Proposals for the reshaping of cancer services in England:
Patient pathways and decision-making

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The Royal College of Radiologists

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Pathology: the science behind the cure

Demand for cancer care continues to rise, and clinical decision-making is becoming ever more complex, with a greater range of options in both diagnostics and treatment and an older, more co-morbid population. Creative and ambitious thinking is required about how to manage these shifts, including a fresh approach to clinical decision-making. This document is intended to apply to the NHS in England, where the National Cancer Plan presents an opportunity to take a fresh and bold approach, though its recommendations could also be taken forward by the NHS in all UK nations.

Preserving and championing multidisciplinary team working

Multidisciplinary teams are essential and, at their best, can really drive improvements in patient care. We need an ambitious approach to multidisciplinary working to meet the needs of modern healthcare, including how we interact with artificial intelligence (AI), high-quality data, and health systems research. **Multidisciplinary teams should focus on quality improvement, audit, and research to transform local diagnostic and treatment pathways for most patients.**

The Multidisciplinary Team (MDT) model was originally developed to improve cancer care by promoting **collaborative, patient-centred decision-making**. However, current structures **do not incentivise such activities**. On the contrary, the main vehicle for MDT working – the MDT Meeting (MDTM) – has little or no focus on service development. Instead, staff rely on informal mechanisms and networks to develop as teams and improve care pathways for patients; or else they fail to do these things at all. It is important to distinguish MDT working and MDTMs (as currently constituted).

MDTM reform is essential, given the workforce shortages facing the NHS. There are serious workforce shortages amongst clinical radiology and clinical oncology,[1] medical oncology, cellular pathology,[2] specialist cancer nursing,[3] palliative care,[4] respiratory medicine, dermatology and other important staff groups.[5] Given the limited cancer workforce available to the NHS, we cannot afford for time to be spent in unproductive MDTMs.

Reform of multidisciplinary team meetings

MDTMs need a radical overhaul. They should be focused exclusively on those patients for whom an in-depth review would genuinely improve their care.

MDTMs in their current form are inefficient and expensive – at an estimated cost of approx. £600m a year.[6] Reducing the number of patient discussions by 50% – an ambitious but very achievable goal – **could save £300m per year**.

Moreover, MDTMs have become overly focused on process. Now that it is established practice to bring every single case to MDTM (often more than once), they have become so busy that a truly multidisciplinary discussion is impossible, and the patient perspective is often not considered. There is ample evidence that patients do not have equitable access to specialised treatments, in spite of MDTMs.

An over-reliance on the MDTM as a decision-making body can hold up decisions, delaying patient care. The most complex patients are often discussed sequentially at multiple MDTMs. The sickest patients cannot wait an additional week or more before a treatment decision is made. Reforming MDTMs would free up many thousands of hours of clinician time. It would also speed up patient pathways to save costs and improve outcomes.

NHS England piloted an MDT streamlining approach in 2018, but the ensuing guidance was never properly implemented.[7] We need a major redesign of MDTMs so that they are:

- **Used to discuss the most complex cases** – with a need to understand how to select cases for MDTM and what questions should be discussed. Senior clinicians need a forum for clinical decision-making and the concentration of their expertise, so complex cases can be evaluated in a comprehensive manner – but it is not necessary to take every single case to MDTM.
- **Repurposed for activities like quality improvement and training** – MDTs should meet regularly to review processes using patient outcome data and the latest audit and research findings. This would facilitate improvements to service quality. It would also help teams to integrate and train new members.
- **Attended only by those who are required and can actively contribute** – MDTM composition should reflect the required expertise for each type of disease or patient group under discussion. **All and only** the relevant individuals should be present, and those who do not need to attend should not be required to join. This would enable more efficient use of staff time. Some MDTMs will require the input of new expertise, such as genomics. Modern communications technology should enable experts from different centres to contribute; information governance and IT policies should enable this collaboration.
- **Not used as the sole decision-making forum for cancer treatment** – instead, we should equip team members with pathways and protocols to enable them to make faster, more consistent and more equitable decisions for their patients. Currently, there is significant variation in such protocols and standards. Treatment decisions may be best made with the patient and the local team in real time, rather than waiting for the MDTM. It should be noted that **MDTMs can only *recommend*** a course of action; the **treatment *decision* can only be made with the patient present**, taking into account their priorities and perspective.
- **Truly focused on patient-centred care** – for instance, reformed MDTMs would help to reduce the number of inappropriate tests for some frail patients with multiple comorbidities.
- **Used to collect and analyse high quality, consistent data in order to inform service development** – currently, MDTM data on diagnosis and treatments are inconsistent and often inaccurate. Better data collection is needed to drive service evaluation and improve patient outcomes.

Reforming MDTMs in this way would **improve patients outcomes.**[8] **Involving the patient voice** in the process by which MDTMs are reformed will be crucial;[9,10] clinical research has recommended that the patient's perspective be given greater weight in MDTM discussions.[11]

Professional bodies such as the Royal Colleges, as well as NHS staff more widely, **need permission and support to revisit cancer team working and MDTMs** and reform them into useful, useable fora. Teams also need the **headspace** and administrative support to do this work.

There is important detail that remains to be worked through to deliver successfully reformed MDTMs that enhance cancer care. The National Cancer Plan is the vehicle by which the government should initiate this work.

Greater centralisation of pathways and protocols

For the above reform to be safe and effective, **it is critical that clinicians are supported with guidance, pathways, and protocols**. Where possible these should be agreed nationally to avoid unnecessary duplication and reduce unwarranted variation. When managed well and developed in close collaboration with clinicians and their teams, it is our experience that services welcome this central support.

For example, there are no nationally agreed optimal treatment pathways or protocols for radiotherapy or systemic anti-cancer therapies (SACT). This means that every service providing SACT or radiotherapy must write their own protocols and keep them up to date. The unnecessary duplication of producing SACT protocols **is estimated to cost £1.1-£1.8 million each year** in staff time.[12] Doing this once, nationally would be more efficient, cheaper and would reduce unwarranted variation.

Organisations such as Royal Colleges, specialist societies and partnership boards have developed a range of tools to reduce duplication of effort (for example, national consent forms) and are well placed to deliver in this area with relevant funding.[13] There are also examples of excellent multidisciplinary working from countries around the globe that should be considered when evaluating and reforming MDT and clinical pathways in the UK.

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[13] Such as the UK Radiotherapy Board, which comprises RCR, the Institute of Physics and Engineering in Medicine (IPEM), and the Society and College of Radiographers (SCoR); and the UK SACT Board, which comprises RCR, the Association of Cancer Physicians (ACP), the British Oncology Pharmacy Association (BOPA), the Royal College of Physicians (RCP), and the UK Oncology Nursing Society (UKONS).

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