attendance is also staggered to allow efficient use of oncology and radiology time.

Streamlining cases using daily pre-clinic core biopsy result MDTMs

Example: Manchester MDTM (Ashu Gandhi & Anthony Maxwell)

Daily MDTMs are held Monday to Friday between 8.30 and 9.00am prior to clinics.

These are used primarily for discussion of biopsy results from screening assessment and symptomatic clinics. The majority of cases are straightforward and it is possible to formulate clear management plans. The patients are seen then in that morning's clinic for their results.

Two radiologists review the screening assessment images prior to the meeting (taking approximately 15 - 20 minutes) with the symptomatic patients' images reviewed during the meeting.

The MDTM is attended by surgeons, radiologists, pathologists, radiographers, CNSs, research nurses, and the MDT Coordinator. Oncologists do not routinely attend. Any patients identified as potentially suitable for neoadjuvant treatments and any complex cases are re-discussed at the weekly plenary MDTM with oncologists in attendance. Often staging investigations are requested in the interim.

The outcome from MDT discussion of biopsies from screening patients is documented on a paper pro forma and also recorded by a radiologist in a radiology report immediately after the meeting, together with a summary of the imaging and pathology results. This acts as a referral letter to the surgeon for women diagnosed with cancer. The completed paper MDT pro forma for the symptomatic patients is scanned into the radiology information system.

The main advantages of these frequent meetings are minimising delays in giving results and taking caseload pressure off the once weekly plenary MDTM through streamlining.

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Oncology and Secondary Breast Cancer MDTM

Example: The Christie, Manchester (Andrew Wardley)

The MDTM is attended by both Medical Oncology and Clinical Oncology consultants, a specialist in supportive care, secondary breast cancer nurses, research nurses, and a phase I team representative.

All newly referred oncology patients are presented by the specialist registrar and treatment options are discussed and a management plan created.

Secondary breast cancer patients with progressive disease or other issues are also discussed for team awareness and to create a management plan.

The service is designed around clinical trials and all patients are considered for trials at every point in their journey. This has led to increased referrals of patients for clinical trials including experimental medicine trials.

There is a separate radiology multi-disciplinary team meeting for cases when clarification of response assessment is required and other difficult radiology issues.

Date	February 2022
Version	2

References:

1. Soukup T, Gandamihardja TAK, McInerney S, et al. Do multidisciplinary cancer care teams suffer decision-making fatigue: an observational, longitudinal team improvement study. BMJ Open 2018;9:e027303.
2. Department of Health. Manual for Cancer Services. London: Department of Health 2004.