RCR
The Royal College of Radiologists

Royal College of Radiologists Feedback: Transforming Multidisciplinary Team meetings

Overall Feedback

The Royal College of Radiologists (RCR) welcomes the opportunity to feed into this important work. The RCR works with our 10,000 members to improve the standards of practice in the specialties of clinical radiology and clinical oncology. We appreciate the importance of multidisciplinary team meetings (MDTM) in patient care and recognise that the meetings must be as effective as possible.

MDTMs are vital for case review, discussion and treatment planning but they also have a key secondary benefit for team learning and development. It is clear that there can be no single approach for developing MDTM and offering guidance not solutions may be the best way forward

We have supplied detailed comments on the proposals below and would welcome the opportunity to continue to work with you as this work develops.

TRANSFORMING MULTIDISCIPLINARY TEAM MEETINGS (MDTMs)

Introduction

The main purpose for the introduction of Multidisciplinary Meetings in the late 1990s early 2000s was to increase evidence-based practice and to stop individuals from treating patients outside accepted standards. The role of MDTMs has developed over time into one of a treatment decision-making body for key points along the patient journey.

In recent years clinicians and particularly those involved in diagnostic services, have found that Multidisciplinary Meetings are causing considerable pressures within the system as the number of patients that are expected to be discussed has increased. This has been highlighted in a number of reports and there is evidence that the time available to discuss individual patients is short.

Patients need to be discussed by professionals whose expertise is most relevant to their clinical situation; this is not always the Multidisciplinary Team (MDT) but may be other professionals within the same discipline

RCR COMMENT

It is not clear when a clinician who is not a core member would be of use, as core members are those treating patients.

The time allocated for MDTMs has become a serious challenge due to an increasing number of patients who are ‘required’ to be discussed.

There are considerable capacity issues in relation to the number of radiologists and pathologists in England and current MDTM practices present additional challenges to these specialties.

The doctor-patient one to one relationship in relation to management decisions is starting to be eroded. Clinicians need to have the responsibility for these decisions returned to them. They must be given permission to make decisions with their patients without necessarily having to seek approval from the MDTM

RCR COMMENT

The MDTM makes a recommendation for treatment which is then discussed with the patient on a one to one basis by the doctor directly in charge of the patient's care (usually in an out patient clinic) and the decision is then taken by the patient who will decide what is best for his/her circumstances. Decisions should not be ratified by MDTM, which is not their purpose. Many clinicians believe that they cannot act with autonomy which means they must be re-educated about the purpose of the MDMT

Quality of care is best assured by regular audit of individual and team performance. Regular audit of compliance to algorithms, outcome and experience must be mandatory and used to benchmark and monitor the success of any MDTM operational processes.

The Cancer Transformation Board and Department of Health have asked Professor Martin Gore to lead a project whose aim is to transform the working of cancer Multidisciplinary Meetings to make them more effective in the light of increasing demands on the service.

The plan is for the reforms to be within the framework set by the recommendations set out in 'Meeting Patients' Needs: improving the effectiveness of multidisciplinary team meetings in cancer services' by Cancer Research UK (January 2017).

<u>Aim of MDTM reform</u>

MDTMs to operate more effectively in relation to:

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

RCR COMMENT

The aims could also include the stratification of patients and pre-meeting organisation.

<u>Principles of the new transformed MDTMs</u>

1. Only patients requiring true multidisciplinary input are to be discussed

RCR Comment

A definition of those patients who require multidisciplinary input needs to be provided. Patients should be stratified and principles agreed as to who should be discussed by whom. Additionally, only those patients who need a decision from the MDT as a whole should be on the list. Often this will be patients who have multiple comorbidities or difficult social circumstances.

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.

RCR COMMENT

For visiting/regional oncologists and surgeons this will be difficult as often the only time that they can interface with radiologists and pathologists with a ~~site~~ organ specialist interest is at an MDTM. Elucidation of a report with demonstration at the MDTM of key features on pertinent images will usually be needed but review of all scans / histopathology is not necessary.

The MDTM also acts as a useful forum for a second opinion but the viewing conditions are far from ideal. The time for preparation for MDTM and recording peer feedback afterwards is generally non-existent. Reviewing difficult radiology, or possibly conflicting radiological findings, is a key advantage of MDTM since all the radiology can be considered together and by the whole team.

3. Accountability for any intervention remains with the clinician responsible for that intervention

RCR COMMENT

Or with the physician or surgeon who requested that the patient is discussed, as often patients are added to the MDTM without ownership. The MDTM needs strong leadership and chairing to ensure that appropriate action is taken.

4. MDTM decisions are guidance for the responsible treating clinician

RCR COMMENT

Agree but sometimes the MDTM guides discussion on whom the patient should be referred to and who the responsible clinician is.

5. Each MDTM will have 2 lists: the first would contain the names of patients who do not require discussion because all their data have been reviewed and are available. These patients will be placed on a pre-agreed, recognised treatment algorithm/pathway. The second list consists of patients who require multi-disciplinary/professional discussion

RCR COMMENT

It may not always be clear to which list a patient belongs prior to discussion. MDTM preparation should agree which patients are treatable along standardised pathways; those patients will not need discussion. Where a patient does not fit a standard pathway, or where imaging or another aspect of the diagnosis is equivocal, then these patients must be discussed

Making the MDTM more streamlined should mean there is more time in the MDTM for training opportunities (and less of the consultant radiologist's time wasted in unnecessary review and preparation of images for display for patients whose imaging does not require review and discussion at the MDTM anyway). The RCR is about to introduce an MDTM assessment for senior trainees and so this would fit in well with a reformed meeting. This will be particularly helpful for trainees in the last year or two of training, where they will need to consider more complex cases which they will inevitably face as a consultant.

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

RCR COMMENT

This will be difficult to achieve the practice; guidance could suggest that if the meeting becomes too long other arrangements should be put in place. Another option would be agreeing a fixed number of cases requiring preparation, with appropriate time allocated for this in job planning. Having a fixed number, which is the maximum that can be prepared in the provided time, should ensure a focused discussion.

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.

RCR COMMENT

In order to reduce pressure on clinical radiologists there must be no "quick looks" or unseen additions at the MDTM. MDTMs should involve only those whose participation is essential, active or educational.

Time for preparation for MDTMs should be included in job planning so that radiologists are able fully to prepare, and to add appropriate addenda to the reports of those patients discussed at the MDTM afterwards. There should also be time in job planning for a nominated clinician to have responsibility for leading an effective MDTM (i.e by triaging in advance which of all the patients suggested for review at the MDTM actually require such review) which should help reduce the time commitment required.

All outside cases must have a properly completed agreed proforma with all the relevant clinical information, including the provision of the imaging reports issued at the referring hospital, for all of the relevant studies, and a clear question to answer

All external cases should have a brief review report generated on RIS and relevant images saved on PACS. All internal cases should be reviewed and a brief review report added to RIS if necessary, with simple recording of the outcome of the MDTM review being a bare minimum, and relevant images saved to PACS.

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.

RCR COMMENT

Technology to support automatic API based query of MDTM worklists does not exist. Currently lists are generally sent via email. Radiologists currently need to copy and paste each patient's ID or name into PACS/RIS in order to find the patients to be reviewed and to create a worklist. This needs to be an automated rather than a manual process. This would result in huge time savings for radiologists.

MDTM radiologists who report elective exams for their specialty provide actionable reporting. They advise on the best next management step, based upon their clinical and radiological expertise in that clinical specialty. Reporting within radiology teams should allow radiologists to contribute to MDTMs for areas where they have a special interest. This will reduce the number of exams discussed in MDTMs simply for a second opinion.

11. MDTM processes should be part of a Trust's cancer data collection systems

Data and Audit

1. Audit of MDTM outcomes and MDTM processes and data will be central to the assurance of standards and mandatory.

RCR COMMENT

Is this envisioned as a decision, variance from decision or patient outcomes?

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. This seems very burdensome for the administrative team.

RCR COMMENT

Audit, feedback to clinicians, change in process and embedding in practice occurring in three months seems extreme, this may be better carried out every four to six months.

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 be 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.

RCR COMMENT

The recording of outcomes of a meeting should be able to accommodate multiple outcomes e.g. chemotherapy and radiotherapy. Recording one outcome does not reflect the complexity of the decisions made.

Advantages of the reformed working arrangements for MDTMs

1. Improved 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

2. Clarification of individual clinician responsibility

3. Clarity of standards of care across England

4. Improved data collection