West Midlands cancer alliance

NHS

WEST MIDLANDS CANCER ALLIANCE

Cancer

Multidisciplinary Meeting

Best Practice Standardisation Guidance

West Midlands Cancer Alliance

Document Title	WMCA Cancer Multidisciplinary Meeting Best Practice Standardisation Guidance	
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Document Purpose	This guidance has been produced to deliver a standardised approach to cancer MDT meetings across the West Midlands; to optimise the clinical management of patients and deliver consistent, high quality care for all patients.	
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Approval Signatures	**MDT Working Group Chair**  John Elliott Date: 05.09.2025	**WMCA Clinical Director**  Dr Lydia Fresco Date: 05.09..2025

Version Control

Version	Date	Summary of Change / Process
V1.0	10/05/2022	Final version approved
V2.0	08/05/2025	Transferred to updated template. Re formatted to include subheadings for each section. Added information regarding best practice for hybrid / virtual MDT meetings. Removed reference to specific Standards of Care within document and link provided to webpage to support ongoing updates.
V3.0	15/07/2025	Final formatting amends

Introduction

Having care reviewed by a multi-disciplinary team (MDT) has been the gold standard for patients with cancer for many years following recommendation in the Calman-Hine report in 1995 and being mandated by the National Cancer Plan in 2000. However, much has changed within the delivery of cancer care, so it is essential that MDT working evolves to meet the needs of patients and continues to provide the best service by ensuring the high quality, safe and effective management of patients.

Cancer service delivery is more sophisticated with more personalised care being provided to greater numbers of patients, many of whom have complex cases. Multi-disciplinary team meetings (MDMs) need to be able to operate efficiently and offer valuable, timely clinical decision making. However, a report by Cancer Research UK in 2017 along with work by the late Professor Martin Gore highlighted not enough time was available to discuss complex cases and as a result the Independent Cancer Taskforce Report in 2015 made the recommendation that there needed to be a focus on those cases which do not follow well-established clinical pathways. The NHS Long Term Plan, 2019 maintains the pledge to improve access to specialist expertise in cancer care.

This document provides guidance on best practice for efficient and effective MDT working, to improve the current variation that exists in the operational management of meetings, in the clinical decision making and in the access to the best care for patients.

The approach taken to develop this best practice guidance document has been by clinical and patient engagement through the WMCA expert advisory groups (EAGs), engagement with other cancer alliance's and with the national team, as well as considering all recommendations from previous MDT effectiveness resources and peer review guidance.

Background/Purpose

The aim of MDT Meeting Optimisation is to deliver a streamlined approach and embed a model which helps to optimise clinical management and deliver an effective operational structure that achieves consistent, high-quality care and improved pathways for all patients.

The purpose of the work:

- to introduce MDT Streamlining including the use of Standards of Care (SoC) as a routine part of MDT Meetings to stratify patient cases into those which require full multidisciplinary discussion and those cases which can be listed but not discussed as patient need is met by a recognised international, national, regional, local level guideline;

- to support delivery of an improved pathway for all patients referred to MDT Meetings by through provision of adequate time for discussion of cases.

- to provide a best practice operational model for MDT Meetings which is sustainable. When implemented the MDT meeting is able to operate more effectively.

Definition of Standards of Care

- A Standard of Care (SoC) is a point in the pathway of patient management where there is a recognised international, national, regional or local guideline on the intervention(s) that should be made available to a patient
- There may be two or more recognised SoCs for a stage of disease or clinical scenario; a 'watch and wait' policy could be a SoC.
- SoCs are identified and drawn up by tumour site specialist MDTs and apply across the geography of the alliance. They must be endorsed and signed off by the cancer alliance board;
- Development of SoCs should focus on those points in the pathway where there is clear clinical consensus on the treatment or care that a patient should receive;
- Where SoCs are introduced, a pre MDT planning meeting is required for the MDT lead and MDT co-ordinator to appropriately triage patients accordingly for discussion;
- SoCs should be reviewed by cancer alliances annually or when there is a change to practice.

Best Practice Recommendations

Development of Best Practice Recommendations

The MDM standardisation process began with tumour specific MDT leads meeting to discuss a number of points and issues raised by the national pilot sites and to review the SoCs already in existence for lung and prostate. This has resulted in a number of consistent best practice recommendations being put forward which will make improvements across all cancer MDMs within the WMCA. These recommendations are outlined below and have been agreed by all the EAGs involved in the process and have been endorsed by the cancer alliance board.

1. Referral Process into MDT Meeting and Specialised MDT Meeting

- Referral of patients should be made using an MDT referral proforma containing:
  - the referral criteria

  - the minimum information required (minimum data set) to be able to clinically discuss the patient and decide on their management
  - a clear deadline for submitting referrals.
- Supporting diagnostic information should accompany each referral to facilitate an initial triage process.
- The ask of a Specialised MDT Meeting must clear, for example, is the patient for discussion and advice on management only, or for treatment.
- All internal patients referred by other tumour specific clinicians or by non-cancer services as well as patients from private providers should be referred using the agreed MDT referral proforma.
- All patients being referred to the Specialised MDM should be presented at the Specialised MDT Meeting by the referring MDT lead or a core member of the referring MDT.
- Trusts must provide an electronic single point of referral for each tumour specific MDT using NHS.net email accounts.
- Referral proformas developed by WMCA Expert Advisory Groups are available via the WMCA website.

2. MDT Meeting / Specialised MDT Meeting Structure

Agenda

An agenda with timings must be used to structure the MDT meeting, this will support the attendance from extended MDT members (who only need to attend on occasion).

Pre meet / Planning meeting

- A pre meet / planning meeting provides the opportunity for the MDT lead/chair and MDT co-ordinator to:
  - structure the MDT meeting agenda and
  - triage referrals in accordance with the agreed tumour specific referral criteria
  - triage patients utilising agreed Standards of Care
- This meeting ensures more time is available in the main MDT meeting for complex case discussion, and ensures the minimum dataset is available for each patient before the full MDT Meeting.

MDT Outcomes

- Real-time electronic completion of the MDT outcomes must occur during the meeting.

- The chairperson must ensure that the outcome of the discussion for each patient is summarised and nominate a clinician to check the accuracy of the real time completion.
- Discussion outcomes must also be shared on a screen for the whole team to see.
- A standard MDT outcome proforma must be used and shared with the referrer within 24 hours.

Appropriate Infrastructure

For an MDT Meeting /Specialised MDT Meeting to function effectively, appropriate infrastructure is required.

In person meetings

- a dedicated room in a suitable, quiet location with sound proofing if necessary, to ensure confidential discussions.
- the room is environmentally appropriate in size and layout to ensure all team members should have a seat and are able to see and hear each other and view the presented data;
- access to equipment for projecting and viewing radiology images, specimen biopsies/resections, pathology reports and the MDT outcome is mandatory;
- connection to PACS;
- access to equipment to allow real-time electronic completion and projection of discussion outcomes is mandatory

Hybrid / virtual meetings

- Fully working video conferencing facilities for MDT Meeting /Specialised MDT Meeting that require members from other locations is mandatory
- Participants joining remotely should join the meeting in a private, quiet (no background noise or interruptions), well-lit space with strong, stable internet connection and no risk to patient confidentiality
- Participants joining should use an appropriately powered laptop or desktop with a webcam. The screen should have sufficient resolution to clearly view imaging.
- Have a back up protocol for if technology fails.
- Ensure there is technical support for MDT Meeting /Specialised MDT Meeting so that assistance can be provided in a timely fashion (during the meeting) if there are problems with any IT systems or video conferencing links during the meeting that could seriously impact clinical decision making.

3. MDT Membership, Attendance, and Quoracy

Membership

- It is recognised that all clinicians involved in treating cancer patients should be an active member of an MDT, but that not all extended members need to be present at every meeting or for the whole of the meeting. The core membership of the meeting must be agreed.
- Radiologists, pathologists and oncologists must attend as core members.
- The MDT co-ordinator is recognised as a core member of the team.
- Both core and extended MDT members must have dedicated time included in their job plans to prepare for and attend MDMs. The amount of dedicated time should be negotiated locally to reflect their caseload.

Attendance and Quoracy

- Attendance for core members is 66% of meetings.
- An alternative minimum attendance of 25% should be reviewed and agreed locally, with extended members attending only for cases that are relevant to them.
- A register of attendance is mandatory with members signing in and out. Any non-members observing the meeting should be invited by the chair and introduced to the meeting and included on the attendance register.
- At least one individual from each core specialist group must be present for the meeting to be quorate.

4. Leadership

- MDT chairs and deputy chairs must be identified to lead meetings (this may/may not also be the MDT lead).
- Excellent chairing skills and strong leadership is essential to effectively manage the meeting and ensure appropriate contribution to relevant cases from all members.
- The appointment of MDT leads/chairs is by the formal process of application and interview and should be for a tenure to be determined by individual trusts.
- Succession planning should also be in place.
- The MDT lead, chair and MDT co-ordinator should have explicit roles and responsibilities set out in a job description.
- Job planning for the MDT lead, chair and MDT co-ordinator is mandatory.

The generic WMCA agreed MDT Lead Cancer Clinician Job Description can be found in Appendix 2.

Leadership training

It is recommended that the MDT lead/chair and deputy lead/chair receive leadership training to ensure they have the following skills:

- meeting management
- listening and communication
- interpersonal relations
- managing disruptive personalities
- conflict and difficult conversations
- facilitating effective consensual clinical decision making
- time management

5. Governance

Mortality and morbidity

There must be an agreed mortality and morbidity process in place for every MDT to ensure all adverse outcomes are discussed within the whole MDT.

Audit

An annual audit must take place to examine treatment decisions compared to MDT Meeting /Specialised MDT Meeting recommendations. It is recommended that if the decision to treat is found to have deviated from the recommendation, this should be re-discussed at the MDT Meeting and documented.

Peer review

MDTs must participate in peer reviews to demonstrate compliance with relevant key performance indicators and quality measures.

Operational business meetings

MDTs must have operational business meetings (minimum twice a year). They should include a review of:

- the MDT workload (activity, performance, outcomes)
- patient experience
- trial recruitment

- root cause analysis
- harm reviews from 62 and 104 day breaches
- peer review sharing and learning from best practice
- updates from new treatments/guidelines.

References

1. Cancer Research UK (2017), *Meeting Patients' Needs: Improving the Effectiveness of Multidisciplinary Team Meetings in Cancer Services,* found at: https://www.cancerresearchuk.org/about-us/we-develop-policy/our-policy-on-cancer-services/improving-the-effectiveness-of-mdts-in-cancer-services

2. Gore, M. (2017). *Transforming Multidisciplinary Team Meetings*, found at: https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2018/10/Transforming-MDM-Martin-Gore-August-2017.pdf

3. Independent Cancer Taskforce (2016). *Achieving World-Class Cancer Outcomes: A Strategy For England 2015-2020 – One Year On (2016),* found at: https://www.england.nhs.uk/wp-content/uploads/2016/10/cancer-one-year-on.pdf

4. National Cancer Action Team (NCAT 2010), *The Characteristics of an Effective Multidisciplinary Team (MDT)*, found at: http://www.ncin.org.uk/cancer_type_and_topic_specific_work/multidisciplinary_teams/mdt_development

5. NHS England and NHS Improvement (NHSEI, 2019), *Streamlining Multi-Disciplinary Team Meetings: Guidance for Cancer Alliances,* found at: https://www.england.nhs.uk/wp-content/uploads/2020/01/multi-disciplinary-team-streamlining-guidance.pdf

6. NHS England (2019), *NHS Long Term Plan*, found at: https://www.longtermplan.nhs.uk/]

7. Queen Mary University of London and the RECONCILE collaboration supported by North Central London Cancer Alliance and funded through Q Exchange by The Health Foundation and NHS England (April 2023) *Running virtual and hybrid cancer multi-disciplinary team meetings - An evidence-based best-practice toolkit*. found at:

MDT toolkit - North Central London Cancer Alliance

Appendix 1

WMCA Approved Clinical Guidelines and Standards of Care

WMCA approved guidelines and Standards of Care will be published via the website at the following address:

Clinical Guidelines and Pathways - West Midlands Cancer Alliance

MDT Lead
Job Description

Introduction

Every Cancer (including specialist palliative care) should be managed through a site-specific multidisciplinary team (MDT).

The objectives of this team approach are to:

1. Ensure designated specialists work effectively together in teams so that all decisions regarding diagnosis, treatment and care of individual patients, and all decisions regarding the team's operational policies are multidisciplinary decisions.

2. Ensure that care is given according to recognised guidelines (including guidelines for onward referrals). Appropriate information should be collected to inform clinical decision making and to support clinical governance/audit.

3. Ensure mechanisms are in place to support entry of eligible patients into clinical trials, with fully informed consent of the patient concerned.

Appointment

The appointment of the MDT lead is by the formal process of application and interview by individual trusts. The post will be for a period to be determined by individual trusts. The MDT Lead role can be undertaken by all clinical workforce groups.

Responsibilities

Cancer Lead will have the following responsibilities:

Clinical Leadership & Governance

1. Lead the clinical activity of the MDT, ensuring adherence to guidelines and high-quality integrated care.

2. Ensure that the objectives of MDT working, as outlined in relevant cancer service documents, are met.

3. Revise clinical management guidelines regularly to align with national best practices.

4. Work with the Trust Cancer team to achieve national cancer performance standards.

5. Attend an annual appraisal with a Trust Lead Cancer Clinician and agree on programmed activities (PA allocation) in recognition of the role.

6. Attend breach and harm review meetings as required.

MDT Meeting Management

7. Ensure MDT pre-meeting preparation is completed, including screening and triage of patients with the MDT coordinator.
8. Structure MDT meetings with a formal agenda.
9. Take overall responsibility for ensuring that the MDT meeting meets Quality standard indicators and participate in peer review processes.
10. Clarify core MDT meeting membership and ensure a register of attendance is maintained.
11. Chair MDT Meetings or nominate a chair and deputy chair.
12. Ensure the appropriate infrastructure for MDT meetings is in place (e.g. dedicated room of adequate size for in person meetings, microphones in place suitable for a mixed in person / online meeting).
13. Ensure that all new cancer patients are listed and discussed at the MDT meeting or listed and not discussed if they can be managed according to agreed Standards of Care.
14. Ensure all referred / discussed patients are appropriately staged with recorded staging.
15. Ensure that electronic mechanisms are in place to record clinically validated outcomes within 24 hours of the MDT meeting and all appropriate data is collected.
16. Ensure that MDT meeting outcomes are approved and communicated to referring clinicians and primary care within agreed timeframes.

Service Improvement & Quality Assurance

17. Lead on or nominate a lead for MDT Service Improvement.
18. Organise MDT operational business meetings (in accordance with MDT meeting best practice guidance requirements - minimum twice yearly) to review MDT workload, performance, patient experience, trial recruitment, and harm reviews.
19. Ensure the MDT uses an agreed mortality and morbidity review process for discussing adverse outcomes.
20. Ensure that an annual audit of treatment decisions compared to MDT meeting / SMDT meeting recommendations takes place and outcomes are shared.

21. Audit selected MDT activities and disseminate results as per best practice guidance.
22. Ensure that relevant MDT members with direct clinical contact complete advanced communication skills training and encourage attendance at appropriate CPD.
23. Ensure core MDT members undergo yearly training on cancer waiting times and cancer standards.

Training & Professional Development

24. Attend cancer-specific regional networking meetings (e.g. WMCA Expert Advisory Group / WMCA MDT Chairs meeting) or arrange for another nominated MDT member to attend in your place.
25. Undertake leadership training either internally through the Trust or an approved external provider.
26. Update the MDT Operational Policy yearly and produce an annual report and work programme.

I agree to take the position of …… MDT Lead as [specialty]

nominated by the Multidisciplinary Team and will work to fulfil the role

according to the outlined responsibilities.

Name: …… **Date:** ……

Signature: ……

I, as Cancer Clinical Director, accept this proposal and look forward to working with the team under this leadership to ensure quality care for patients.

Name: …..…… **Date:** ……..

Signature: ……

Acknowledgements

Gynaecology

Mr Janos Balega, Gynae-oncology Consultant, Sandwell and West Birmingham Hospitals NHS Trust

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