Thames Valley Cancer Alliance
Multi Disciplinary Team Meeting Guidance

January 2023

A Multidisciplinary Team is a group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual patients.

The MDT Meeting (MDTM) has become a central part of the cancer pathway since its introduction 20 years ago. However, in that time there have been significant changes to the cancer landscape: cases are increasingly complex, treatment options more diverse than ever and demand higher than before. For MDTMs to derive their full benefit they need to be able to operate effectively and provide full multi-disciplinary input where it is needed. As such, it is incumbent on all those involved in the MDTM to ensure MDTM’s continue to provide the best possible service for patients.

To this effect, TVCA has produced guidance on what makes a good MDTM and how to make the most of the meeting. This document will not seek to protocolise or produce standards of care for any tumour types although any teams who think this would be beneficial would be welcomed and supported to look at this. Contributors to this document included Cancer Leads from each Trust, CAG Leads, Nursing and GP colleagues and patients.

Variation exists in the number of patients being discussed at different MDTM’s with an overall trend for increasing numbers of new cancer diagnoses and Trusts should keep under review the volume of patients being discussed to ensure adequate time is available to ensure efficiency as well as equity for all patients. Job plans for those attending should be proportionate for the amount of time required to prepare, administer and attend the MDTM (and validate any data required for mandatory national audits).

It has previously been considered whether patients should be involved in MDTM meetings. Current opinion suggests this is not physically possible due to the large number of patients discussed over a short period of time. Patients have been consulted in the creation of this document and the opinion was that individual patients would want and expect different things and a request was made for a video which would explain MDTM’s and their function that patients could view as part of their care. TVCA has committed to creating this video.

It is also acknowledged that there are many essential and critical discussions which need to take place, however many decisions are routine and follow protocols and need minimal discussion. Creating these protocols lies outside the remit of this document.

The overall aim is to have a well functioning, safe and effective MDTM for patients and the key to this is to be clear about who is responsible for each patient and the associated actions, ensure that the outcomes are clearly tracked and communicated and that the amount of time allocated to each MDT is appropriate for the volume of patients being discussed.

1. There should be a Clinical Lead as well as an MDT co-ordinator for each MDTM
2. MDTM paperwork should be produced within the Infoflex/Somerset system
3. There should be agreed mandatory data requirements for each MDTM including expertise in collecting and maintaining this data.
4. There should be an agreed process and point of referral for patients to be added to the MDTM.
5. Consideration should be given by individual MDTM's as to whether management protocols can be created to put patients on a treatment pathway without the need for formal discussion by the full MDTM.
6. There should be a pre-MDTM meet of agreed personnel to ensure that appropriate cases can be triaged for as per protocol and complex cases identified that may need additional time for discussion as well as ensuring the required paperwork and investigations are available to ensure the meeting will be fruitful for individual patients.
7. There should be a review every 6 months of who is attending the MDTM and why (specifically aimed at extended members, trainees and students to ensure information governance is maintained).
8. There should be training for the MDT Clinical Lead and the MDT co-ordinator to ensure the process runs smoothly
9. Outcomes should be recorded live during the MDTM meeting with the lead clinician agreeing the outcome with the rest of the attendees. It is vital that this includes details of the responsible clinician and who is responsible for any agreed actions.
10. Communication of outcomes with a plan should be readily available and clear within 24 hours of the MDTM with clear documentation about how this will be communicated to the patient and the GP
11. There should be continuing education and development for members of the MDTM
12. After seeing the patient, treatment decisions can change. These do not necessarily need to be re-discussed, but should be documented. It is at the discretion of the responsible clinician to determine if further discussion is warranted.
13. One does not necessarily need to wait for MDT discussion to start non-complex protocol driven treatment.
14. Clinicians and trackers can decide on first MDTM date as patient comes through the door to ensure diagnostic teams are working to this target.
15. MDTMs as a group should consider how to deal with private patients referred to the MDTM. There are no clear national guidelines to advise us on this. It is good practice to discuss private patients given it is considered the best standard of care. Trusts are responsible for financial renumeration for this work.
16. A pathway should be available to allow patients seen through ED with suspected or confirmed cancer to be routed into the correct pathway at an appropriate point without requiring a further visit to their GP's for onward referral.
17. Referrals for opinions remain under the care of the referring clinician until a transfer of care is agreed and the patient is accepted under the named care of a Consultant from the MDTM
18. Communication of outcomes back to the patient and the GP should happen in a timely manner as soon after the MDT as practical.