The Royal College of Radiologists

MACMILLAN CANCER SUPPORT

Review of Opportunities for Cancer MDT Modernisation

November 2026

Endorsed by

Royal College of Physicians

Royal College of Surgeons of England

The Royal College of Pathologists
Pathology: the science behind the cure

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Executive Summary

Multidisciplinary team (MDT) working is a cornerstone of high-quality cancer care. However, growing demand, increasingly complex patient pathways and continued pressure on specialist clinical capacity mean the way that multidisciplinary expertise is delivered must change. With cancer diagnoses in the UK projected to exceed half a million annually by 2040 [1], cancer services need a model of MDT working that makes better use of National Health Service (NHS) resources, removes avoidable delays and ensures patients receive timely access to the right specialist expertise.

Over time, MDT working has become synonymous with the formal multidisciplinary team meeting (MDTM), which is often used as the default mechanism for progressing care, including for routine and protocolised cases. This can result in lengthy meetings, repeated discussion of patients and delays to treatment while patients wait for the next scheduled meeting. Not every patient requires discussion by a full MDT and the current approach is not sustainable in the face of rising demand.

The Department of Health and Social Care (DHSC) asked the Royal College of Radiologists (RCR) to lead a review of opportunities to modernise cancer MDT working. The RCR partnered with Macmillan Cancer Support to conduct this review. Our review was informed by stake-holder engagement, published evidence, existing guidance and examples of MDT innovation and improvement across the UK and internationally. A Cancer MDT Reform Expert Advisory Group (see Appendix A) helped shape the strategic direction of the review and the opportunities and actions identified.

Although this work is taking place in England, the opportunities and actions described in this report are relevant across all four UK nations. Our review drew on expertise, experience and examples of MDT innovation from England, Scotland, Wales and Northern Ireland, and the principles underpinning it are intended to support MDT modernisation wherever cancer services are delivered.

Our review identified the need for a fundamental reorientation of MDT working around a simple principle: patients should receive the right expertise, at the right time, to ensure the best treatment is available to them without unnecessary delay. Formal MDTMs should no longer be the automatic route for every patient. Instead, multidisciplinary expertise should be focused where it adds greatest value, with proportionate approaches enabling routine and protocolised patients to progress safely through agreed pathways without unnecessary formal MDT discussion.

Modernising MDT working is not simply about changing MDT meetings alone. It must be supported by clear standards and governance, stronger referral processes, effective leadership and teamworking, meaningful incorporation of patient preferences, interoperable technology and consistent evaluation of MDT effectiveness.

Actions for the Next Phase of MDT Modernisation

To take forward the findings of our review, the RCR and Macmillan Cancer Support will lead eight actions designed to develop, test and support the implementation of MDT modernisation across cancer services:

1. Develop tumour-specific National Cancer Streamlining Protocols.
2. Develop implementable, flexible models of MDT working.
3. Strengthen patient-centred treatment recommendations.
4. Develop a nationally endorsed model for MDT leadership and teamworking.
5. Establish nationally agreed referral standards and minimum datasets.
6. Define core MDT technology capabilities, information standards and interoperability requirements.
7. Promote collaborative approaches to technology procurement and implementation.
8. Develop a consistent approach to assessing MDT effectiveness.

Together, these actions will support more timely and consistent treatment recommendations, reduce duplication and avoidable delays, improve access to specialist expertise and release valuable clinical capacity. They will also help reduce unwarranted variation by establishing clearer national expectations while retaining flexibility for different tumour pathways, providers and service contexts.

The actions described in this report should not be viewed as a reason to pause local improvement activity. Many services are already implementing approaches that align with the direction of travel set out in our review. The next phase of work will build on and learn from this activity, helping to accelerate adoption, support implementation and scale effective practice more consistently and sustainably across cancer services.

Across our sector, there is widespread support for MDT modernisation, but a clear message that implementation is challenging and that support is needed to translate ambition into practice. Over the next six months, the RCR and Macmillan Cancer Support will deliver the key actions described in this report and, in spring next year, launch a toolkit of resources to support meaningful MDT modernisation in practice.

01 Introduction

Demand for cancer care is growing, with cancer diagnoses in the UK projected to exceed half a million annually by 2040.[1] At the same time, patient pathways and treatment are becoming more complex, creating greater demand for timely access to multidisciplinary expertise. Ensuring patients can access the right specialist input without unnecessary delay is vital for delivering high-quality care and improving performance against Cancer Waiting Time standards.

The 1995 *Calman-Hine Report*[2] established MDT working as the gold standard for improving patient care and reducing unwarranted variation. MDTs bring together expertise from a range of disciplines, including surgeons, oncologists, radiologists, pathologists and specialist nurses. Over time, MDT working has become synonymous with the MDTM, and the meetings are increasingly used as the default mechanism for delivering multidisciplinary care, including for routine cases.

It is now standard practice for all patients with a cancer diagnosis to be discussed within formal meetings before treatment is initiated. These MDTMs can last for several hours and involve dozens of senior clinicians discussing a high number of patients. Due to time pressures, individual patient discussions can often last only a few minutes, with only a few of the clinicians present contributing to that discussion. Repeat discussion of patients across multiple meetings is common, often due to the non-availability of key patient information. This results in avoidable delays to treatment. The current approach is not working. It is expensive for the NHS because of the scale of senior clinical time involved in MDTMs. Evidence to support the use of MDTMs as the primary mechanism for MDT working is limited, and despite the significant time and resource invested in MDTMs, unwarranted variation in treatment and outcomes persists.[3]

With cancer incidence expected to rise, cancer services must move to a new model of MDT working that makes better use of NHS resources and specialist clinical capacity, eliminates avoidable delays and gives patients timely access to high-quality specialist care.

The *2026 National Cancer Plan for England* [4] rightly identified an opportunity to improve NHS cancer performance through more effective MDT working. The Department of Health and Social Care asked the Royal College of Radiologists (RCR) to lead a review of opportunities to modernise cancer MDT working. The RCR partnered with Macmillan Cancer Support to conduct this review.

Our review was centred on a simple principle: patients should receive the right expertise, at the right time, to ensure the best treatment is available to them without unnecessary delay. Through stakeholder engagement, evidence gathering and review of existing practice, we identified many examples of innovation and improvement already taking place across cancer services. We also identified opportunities to go further in improving the efficiency and effectiveness of MDT working at scale, strengthening the quality and consistency of multidisciplinary treatment recommendations and ensuring MDT working remains genuinely patient-centred by reflecting patients' needs, preferences and circumstances.

The opportunities identified through our review are expected to support improved performance against Cancer Waiting Time standards by reducing avoidable delays, minimising repeat discussion, improving referral quality and enabling more timely access to specialist expertise.

01

Introduction

This report sets out the findings of the RCR and Macmillan Cancer Support review of opportunities to modernise MDT working. The actions described throughout this report represent the next phase of work that the RCR and Macmillan Cancer Support will lead to translate the opportunities for modernisation we have identified into meaningful resources which will support cancer services to implement these changes. We will bring these resources together into a single toolkit which will support on the ground MDT modernisation, helping cancer services meet future demand, improve operational efficiency, accelerate patient pathways and reduce unwarranted variation in care.

02 Engagement and Evidence Gathering

This review formally began with a cross-sector collaboration event hosted by the RCR and Macmillan Cancer Support in May 2026. The event brought together clinicians, Cancer Alliances, Royal Colleges and professional bodies, NHS England, the Department of Health and Social Care (DHSC), MDT Coordinators, lived experience contributors, academic experts and industry representatives. The event explored current approaches to MDT improvement, international models of MDT working, patient-centred care, the role of data and technology, highly specialised MDT models and the implementation of change. The attendees were also invited to define the characteristics of a 'Model' MDT and to identify and explore the key themes of MDT improvement.

The discussions and themes identified during the event were explored in greater depth through a programme of ongoing stakeholder engagement. The review was also supported by a Cancer MDT Reform Expert Advisory Group (EAG), which has informed the strategic direction of the review and played a vital role in shaping the opportunities for MDT modernisation identified throughout this report. We would like to thank all EAG members (see Appendix A) for their generous contribution of time, expertise and insight throughout the review, as well as their continued support as we now move into the next phase of work to develop, test and refine the opportunities identified through this review.

We are particularly grateful to lived-experience contributors who have helped ensure the opportunities identified through this review remain focused on what matters most to patients and those affected by cancer.

Stakeholder experience and perspectives were considered alongside existing MDT guidance, published literature, evaluations of MDTMs and examples of MDT improvement from across the UK and internationally.

The findings from these engagement activities and evidence sources informed the key themes presented throughout this report, shaped the opportunities for MDT modernisation identified through the review and continue to underpin the actions described in the next phase of work.

03 Review Findings and Actions for MDT Modernisation

The Right Discussion at the Right Time

Our review found that MDTMs are used as the default mechanism for delivering multi-disciplinary care, despite growing recognition that multidisciplinary expertise can be applied through a wider range of approaches across the patient pathway.

MDTMs are resource-intensive and place significant demands on clinical time.[5] Patients can also experience avoidable delays when they must wait for the next scheduled MDTM or when discussion is deferred because essential information is unavailable. We identified examples of patients being discussed repeatedly across multiple MDTMs, contributing to duplication of effort and inefficient use of multidisciplinary expertise. In some cases, routine or protocolised patients were discussed despite the MDTM having no impact on the final treatment recommendations, meaning treatment initiation was unnecessarily delayed. Additionally, we heard that not all clinicians attending MDTMs actively participate in discussions, often because their input was not required.

These findings are not new. Indeed, NHS England published 'MDT Meeting Streamlining' guidance in 2020[6] which was designed to ensure MDTMs focused on the cases that would benefit most from detailed, multidisciplinary discussion. Findings from a 2024/25 survey [7] conducted by Thiscovery found extremely limited uptake of the guidance[6], with only 13% of respondents reporting full implementation.

The 2020 guidance[6] sought to promote more proportionate MDT discussion by focusing formal MDTMs on the patients most likely to benefit from detailed multidisciplinary input. Our review builds on that ambition by considering how multidisciplinary expertise can be applied more effectively across the entire patient pathway and identifying the wider enablers needed to support implementation, including National Cancer Streamlining Protocols (sometimes referred to as Standards of Care), flexible models of MDT working, strengthened referral processes, digital enablement, leadership and team-working, and evaluation. Collectively, these opportunities represent the next stage of MDT modernisation.

The *National Cancer Plan*[4] highlighted the importance of focusing specialist expertise on the patients who need it most, whilst reducing duplication and improving operational efficiency. Our review concluded that:

- Cancer services must adopt a more risk-based and proportionate approach to MDTM discussion, focusing on patients with diagnostic uncertainty, competing or complex treatment options, rare and less common cancers, or other circumstances where access to collective specialist expertise is most likely to influence management.
- Routine and protocolised cases must be enabled to progress through agreed pathways without unnecessary formal MDTM discussion. MDT expertise should not be constrained to formal meetings and should instead be applied at the point in the pathway where it is most likely to add value.

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  - This will reduce unnecessary repeat discussions, avoid delays associated with waiting for formal MDTMs, release specialist clinical capacity and create greater capacity for detailed discussion of rare cancers and atypical presentations, supporting more timely treatment recommendations informed by complete diagnostic and staging information.

This requires greater use of agreed standards, pathways and protocols to support routine and protocolised care.

- The formal MDTM should not be the default mechanism for every patient. It is neither necessary nor appropriate for every patient to be discussed within a full MDTM. Formal multidisciplinary discussion should be reserved for patients who would benefit most from collective specialist input.
  - National Cancer Streamlining Protocols will provide the foundation for this new model of MDT working.

National Cancer Streamlining Protocols will bring together existing resources, such as NICE guidance and tumour-specific protocols, in a more consistent, comprehensive and accessible set of guidance, promoting, aligning and operationalising existing good practice rather than creating entirely new standards. A nationally supported and accessible set of Cancer Streamlining Protocols will enable greater consistency in treatment recommendations, reduce unwarranted variation and give patients equitable access to high-quality specialist expertise regardless of where they receive care. They will help reduce the reliance on MDTMs, in turn helping to speed up treatment initiation and support improved performance against the Cancer Waiting Time standards.

Any move towards new models of MDT working must be supported by clear governance arrangements, accountability frameworks, and robust audit trails. Effective governance is essential to protecting patient safety, providing assurance to clinicians, and securing greater consistency across providers. Where patients progress through agreed pathways without formal MDTM discussion, there must be clear arrangements regarding treatment recommendation development responsibilities, documentation, escalation processes and audit requirements to ensure care remains safe, transparent and accountable. Alignment with national standards and assurance frameworks, including those developed by organisations such as NICE and the Care Quality Commission (CQC), is an important enabler of implementation.

Action 1

We will work with NHS England's Getting It Right First Time (GIRFT) Team and other stakeholders to develop and support the implementation of tumour-specific National Cancer Streamlining Protocols that help streamline MDT discussions, define when formal MDT discussion is required, support consistent treatment recommendations and reduce unwarranted variation.

Action 2

We will develop and support the implementation of flexible models of MDT working, including clear criteria for when different approaches can be used and the governance, accountability and audit arrangements required for their safe implementation, ensuring multidisciplinary expertise is applied at the right time, through the most appropriate mechanism, where it adds greatest value and without introducing unnecessary delays to patient care.

We will establish a dedicated workstream to support the development and implementation of National Cancer Streamlining Protocols and flexible models of MDT working. Working with GIRFT and other stakeholders across the cancer care community, the workstream will bring together and operationalise existing standards, pathways and protocols, define and test

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practical models of flexible MDT working and develop the governance arrangements required to support their safe implementation. The workstream will also develop practical resources to support local adoption.

The Ependymoma Management Advisory Group

The Ependymoma Management Advisory Group (EMAG) is a national specialist advisory panel that brings together multidisciplinary expertise to support the management of children and young people with ependymoma, a rare and complex brain tumour. Established more than a decade ago, EMAG enables clinicians across the UK to access specialist advice on complex cases, helping to ensure patients benefit from collective expertise regardless of where care is delivered.

EMAG operates as a weekly virtual forum, bringing together specialists in radiology, surgery, oncology and other disciplines to review imaging, discuss clinical complexities and provide advice on patient management. A key feature of the model is that it functions as a national advisory panel rather than a formal MDT. Responsibility for treatment recommendation development remains with the local clinical team and patients, while EMAG provides specialist recommendations to inform local discussions and treatment recommendation development. Patients and families do not attend EMAG meetings directly, instead recommendations are fed back through the local clinical team to support subsequent discussions and shared decision-making. This approach enables expert input to be shared nationally while preserving accountability and local management of care, recognising the importance of established relationships between patients, parents/guardians and their local clinical teams. The model has also helped establish strong relationships between EMAG and local teams, supporting collaborative discussion of complex cases while ensuring responsibility for care remains with the referring clinician and patient.

The model supports detailed discussion of challenging cases and provides opportunities for shared learning, helping clinicians build confidence in managing rare presentations. By facilitating access to specialist expertise, strengthening multidisciplinary collaboration and supporting informed local treatment recommendation development, EMAG demonstrates how flexible, networked models of multidisciplinary working can improve access to expert advice and support personalised care for patients with rare cancers.

No Decision About Me Without Me: Strengthening Patient-Centred Recommendations

MDTs play a critical role in ensuring treatment recommendations for patients are informed by multidisciplinary expertise. However, our review found that most MDT discussions focus predominantly on clinical and diagnostic information without sufficient consideration of wider patient needs and preferences. MDTs do not consistently have access to information about patient circumstances, social support networks, individual preferences and psychological factors when developing treatment recommendations.

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Clinical suitability alone does not determine whether a treatment option is acceptable, achievable or right for an individual patient. Wider patient factors can influence whether a patient is willing or able to proceed with treatment, what treatment they choose, their experience of care and ultimately their outcomes. Treatment recommendations that do not consider an individual's circumstances can be less acceptable to the patient, more difficult to deliver in practice and less likely to reflect what matters most to them. This can result in recommendations needing to be reconsidered following MDT discussion, delaying agreement and implementation of an appropriate treatment plan.

The role of the MDT is to develop treatment recommendations for patients, rather than make final decisions on their behalf. Decisions regarding treatment and management options should be made through direct discussion between clinicians and patients using a shared decision-making model, informed by treatment guidelines and MDT recommendations, where appropriate.[8] Where relevant, this should include consideration of clinical trial opportunities, informed by advice regarding trial availability and patient eligibility.

Patient preferences, wider psychosocial factors and direct knowledge of the patient must become integral to treatment recommendation development across MDT pathways. Embedding this information throughout the patient pathway will produce recommendations that better reflect individual circumstances, are more acceptable and deliverable and enable meaningful shared decision-making between clinicians and patients.

Action 3

We will define, test and support practical mechanisms for bringing the patient voice into treatment recommendation development through consideration of patient preferences and wider psychosocial factors.

We will establish a dedicated patient-centred treatment recommendations workstream to define, test and refine practical mechanisms for incorporating patient preferences and wider psychosocial factors into MDT pathways. Through this workstream, we will explore approaches such as structured patient-perspective summaries, improved documentation within MDT referrals and mechanisms that enable clinicians and other team members with direct knowledge of the patient to contribute to treatment recommendation development. We will work closely with lived-experience representatives, Clinical Nurse Specialists (CNSs), MDT Coordinators and other relevant stakeholders to ensure the resulting approaches reflect patient experience, clinical practice and the practical requirements of MDT delivery.

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The UK Cancer and Transition Service

The UK Cancer and Transition Service (UCATS) is the world's first service established to address the specific needs of transgender, non-binary and gender-diverse people affected by cancer. UCATS was developed in response to the complex challenges many patients face when navigating cancer care alongside gender-affirming care, including fragmented communication between services, conflicting advice and a lack of accessible information to support informed decision-making. Co-designed with patients and the charity sector, UCATS brings together multidisciplinary expertise to provide coordinated advice for both patients and healthcare professionals. UCATS operates as a combined virtual MDT and clinic, bringing together patients, specialist clinicians and local care teams within a single coordinated model. Drawing on expertise from oncology, gender medicine, nursing, pharmacy, palliative care and a dedicated pathway coordinator, the service supports treatment planning by considering not only clinical information, but also the wider factors that may influence treatment decisions and patient experience, including gender identity, personal priorities, psychosocial circumstances and individual preferences. A key feature of the UCATS model is its commitment to patient involvement and shared decision-making. Rather than making decisions on behalf of patients, the MDT provides advice and recommendations that support informed discussions between patients and clinicians. Patients are actively involved in decisions about their care and treatment options, helping to ensure management plans reflect their goals, values and circumstances. Through ongoing patient and public involvement, people with lived experience continue to shape the development of the service. UCATS demonstrates how multidisciplinary expertise and meaningful patient involvement can support more personalised care and ensure treatment recommendations reflect the whole person, not just their diagnosis.

"It's really important that a service like this exists to guide transgender cancer patients through an already difficult time with a lot of information to process. The expertise and connections of the UCATS team is invaluable for helping me to understand what was coming up in terms of my treatment and what options I had available to me and advocate for my needs."

Putting the 'T' back into MDT

The review found considerable variation in MDT leadership and teamworking, including different levels of multidisciplinary participation, psychological safety, trust, constructive challenge and shared accountability. MDT leadership extends beyond chairing MDTMs and includes setting strategic direction, supporting team development, continuous improvement and the effective functioning of the wider MDT.[9] Opportunities for MDTs to undertake team development, leadership training, education, audit and quality improvement activities also vary considerably.

Effective MDT working requires mutual respect within the team, with all team members understanding their roles and responsibilities, feeling empowered to contribute their expertise, working collaboratively, sharing accountability and challenging constructively where appropriate. Multidisciplinary involvement should be purposeful and proportionate, with the right expertise contributing at the right time to support high-quality treatment recommendations. This will improve operational efficiency by making better use of senior

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clinician time. Clearer leadership expectations and better supported teams will also enable MDTs to function more effectively.

Effective MDT working extends beyond routine meetings and requires dedicated opportunities for reflection, quality improvement, education and service development.

MDT leaders shape how teams function, create the conditions for effective collaboration and support the adoption of new approaches to MDT working.

Strong and effective MDT leaders:

- provide strategic direction for the MDT
- support effective multidisciplinary teamworking
- create psychologically safe environments
- champion continuous improvement and enable the successful adoption of new approaches to MDT working
- promote constructive challenge, shared accountability and patient-centred care

Many MDT leaders undertake their roles without formal leadership training, development opportunities or sufficient programmed activities (PAs) in their job plans to fulfil their leadership responsibilities, including service improvement. This can contribute to significant variation between MDTs and inconsistent care within and between cancer services.

MDT leadership roles should be recognised, valued and appropriately supported, creating roles that clinicians actively aspire to undertake rather than acquire by default. Protected time, leadership training and development opportunities were identified as important enablers of this ambition.

A nationally endorsed model will establish clear expectations for effective MDT leadership and teamworking across cancer services. This model will create greater consistency in how MDT leaders and teams are supported, while accommodating differences between tumour types, providers and service contexts. It will strengthen multidisciplinary participation and effective collaboration across formal MDT meetings and emerging models of MDT working. Clearly defined characteristics, behaviours and enablers will help providers recognise, support and develop MDT leadership and teamworking more consistently.

Action 4

We will work with clinicians, MDT leads, MDT Coordinators and other stakeholders to develop and test a nationally agreed standard for effective MDT leadership and teamworking across all forms of MDT working, including formal MDT meetings and emerging flexible models. This model will strengthen multidisciplinary participation, support continuous improvement and define the characteristics, roles, behaviours and organisational enablers required for high-quality MDT working, whilst recognising that leadership may be exercised through different roles and approaches.

We will establish a leadership and teamworking workstream to define, test and refine the characteristics, roles, behaviours and enablers required for effective MDT working. We will explore leadership and teamworking across formal MDTMs and emerging flexible models, recognising that leadership may be exercised through different roles and approaches across tumour types, providers and service contexts. We will develop practical approaches to strengthening leadership and teamworking, by focusing on implementation of consistent role descriptions, leadership development opportunities and job planning.

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The Right Information at the Right Time: Standardising MDT Referrals

Cancer MDT working relies on the timely referral of patients and information between providers, specialist MDTs and local treatment teams. In practice, referrals are often made using a range of forms, emails and local processes, with significant variation in the information provided and how it is exchanged.

MDTs frequently do not have access to the clinical, diagnostic, and patient information required to support treatment recommendation development on referral. Referral information is often fragmented, variable in quality and difficult to share across providers, resulting in repeated requests for missing information and duplication of effort. Where formal MDTMs remain the default mechanism for progressing care, patients may be deferred to later discussions, delaying treatment recommendations and causing avoidable delays to patient pathways.

High-quality referral information supports informed treatment recommendations and helps ensure patients receive the right expertise at the right time. Nationally agreed referral requirements and minimum datasets will ensure MDTs consistently receive the information needed to develop high-quality treatment recommendations, reducing variation between providers. This is particularly important for referrals to specialist MDTs managing rare and less common cancers, where complete and timely referral information can help patients access specialist expertise more quickly and support earlier treatment planning. Improving the quality, consistency and accessibility of MDT data is critical to enabling more efficient MDT working, reducing duplication, improving the flow of information across MDT pathways, and supporting improved performance against Cancer Waiting Time standards.

Effective referral processes should support the consistent collection of information needed to produce personalised treatment recommendations for patients. This should include diagnostic results, relevant clinical information, patient preferences, wider psychosocial factors, and other information that may influence treatment options. An effective referral model should combine a standardised electronic referral proforma, agreed minimum datasets, clear clinical questions, and structured information relating to relevant patient factors and preferences.

Nationally consistent referral requirements are essential to improving information quality, reducing administrative burden, and eliminating avoidable delays caused by missing or incomplete information. National consistency must be delivered without imposing a one-size-fits-all model. Referral processes should retain sufficient flexibility to accommodate different tumour pathways, specialist MDT requirements and local service contexts.

Action 5a

We will work with MDT Coordinators, clinicians and other stakeholders to define nationally agreed minimum datasets for MDT referrals, tailored to tumour type and specialist MDT requirements, to support consistent and high-quality treatment recommendations.

Action 5b

We will work with MDT Coordinators, clinicians and other stakeholders to establish a nationally endorsed approach to MDT referrals, supported by agreed information standards and interoperability requirements to enable the consistent exchange of referral information across providers.

Through this work we will define and test nationally consistent requirements for referral quality, minimum datasets and effective information exchange across providers. We will also identify the practical conditions, resources and enablers required to support the implementation of improved MDT referral processes across cancer services.

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Designing Technology Around MDT Needs: Enabling a Digitally Supported MDT Model

Effective MDT working relies heavily on technology to ensure the relevant patient data is accessible to the right members of the clinical team to support effective care provision. At present, however, fragmented systems, duplication of data entry and poor information exchange across clinical systems and providers create significant barriers to effective MDT working.

Improving the quality, consistency and accessibility of data available to MDTs is critical to enabling more efficient MDT working, supporting high-quality treatment recommendations for patients and reducing the administrative burden across MDT pathways. Over recent years, NHS-developed, clinician-developed, and commercially developed technology solutions for cancer MDT working have emerged that are designed to address the challenges described above. This is a positive step, and our review found extensive interest in the use of new technologies and AI to support MDT working amongst cancer services.

Cancer services need a shared national vision that ensures MDT technology is designed around the requirements of modern cancer care. The priority should be to define the capabilities, information standards and interoperability requirements needed to support modern MDT working, rather than prescribe specific technology solutions. This will help assess existing and future technology solutions and clearly signal to technology suppliers the capabilities needed to support evolving models of MDT working.

Modern MDT technology must do more than support existing meeting processes. It must enable more efficient and flexible approaches to MDT working through improved referral management, reduced administrative burden, better access to specialist expertise and workflow automation. By reducing duplication, automating routine processes, and enabling information to move more efficiently between teams and providers, interoperable technology will support faster treatment recommendation development and reduce avoidable delays in patient pathways.

Achieving this will require greater consistency in information standards, data requirements and interoperability across cancer services. Clear national expectations will help ensure critical patient information can be exchanged more effectively between providers, specialist MDTs and regional networks, whilst supporting local flexibility in how these capabilities are delivered.

These clear national expectations will align providers around common interoperability, data and information-sharing requirements, supporting more consistent access to information across providers, specialist MDTs and regional networks.

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Action 6

We will define and signal to market the core national MDT technology requirements, including interoperability, data standardisation and information-sharing capabilities, which are needed to facilitate more efficient, flexible and patient-centred MDT working.

Action 7

We will build support for providers to procure the MDT technologies that will best meet their needs, including for inter-provider MDT working.

We will establish a data and technology workstream to define the core capabilities required from MDT technology solutions and develop a shared set of functional expectations for future models of MDT working. Through this work, we will consider the information standards, data requirements and interoperability requirements needed to support more effective MDT working across providers. We will distinguish between improvements that can be achieved within the existing digital landscape and the longer-term capabilities required as systems and infrastructure develop, whilst identifying practical opportunities to improve the use of existing technology, reduce duplication and support more effective referral management and information sharing.

Measuring What Matters: Assessing MDT Effectiveness

Whilst MDTs remain a cornerstone of cancer care, there is no nationally agreed or routinely adopted approach to assessing MDT effectiveness and its contribution to patient care across providers.

Efforts to define and assess MDT effectiveness began in 2010 with the publication of *The Characteristics of an Effective Multidisciplinary Team (MDT)*[10], followed by the development of a range of assessment tools and frameworks. However, these approaches remain variable and are not consistently applied across providers, making benchmarking a challenge. The 2020 MDT Streamlining Guidance for Cancer Alliances recognised the importance of audit, outcome monitoring and ongoing evaluation when implementing new approaches to MDT working.[6]

MDT effectiveness extends beyond the operational performance of MDTMs alone. Effective MDT working delivers high-quality, patient-centred treatment recommendations, applies multidisciplinary expertise where it adds greatest value, supports efficient and timely patient pathways and contributes to reducing unwarranted variation in treatment and care. It also enables effective multidisciplinary collaboration and facilitates continuous learning and service improvement. Assessment should therefore consider not only the quality of MDTMs and attendance, but also the wider impact of MDT working on patient pathways, treatment recommendation development, access to specialist expertise and patient outcomes.

A national approach to assessing MDT effectiveness is essential to establish clear expectations, benchmark performance and drive improvement across cancer services. The national approach will measure the quality and timeliness of treatment recommendations, access to specialist expertise, pathway efficiency, patient experience and outcomes, and the impact of MDT reform on productivity and service delivery. Measures of operational impact may include the use of specialist clinical time, pathway timeliness, time to treatment initiation, access to specialist expertise and rates of repeat discussion. Measures relating to formal MDTMs, including the proportion of patients discussed through MDTMs, may also provide insight into the impact of reforms intended to support more proportionate MDT discussion. These measures should be considered alongside treatment recommendation quality, patient experience and

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outcomes to ensure improvements in efficiency do not come at the expense of the quality or safety of care. These measures should be clinically and operationally led, with digital capabilities used to support consistent data collection, benchmarking and evaluation at scale. Regular assessment, benchmarking and evaluation will support continuous improvement by enabling providers to identify, share and adopt effective practice, improving consistency, reducing unwarranted variation and strengthening the evidence base for future MDT reform. This approach will provide a consistent basis for evaluating National Cancer Streamlining Protocols, flexible MDT models and technology-enabled approaches, demonstrating their impact on the quality, efficiency and sustainability of MDT working.

Action 8

We will work with stakeholders to establish a consistent approach to evaluating the effectiveness of MDT working as a whole, supported by complementary measures covering formal MDT meetings, wider multidisciplinary activity and patient and service outcomes. This should support continuous improvement and allow the impact of MDT reform initiatives on the quality, efficiency and sustainability of MDT working to be assessed over time.

We will work with stakeholders and members of the Expert Advisory Group to define and test a consistent approach to assessing MDT effectiveness. The framework will evaluate MDT working as a whole, rather than formal MDTM activity alone, and will use complementary measures to reflect its different components and impacts. This work will establish how the wider impact of MDT working can be measured beyond meeting activity alone and develop practical approaches to evaluation, benchmarking and continuous improvement to support MDT reform.

04 Summary of Actions for the Next Phase of MDT Modernisation

The actions described below represent the next phase of work arising from the RCR and Macmillan Cancer Support review of opportunities to modernise MDT working. Together, they will support the development, testing and implementation of approaches designed to improve operational efficiency, strengthen treatment recommendation development, accelerate patient pathways, improve treatment quality and promote equitable access to specialist expertise. By focusing specialist expertise where it adds greatest value, these actions will deliver measurable improvements for patients and cancer services.

Theme	Action	Intended Impact
The Right Discussion at the Right Time	**1.** We will work with NHS England's Getting It Right First Time (GIRFT) Team and other stakeholders to develop and support the implementation of tumour-specific National Cancer Streamlining Protocols that help streamline MDT discussions, define when formal MDT discussion is required, support consistent treatment recommendations and reduce unwarranted variation.	Increase efficiency and accelerate patient pathways by enabling routine cases to progress without unnecessary formal MDT discussion. Improve treatment quality and access to specialist expertise and reduce variation by focusing specialist MDT capacity on patients with complex, rare and less common cancers, supported by nationally consistent recommendations and clear governance arrangements.
	2. We will develop and support the implementation of flexible models of MDT working, including clear criteria for when different approaches can be used and the governance, accountability and audit arrangements required for their safe implementation, ensuring multidisciplinary expertise is applied at the right time, through the most appropriate mechanism, where it adds greatest value and without introducing unnecessary delays to patient care.	Increase efficiency and accelerate patient pathways by matching multidisciplinary input to patient need and enabling appropriate cases to progress outside formal MDT meetings. Improve treatment quality and access to specialist expertise by focusing specialist capacity where it adds greatest value, supported by clear governance and accountability arrangements.

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Summary of Actions for the Next Phase of MDT Modernisation

No Decision About Me Without Me: Strengthening Patient-Centred Recommendations	**3.** We will define, test and support practical mechanisms for bringing the patient voice into treatment recommendation development through consideration of patient preferences and wider psychosocial factors.	Improve treatment quality by ensuring patient preferences, wider psychosocial factors and direct knowledge of the patient inform treatment recommendation development. Support more timely, deliverable care by reducing the risk that recommendations prove unacceptable or impractical following MDT discussion.
Putting the 'T' back into MDT	**4.** We will work with clinicians, MDT leads, MDT Coordinators and other stakeholders to develop and test a nationally agreed standard for effective MDT leadership and teamworking across all forms of MDT working, including formal MDT meetings and emerging flexible models. This model will strengthen multidisciplinary participation, support continuous improvement and define the characteristics, roles, behaviours and organisational enablers required for high-quality MDT working, whilst recognising that leadership may be exercised through different roles and approaches.	Improve treatment quality and consistency through stronger multidisciplinary participation, constructive challenge, shared accountability and more effective MDT leadership. Increase operational efficiency through clearer leadership expectations, purposeful involvement and better-supported MDT teams.

04

Summary of Actions for the Next Phase of MDT Modernisation

The Right Information at the Right Time: Standardising MDT Referrals	**5a.** We will work with MDT Coordinators, clinicians and other stakeholders to define nationally agreed minimum datasets for MDT referrals, tailored to tumour type and specialist MDT requirements, to support consistent and high-quality treatment recommendations.	Increase efficiency and accelerate patient pathways by ensuring MDTs receive complete, consistent referral information, reducing duplication, repeat discussion and delays caused by missing information. Improve treatment quality and reduce variation through nationally agreed referral requirements, minimum datasets and more consistent information exchange across providers.
	5b. We will work with MDT Coordinators, clinicians and other stakeholders to establish a nationally endorsed approach to MDT referrals, supported by agreed information standards and interoperability requirements to enable the consistent exchange of referral information across providers.	
Designing Technology Around MDT Needs: Enabling a Digitally Supported MDT Model	**6.** We will define and signal to market the core national MDT technology requirements, including interoperability, data standardisation and information-sharing capabilities, which are needed to facilitate more efficient, flexible and patient-centred MDT working.	Increase efficiency and accelerate patient pathways through interoperable technology, improved referral management, workflow automation and reduced duplication. Improve access and reduce variation by defining clear expectations for MDT technology, enabling critical patient information and specialist expertise to move across providers, specialist MDTs and regional networks.
	7. We will build support for providers to procure the MDT technologies that will best meet their needs, including for inter-provider MDT working.	
Measuring What Matters: Assessing MDT Effectiveness	**8.** We will work with stakeholders to establish a consistent approach to evaluating the effectiveness of MDT working as a whole, supported by complementary measures covering formal MDT meetings, wider multidisciplinary activity and patient and service outcomes. This should support continuous improvement and allow the impact of MDT reform initiatives on the quality, efficiency and sustainability of MDT working to be assessed over time.	Drive continuous improvement through consistent assessment of productivity, pathway efficiency, treatment recommendation quality and patient outcomes. Improve consistency and reduce variation through benchmarking, evaluation and the spread of effective practice across cancer services.

05 Next Steps

The RCR and Macmillan Cancer Support will now lead a programme of work to establish the standards, resources and practical approaches needed to support MDT modernisation across cancer services. We will produce an MDT Improvement Toolkit in spring 2027 to support at scale implementation.

Services do not need to wait for the completion of this work before acting. Many are already taking steps to modernise their MDTs and this momentum should be maintained while the review's recommendations are further developed.

Ultimately, our review identifies an opportunity to move beyond formal MDTMs as the default mechanism for multidisciplinary care and towards a more flexible, patient-centred model in which every patient receives the right expertise, at the right time and without unnecessary delay.

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A1 Appendices

Appendix A – Cancer MDT Reform Expert Advisory Group Membership and Representation

Name	Representative Capacity
Dr Stephen Harden	The Royal College of Radiologists
Dr Nicky Thorp	The Royal College of Radiologists
Dr Anthony Cunliffe	Macmillan Cancer Support
Rachel Rowson	Macmillan Cancer Support
Dr Hilary Williams	The Royal College of Physicians
Professor Peter Sagar	The Royal College of Surgeons of England
Hayley Rixon	The Royal College of Nursing
Professor Sarah Coupland	The Royal College of Pathologists
Robert Otira	The Department of Health and Social Care
Robyn Cutforth	NHS England
Jo Williams	Lived Experience Representative
Dr Helen Winter	Cancer Alliance Representative
Laura Felton	MDT Coordinator Representative
Dr Kevin Burton	Glasgow Royal Infirmary
Dr Kakali Mitra	Betsi Cadwaladr University Health Board and NHS Executive Wales
Dr Keith Rooney	Belfast Health and Social Care Trust

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