GIG CYMRU NHS WALES
Rhwydwaith Canser
Cancer Network

Multidisciplinary Team (MDT) Charter

January 2024

Organisation	Cancer Network
Specialty/Project	MDT Charter
Document Title	MDT Charter
Document Number	v17

Version	**Author/s**	**Ratified by**
3rd Edition	Cancer Network	Health Board and Trust Cancer Site Clinicians, Nurses, AHPs, Co-ordinators and Managers
Approved by	**Approval date**	**Next review**
Health Board and Trust Cancer Site Clinicians, Nurses, AHPs, Co-ordinators and Managers	January 2024	2 years, subject to significant change

Foreword

The Calman Hine[1] and Cameron[2] reports first introduced the concept of multidisciplinary working as the 'gold standard of care' for cancer patients. Since 2005, Cancer multidisciplinary working in Wales has increased significantly and has become a well-established practice that has facilitated improvements in the cancer pathway and delivery of excellent cancer care.

However, the health service landscape has undergone major change in recent years and is facing significant challenges ahead. An increasing demand of suspected cancer patients requiring more complex and additional diagnostic tests; year-on-year increased incidence in cancer diagnosis; workforce issues; and financial pressures. Combined with the popularity of multidisciplinary working; complexity of patients and the significant increase in number of patients to be discussed in multidisciplinary meetings, there is now a real need to review cancer multidisciplinary working to make it as effective and efficient use of resource as possible.

There are also concerns that patient pathways and patient management decisions are being held up by the perceived requirement to discuss all cases at multidisciplinary meetings.

The development of the new Cancer Informatics Solution for the NHS in Wales is a further instigator for change; cancer teams will need to adapt current processes and adopt new and innovative ways of working to implement the new system.

This document sets out best practice guidelines for cancer multidisciplinary meetings and the attributes of a well-functioning cancer multidisciplinary team. The document guides cancer clinicians and supporting teams to make meetings more robust, effective, and efficient and support learning in organisations. The guidance outlines structures, processes, and outputs which are designed to support multidisciplinary team working. All cancer teams in Wales are encouraged to read this document, undertake self-assessment of the teams' performance, and agree objectives to achieve continuous improvement in service quality and patient care.

[1] Department of Health/Welsh Office (1995). *A Policy Framework for Commissioning Cancer Services: A report by the Expert Advisory Group on Cancer to the Chief Medical Officers of England and Wales* (the Calman Hine report).

[2] Cancer Services Expert Group (1996). *Cancer Services in Wales* (the Cameron Report). Cardiff: NHS Wales.

Table of Contents

Foreword 2
Multidisciplinary Meeting (MDM) 4
Multidisciplinary Team (MDT) 7
Role of the MDM Chair 8
Role of the MDT Lead 9
Role of the MDT Co-ordinator 10
Regional/Tertiary/Specialist Cancer Multidisciplinary Teams 11
Data Collection/Entry 12
Pre-Meeting 12
During Meeting 12
Post Meeting 12
Appendices 13
Useful documents and website links 13

Multidisciplinary Meeting (MDM)

While it is recognised that Cancer Multidisciplinary Meetings (MDMs) form a pivotal place for discussion of cancer diagnosis and treatment decisions, they are resource intensive and need to be managed effectively and efficiently. The key features of a well-functioning meeting are set out below:

Cancer multidisciplinary meetings need to be well led and organised. The Chair and/or Lead of the meeting should ensure that:

1. All relevant professionals/disciplines are represented within the meeting. This will vary according to cancer site and MDT requirements. The role of the National Cancer Site Group should provide guidance and support consistency across Wales where necessary.
2. Team members and specialities have a nominated deputy or suitable arrangements in place to cover absence. Advanced notice of absence should be given so that cover can be provided. Cross cover for MDTs should be enabled wherever possible through planning ahead for known absence and making reasonable flexible changes to job plans to accommodate cover. It is recognised that this is not always possible, and the MDT Chair should ensure action is taken to mitigate risk when key roles are not able to be covered.
3. Referral criteria are in place with clear guidance of when and how to send a case for discussion.
4. There is a locally agreed cut-off time for listing patients that is adhered to by all team members so that the patient list can be circulated well in advance of the meeting. However, there should be some flexibility for any urgent cases that need to be added: in this situation, the MDT co-ordinator, chair and in particular radiology and pathology should be given advance notice if possible.
5. There is agreement about what and how many cases can be discussed. Discussion should centre on complex patients or patients that require the expertise of specific MDT members. This does not mean every cancer or suspected cancer case needs to be discussed where well defined and agreed pathways are in place. The lead clinician supervising the care of the patient is ultimately responsible for the care of the patient bearing in mind, where appropriate, the advice of the MDT.
6. Protocols that underpin rapid decision making for non-complex patients and/or systems for decision making regarding non-complex patients outside of the meeting should be established by each cancer site.
7. MDTs should agree the process for out of MDM discussion where the pathway needs to be accelerated in the interests of the patient receiving treatment. Absence of an MDT decision due to MDM delays should be avoided and considered unacceptable by the MDT. The MDT should have clear, approved, straight to treatment protocols that remove the need for multiple MDM discussions.
8. Cases should be appropriately prepared prior to the meeting to ensure all relevant clinical information is available. These should be agreed by the relevant MDT but may include:
    a. Patient identifiers
    b. Diagnostic/staging work up (radiology/pathology/genomics/biomarkers)
    c. Symptoms, co-morbidities, performance status, frailty score
    d. The patients' views, preferences, and individual needs

e. Emotional and Psychosocial needs
f. Social care needs
g. Specialist Palliative Care needs
h. Reason for discussion

9. Patients should be presented by someone who knows the patient. For many patients this will be the one time their case is subject to specialist multi-disciplinary review, and they should have an advocate who understands as much about the individual case as possible. Specialist nurses and Allied Health Professionals can provide specific information about the patient which is highly pertinent to treatment decision making and the Chair should positively encourage their participation in such discussions.

10. Patients should be aware that their case is being discussed at the MDM, its purpose, who attends and when it meets. Patients should be informed that their case has been discussed and given the outcome within 24 hours of the meeting and where possible on the same day. This is in line with National Optimal Pathways (NOPs).

11. The purpose of an MDM is to make a recommendation regarding the best clinical management for each patient. Discussion should consider the patient's individual circumstances and preferences; the patient's named Specialist Nurse or Keyworker will represent the patient at the meeting. It is generally not appropriate for patients to attend MDMs themselves. In exceptional circumstances, this might be considered by the MDT Chair at the patients request, but other more suitable forums should be explored to provide a suitable environment and time for the discussion which the patient is requesting. All treatment recommendations will be shared with patients after the MDM and it is for the patient to come to a decision, with the support of their clinical team, regarding the optimal care for them.

12. It is important to incorporate objective measures of physiological and functional health status to support patients to make informed decisions around their treatment options. Prehabilitation services should be embedded as standard into cancer pathways as early as possible to enhance nutritional status, psychological preparedness, fitness and reduce impact from comorbidities to prepare patients for treatment and improve post treatment outcomes and survival.

13. Discussions are focused, polite and inclusive of all team members. Each MDT should agree what is acceptable team behaviour/etiquette including:

    a. Mutual trust and respect between all team members
    b. An equal voice for all team members allowing all opinions to be valued
    c. Resolution of conflict between team members
    d. Encouragement and documentation of constructive discussion/debate
    e. The ability to request and provide clarification if anything is unclear

    Any concerns over the behaviour or practice of a team member should be reported to the MDT Lead and/or the appropriate Health Board Manager(s).

14. Discussions result in clear recommendations leading to an appropriate treatment plan. These recommendations are:

    a. Patient-centred
    b. Evidence based (in line with NICE and/or all-Wales Guidelines)
    c. Inclusive of suitability for clinical trials

d. In line with standard treatment protocols unless there is a good reason against this, which should then be documented. The majority of patients' treatment should be protocol driven and not necessarily require a prolonged discussion
e. Aligned with NOPs in terms of timeliness of the planned treatment

15. Discussions, recommendations and treatment plans are documented electronically via the Cancer Informatics Solution All-Wales MDT e-form or alternative system. All data items required as part of the Cancer Informatics Solution All-Wales Cancer Dataset e-forms should be captured and validated during the meeting or shortly afterwards by a designated named person. Data capture and accuracy is a responsibility of the MDT. Although data entry is performed by the MDT co-ordinator, they should be supported outside of meetings by clinical colleagues to validate data.

16. A named Specialist Nurse or Keyworker is assigned to the patient and their details recorded electronically in the All-Wales Cancer Dataset e-form.

17. Processes are in place for:
    a. Referral onto, and discussion at a network or regional cancer multidisciplinary meeting if required.
    b. Communicating recommendations to patients, GPs, and clinical teams within 24 hours of the meeting.
    c. Ensuring outcomes agreed at the meeting are implemented. It is the responsibility of the supervising clinician, bearing advice of the MDT and discussion with the patient, to implement what is considered best for the patient and ensure that this care, and its intent, is available to wider healthcare services in a timely way.
    d. Managing patient referrals between other MDTs (including referrals to MDTs in a different organisation).
    e. Tracking patients through their pathway to ensure any tests, treatments or appointments are carried out in a timely manner and comply with the Suspected Cancer Pathway and National Optimal Pathways.

18. A meeting should be held during office hours and should not clash with any clinical commitments. If meetings fall on a bank holiday, alternative arrangements should be agreed to avoid the hold up of patient care.

19. MDM etiquette should be agreed by the team and supported by the Chair e.g. minimising disruptions by the use of mobile phones or muting microphones.

20. Consideration should be given to dedicated discussion of metastatic patients where relevant. Scheduling of MDMs should be designed so that patients can be discussed at a time when key core team MDT members are present.

Multidisciplinary Team (MDT)

The role of the Multidisciplinary team (MDT) is an advisory one, supporting clinicians and patients to agree the most appropriate care plan. It is however the responsibility of the clinician supervising the case to deliver the most appropriate treatment plan. The purpose of the MDT and its expected outcomes should be clearly defined:

21. The MDT should have agreed operational guidelines and/or protocols in place.
22. MDT operational guidelines and/or protocols should be reviewed annually.
23. There are procedures in place to:
    a. Record the MDT recommendations. The MDT should have agreed means of notifying the wider team where treatment recommendations are not adopted and the reason for this.
    b. Undertake regular audits to ensure agreed clinical pathways are being followed.
    c. Ensure that the MDT is alerted to any serious treatment complications and adverse/unexpected events or death in treatment and an appropriate review process is place for any cases identified.
24. MDTs consider all clinically appropriate treatment options for a patient even those they cannot offer or provide locally.
25. A designated named person from the MDT is responsible for ensuring that the patient's information needs have been or will be addressed/assessed. To enable patients to make a well-informed decision on their treatment and care, information regarding their cancer diagnosis and treatment options (including any available clinical trials and/or therapies that may be available via referral to other MDTs) should be offered in a way that is consistent with their wishes and needs.
26. All relevant professionals and disciplines are represented within the team. This will vary according to cancer tumour site. The recommended membership of the MDT will ensure the most effective and comprehensive discussion of each case. If a profession/discipline cannot attend regularly this should be explored by the MDT Chair with the individual or service and where this cannot be resolved, raised with the relevant Clinical Director to resolve through job planning/enabling virtual attendance/varying the times of the meetings.
27. Every team member has clearly defined roles and responsibilities which they have agreed to and are included in their job plans or job descriptions.
28. MDT members have dedicated time included in their job plans to prepare for, travel to (if required) and attend cancer multidisciplinary meetings. The amount of time should be negotiated locally to reflect workload and will vary according to cancer tumour site and discipline.
29. All members should recognise the need for continued learning and development. Individual members need to be supported to gain the necessary knowledge and skills for their roles and responsibilities within the MDT and for their professional role. Support should be available from the team and the organisation, and members should participate in relevant Continuing Professional Development (CPD) opportunities.

30. Access to training opportunities should be provided to support MDT members in areas such as:
    a. Leadership skills
    b. Chairing skills
    c. Advanced communication skills including listening, presenting and, if relevant, writing
    d. Time management
    e. Confidence and assertiveness
    f. Use of IT equipment including MS Teams
    g. Knowledge of anatomy, oncology, radiology, pathology, genomics, and biomarkers for members of the MDT not expert in these areas
31. All members play a role in sharing learning and best practice with peers.
32. The MDT shares good practice and discusses local problem areas with MDTs within its own Health Board. Networking opportunities are important to share learning and experiences with other MDTs within the same Health Board, Network or beyond.
33. The MDT takes part in internal and external audits of process, outcomes, and reviews of audit data, these should include regular analysis of 30day mortality, and mortality and morbidity reviews.
34. The MDT has representation on the National and Cancer Site Groups (CSG) for its cancer site and a representative attends the meetings or sends a deputy.
35. Every MDT should have a named managerial lead e.g., Directorate or General manager, and clinical lead. An Executive Lead for cancer is identified in each health board and Trust and should be available to escalate unresolvable governance, capacity, regional, environmental and equipment issues to. This should not substitute real time investigation of incidents/adverse outcomes or the Duty of Candour process.

Role of the MDM Chair

The role of the MDM Chair should be agreed but will normally be responsible for the organisation and the smooth running of the meeting. The Chair should be formally appointed through a process agreed with the host organisation of the MDM.

It is the responsibility of the Chair to:

36. Agree the final MDM list with the MDT Co-ordinator based on the MDTs agreed referral criteria.
37. Agree to Urgent cases being added to the MDM list after the MDM deadline and to notify the MDT Co-ordinator.
38. Ensure all relevant cases are discussed and prioritised as necessary.
39. Ensure all relevant team members are included in the discussion.
40. Ensure discussions are focused and relevant.
41. Ensure that the cancer waiting time is noted and taken into consideration when patients are discussed.
42. Promotes evidence-based and patient centred recommendations, and ensures that eligibility for relevant clinical trials is considered.
43. Ensure the meeting runs to time.

44. Ensure that each patient discussed has a clear discussion and treatment plan recorded, ideally within the meeting, or shortly afterwards. Where there is more than one opinion around best care these are also recorded.
45. Ensure that all necessary clinical data items are recorded accurately and is validated by all of the MDT members present during the discussion, ideally during the meeting but if not shortly afterwards.
46. Ensure there are agreed processes whereby recommendations within the treatment plan are documented, recorded, and fed back to the patient, GP, and the wider healthcare service within 24 hours of the meeting.
47. Ensure that there is a named clinician responsible for the patients' care and a named Specialist Nurse or Keyworker to support the patient through that care.

The Chair has skills in the following areas:

48. Meeting management.
49. Listening and effective communication skills.
50. Interpersonal relations.
51. Managing disruptive personalities & conflict.
52. Negotiating.
53. Facilitating consensual clinical decision-making.
54. Time management.
55. Adequate overview of the relevant specialty.

Role of the MDT Lead

The MDT Lead should ideally be formally appointed through an application and interview process. The MDT Lead (who may also be the Chair) has a wider remit, not just confined to MDT meetings, with sufficient time allocated in their timetable to lead this work. This role should be recognised in the individual's job plan.

It is the responsibility of the Lead to:

56. Agree with the team issues around governance, e.g., setting clear team objectives, purpose for the team, what is expected of members etc.
57. Ensure that other professionals/disciplines within the organisation understand the role of the MDT and why it is important within the cancer care environment.
58. Support negotiations for funding and/or resources required for the MDT.
59. Ensure that any issues of concern that impact on the safety of MDT recommendations are escalated accordingly.
60. Work with the MDT Co-ordinator and Cancer Services and/or the core Network team to participate in National and local audits; measure performance against agreed Quality Performance Indicators (QPIs) and undertake service improvement.
61. Ensure that at agreed intervals (e.g., 1-4 times per year) separate business/review meetings are organised to discuss MDT business including patient pathway development, service improvement, research, and audit.
62. Lead on and respond to Peer Review on behalf of the team, leading on any recommendations.
63. Contribute to the Cancer Site Group (CSG).

Role of the MDT Co-ordinator

The MDT Co-ordinator is an extremely important member of the MDT, helping to navigate patients through their pathways, and is crucial for the successful operation of meetings.

The primary responsibilities of the MDT Co-ordinator are to:

64. Plan, organise and facilitate meetings effectively and efficiently. This will involve:
    a. Preparing MDM patient lists by liaising with the MDT Chair, MDT Lead and all departments involved in providing cancer care and services.
    b. Circulating MDM patient lists to MDT members prior to the meeting and in accordance with locally agreed policies, pathways, and deadlines.
    c. Collating all relevant clinical and patient information prior to the meeting and ensuring the information can be viewed within the meeting.
    d. Accurately documenting discussions, recommendations and treatment plans within the meeting via the Cancer Informatics Solution All-Wales MDT e-form or alternative electronic system.
    e. Supporting the capture, validation, and quality assurance of data items required as part of the All-Wales Cancer Dataset e-forms.
    f. Recording and maintaining meeting attendance.
    g. Producing any locally agreed outputs following the meeting such as GP letters, tertiary referral letters or minutes, and distributing to the relevant individuals.
65. Proactively monitor patients progress through their pathways alongside other members of the cancer services team e.g. cancer trackers, in line with the Suspected Cancer Pathway and National Optimal Pathways. This will involve liaising with the MDT Chair, MDT Lead and all departments involved in providing cancer care and services. Collaboration across different MDTs, hospitals and health boards may also be required.
66. Collaborate with the MDT Lead and Cancer Network Information team to ensure that information required for National, Network and Local Audits; Quality Performance Indicators (QPI's); Peer Review; and the Wales Cancer Registry and Intelligence Surveillance Unit (WCISU), is accurate and up to date.
67. Help to organise regular MDT business meetings, and to prepare for Peer Review.

The MDT Chair, Lead and Co-ordinator should receive an annual appraisal regarding their MDT duties.

Regional/Tertiary/Specialist Cancer Multidisciplinary Teams

68. Clinical and organisational governance needs specific consideration due to the nature of cross organisational MDTs which not only discuss patients from different Health Boards but also employ staff from different Health Boards. The host organisation should be clearly identified and commissioned with relevant governance and capacity to take on the hosting arrangements.
69. Clinical governance in terms of the function of the MDT will be the responsibility of the host organisation, working closely with the Chair of the MDT. Concerns regarding the functionality of the MDT should be referred to the Chairperson who should then discuss the issue with the host organisation, ideally at Clinical Director or Chief Operating Officer level.
70. The Chairperson should ensure that the host organisation is identified and that the organisation both realises and accepts its role as the host of the MDT. In most cases the host organisation will be that organisation which delivers the tertiary aspects of care. It is essential that this negotiation takes place and is resolved as the functionality of the MDT will be subject to Peer Review and organisational ownership will be required.
71. When a host organisation has been agreed it will be for the cancer services management team of that organisation to include the MDT in its scope of responsibility. In addressing any issues regarding the MDT there is an expectation that the host organisation will consult with other Health Boards in terms of MDT functionality, patients' pathways, and MDT participants.
72. A Memorandum of Understanding (MoU) between the host and participant organisations should be agreed to ensure clarity of responsibility. An example MoU template has been provided in Appendix 1.

Data Collection/Entry

Pre-Meeting

73. Preparation is key for an efficient and effective meeting. Key clinical and patient information should be recorded prior to the cancer multidisciplinary meeting via the Cancer Informatics Solution All-Wales MDT e-form or alternative electronic system, including:
74. Patient Identifiers/Demographics.
75. Reason for discussion.
76. Clinical History:
    a. Significant co-morbidities, co-morbidity score
    b. Past Medical History (PMH)
    c. Performance Status (PS), or Frailty Index (FI)
    d. Patient wishes and anything else known about the patient that will contribute to enabling discussion and decisions by the multidisciplinary team

    Diagnostic information (Radiology, pathology, genomics, biomarkers).

During Meeting

77. If meetings are held face to face the MDT Co-ordinator should be positioned where they can hear discussions and have easy access to the relevant electronic systems for displaying and capturing key clinical and patient information. If meetings are held via Microsoft teams please ensure that you follow agreed etiquette, example guidance is available in Appendix 2.
78. Key information to be validated and recorded electronically will typically include: *
    Diagnosis, Morphology and Grade.
    Any pre-treatment clinical or post-surgical pathological staging.
    Suitability/eligibility for clinical trials.
    An accurate summary of the meeting discussion. Discussions should either be dictated or verified by the lead clinician or an MDT member. Any abbreviations/acronyms used within the meeting should be entered in full following the meeting.
    Treatment/Care plan - For the purpose of the All-Wales Cancer Dataset e-form there should only be one definitive care plan per tumour. The agreed Treatment Plan once all MDT discussions have taken place should be recorded.
79. *There may be variations or additional tumour site specific data items required as part of the All-Wales MDT e-form and All-Wales Cancer Dataset e-form

Post Meeting

80. Add any clinical information (if not already completed during the meeting):
    Check for any spelling errors and grammar.
    Update any abbreviations/acronyms to full descriptions.
    Ensure discussions are a true and accurate reflection of the meeting.

Produce any outputs – GP letters, tertiary referral letters or minutes.

Appendices

1. Regional/Tertiary/Specialist MDTs Memorandum of Understanding (MOU)
2. Example of Virtual (MS Teams / Zoom etiquette)

Useful documents and website links

Best Practice example

British Journal of Urology International (BJUI) *The Cancer multidisciplinary team meeting: in need of change? History, challenges and future perspectives*

Cancer Multidisciplinary Working Charter Criteria Checklist

Cancer Network Peer Review Cancer Multidisciplinary Working Charter Criteria

Cancer Network - Single Cancer Pathway

Cheshire & Merseyside Cancer Alliance (CMCA) MDT Optimisation: Improving the effectiveness and efficiency of MDTs

Duty of Candor statutory guidance 2023

Multidisciplinary Team (MDT) Core & Extended Members Diagram

NHS England Multidisciplinary Streamlining Multi-Disciplinary Team Meetings

CRUK Meeting Patients Needs Improving the Effectiveness of Multidisciplinary Team Meetings

Royal College of Pathologists (RCP) Best Practice Guidelines

Suspected cancer pathway: guidelines (WHC/2023/025)