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Improving cancer patient outcomes through collaboration

Enhancing multidisciplinary team (MDT) meetings

Introduction

Multidisciplinary teams (MDTs) are a critical pillar within all cancer pathways, acting as the linchpin in ensuring patients receive timely, appropriate and personalised treatments. First established in the 1980s,[1] they were formalised in the 2000 *NHS Cancer Plan,* which mandated that all patients living with cancer in the UK should have their care reviewed by an MDT.[2]

MDTs bring together healthcare professionals (HCPs) involved in the cancer pathway to review diagnostic test results and determine the most appropriate treatments for cancer patients. Meetings may include surgeons, oncologists, clinical nurse specialists (CNS), pathologists and radiologists (the full detail of required roles and what constitutes a quorum is set out nationally in the Quality Surveillance quality indicators and Service Specifications).[2] While regional policies vary as to which specialties are required to make a quorum, MDTs are required to be quorate on at least 95% of occasions.[2]

Despite their success in improving the efficiency and efficacy of the cancer pathway, in the 40 years since MDTs were originally introduced, their ways of working have not evolved at the same pace as advances in cancer treatment and care, and increasing patient numbers.[3] One clinician described this change in the cancer pathway, resulting in MDTs that are now *"unrecognisably more complex"*. These challenges have led to a dramatic rise in caseloads for clinicians, while resources to address these cases have plateaued, exacerbating existing challenges for MDTs, including time constraints and broader workforce shortages.[3] Additionally, the move of many MDT meetings to online/hybrid platforms in the wake of the COVID-19 pandemic has impacted ways of working, with many MDTs now rarely meeting fully in person.[4]

This has had a knock-on impact on the patient pathway. While the target for patients to begin treatment from initial suspicion of cancer is 62 days, current data indicates that just under 70% of patients achieve this[5] – this is far below the target of 85% set by the NHS which has not been met since 2015.[6] With MDTs being the main gatekeeper for patients in accessing treatment,[3] it is vital that this step in the pathway is as efficient as possible. Similarly, delivering a more streamlined pathway would be beneficial for the NHS – as patient demand increases under ever more restrictive resourcing and financial constraints, identifying ways to make MDTs more efficient will help to future proof services over the coming years.

While efforts have been made by NHS England (NHSE) to improve cancer care and the effectiveness of MDTs, the Government's forthcoming National Cancer Plan offers a valuable opportunity to accelerate progress. It remains crucial, following the announcement that NHSE and the Department of Health and Social Care (DHSC) are merging,[7] that attention is not lost from this important issue. MDT reform has the potential to deliver improved NHS efficiency, enhance patient experience and outcomes, and help ensure that cancer services are fit for the future.

About this report

While the overarching issues in MDT working are known within the NHS – and national guidance was produced in 2019 with the aim of addressing these[2] – MSD wanted to understand the perspectives of HCPs directly involved in MDTs, both to uncover additional challenges being faced and opportunities to improve MDT efficiency. By undertaking this exercise, MSD hopes to contribute toward efforts to ensure that: patients diagnosed with cancer are treated in a timely, effective and respectful manner; MDTs are equipped to effectively and efficiently deliver this care; and cancer services are positioned to capitalise on future innovations.

This paper summarises key themes from qualitative research and structured 1:1 discussions conducted between October 2024 and January 2025 with patient group representatives and HCPs involved in MDTs across the breadth of England and across roles, including oncologists, surgeons and nurses. It highlights clear opportunities for improving MDT quality and efficiency and makes a series of recommendations to realise these opportunities to support equity in patient care across the country and reduce variability depending on the quality and capabilities of local services.

As the Government and NHSE seeks to improve the efficiency of the cancer pathway, it is incumbent upon national, regional and local leaders to understand the importance of MDTs, the challenges they are facing and the necessity for driving improvements in working practices and resourcing. Through coordinated action and appropriate accountability, MSD believes that MDTs can be reformed to deliver the timeliness and quality of care all patients deserve.

Key findings

Opportunities for improving MDT quality and efficiency

All interviewees agreed that the underlying model and founding principles of MDTs are right, and that they are essential in ensuring patients receive the best and most appropriate treatment for them. The key strength of MDTs is their ability to draw upon the expertise of a team of clinicians, nurses, radiologists and pathologists with decades of experience between them to ensure treatment-determining test results are interpreted accurately and treatment plans are co-designed. Interviewees also highlighted the role of MDTs in the training of junior colleagues, enabling them to learn from senior clinicians.

Looking to the opportunities to ensure MDTs operate effectively and to the highest standards, key themes included:

Training for MDT chairs could help improve meeting efficiency and outcomes

The impact of effective leadership on the organisation and efficiency of MDT meetings was cited by all interviewees as being the most important element of successful team working. MDT chairs – who are usually the most senior consultant present – are pivotal in ensuring that meetings run smoothly, patient cases are prepared in advance and discussed thoroughly, and decisions are made promptly.

One of the key responsibilities of an MDT chair is to foster an environment in which all participants can contribute their expertise. MDT chairs play a critical role in maintaining good etiquette, particularly with respect to communication dynamics. In a fast-paced setting with many professionals in attendance in-person and online (including hybrid or fully virtual meetings), it is easy for individuals to talk over one another or for discussions to become fragmented. Interviewees noted that effective chairs set the tone for respectful dialogue, making sure each participant can present their case or ask questions without interruption.

Another key role of MDT chairs – in tandem with MDT coordinators – is meeting preparation, which can take a number of hours and is not always recognised in job plans. Effective MDT preparation relies on chairs and coordinators working together to understand which patients will be discussed and who from the team will be required to attend the meeting. Thorough planning allows meetings to be run more efficiently and ensures that the HCPs who join meetings play an active role, freeing up time for those HCPs who would not benefit from attending.

Despite the importance of the MDT chair role, there is limited formal training available for current or incoming MDT chairs provided by either NHSE or professional organisations. As a result, MDT chairs perform these roles without training on how to manage diverse teams, coordinate complex discussions and ensure efficient decision-making processes. The lack of structured leadership development programmes means efficiency varies across different departments or Trusts. Given the increasing demands on the NHS, there is a need to recognise and address this gap in leadership development to enhance the quality and efficiency of MDTs.

Making the role of MDT coordinator clearer in job descriptions and MDT organisation maps would help to drive efficiency

An MDT coordinator – usually a Band 4 administrative member of staff – performs a vital role in the running of MDTs, by working with the MDT chair to ensure that processes run smoothly. These coordinators play a central role in MDT working; however, we heard from interviewees that their responsibilities can often be undefined in job descriptions leading to variation in the role that coordinators play across the country.

Some interviewees described how MDT coordinators send pro-formas out to all attendees of the MDT in advance, enabling test results and clinical reflections to be gathered before the meeting and where scan or test results are yet to be received, ensuring these are followed up on and patient cases are moved to the next MDT meeting to ensure time is not wasted. However, as this further delays patient care, there is a clear need for balance – ensuring MDTs are efficient, while prioritising patient care. One interviewee said that a *"good MDT coordinator is worth their weight in gold"*, providing a vital service in ensuring the time of all MDT members is used efficiently and that all patient cases are ready for discussion.

Given the importance of this role, ensuring coordinators are appropriately qualified is essential – interviewees reported that, in some trusts, MDT coordination is not undertaken by a dedicated and qualified staff member, but by nurses or other administrative staff with additional responsibilities. This can be problematic for MDTs as large caseloads and tight time constraints make it difficult for inexperienced staff members to effectively plan for meetings, potentially wasting the time of HCPs. To resolve this, job specification must require coordinators to be appropriately trained and experienced.

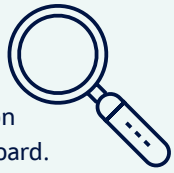
Technological assistance, such as digital patient information systems, could streamline pre- and post-MDT coordination

All the HCPs interviewed recognised the importance of digital systems in their MDT meetings. Technology is a key enabler of effective MDT working, with decision-making relying on data sharing across multiple systems. However, nearly all the interviewees named IT issues as barriers to effective meetings; from having to navigate between multiple dashboards on different systems, to screens that could not display imaging in enough detail in meeting rooms (preventing some MDT members from attending in person). Technological assistance can take the form of digital meeting platforms (e.g. Microsoft Teams) to enable people to join remotely or from other locations, through to more innovative solutions like use of the NextGen MDT programme[8] and other data platforms that use intelligent software to integrate patient information and test results into one dashboard, making MDT preparation more efficient.

Interviewees noted that virtual and hybrid meetings were often less effective than in-person meetings due to a lack of digital meeting etiquette and added technical issues, and expressed a preference for face-to-face meetings because of this, further emphasising the need for effective leadership and easy-to-use digital platforms. It is clear however that hybrid meetings have their advantages, especially for smaller centres or Trusts that cover large geographical areas. Hybrid meetings allow HCPs flexibility when managing other responsibilities – with many services already stretched, hybrid meetings save time and potentially avoid delays in patient care, while still allowing HCPs to contribute to important MDT discussions remotely.

While there are benefits, a lack of guidance and effective transition from solely in-person to hybrid and fully remote meetings has caused issues in meeting efficiency. As the NHS continues its digitisation, it is vital that HCPs are trained in the effective use of assistive technologies, and that chairs encourage appropriate digital meeting etiquette to ensure these technologies do not burden patients with longer waiting times for treatment.

CASE STUDY: NextGen MDT



MSD is supporting NextGen MDT,[8] a software tool that is in development which could help streamline patient data to support productive MDT meetings. The software collates the available results and information for patients to be discussed at an MDT, streamlining data collection and harmonisation into a singular dashboard. Clinicians cited moving between multiple screens and dashboards for patient results as time consuming in meetings due to technological issues. They provided examples of futile discussions, where patients were discussed at length only to find a result was not complete, causing the patient's care planning to be delayed to a later meeting.

The software could also act as a 'decision support' tool for clinicians in MDTs by using artificial intelligence to help make sense of complex data points and highlight relevant clinical guidelines or clinical trials that match patient results. These suggestions will support clinicians through targeted discussions across MDTs rather than replacing them, aiding the effective running of MDT meetings.

There are opportunities to strengthen the patient voice in MDT decision-making

Ensuring the patient voice is reflected in MDT meetings is essential to ensure preferences and values are considered when making treatment recommendations. In an environment where clinical experts discuss complex cases and treatment options, it is crucial that decisions reflect not only the best clinical practices, but also the patient's personal wishes, especially regarding quality of life, treatment goals and potential side effects. Interviewees noted that in order for patients to effectively feed in their wishes, it is important that they understand the role MDTs play in their treatment and how their wishes are communicated – at present, interviewees noted patient knowledge is highly variable, indicating that better resources or communication methods are needed.

During meetings, it is the responsibility of HCPs who have directly spoken with the patient about their treatment preferences to communicate the patient voice within the MDT – if this is not possible due to illness or scheduling issues, at the very least patient views must be recorded into a system for the MDT to review. Interviewees noted that discussions with patients about their treatment options are typically conducted by their CNS or their lead clinician, both of whom attend MDT meetings. On occasion a patient's lead clinician or CNS is not a member of the MDT, meaning they are not present to express their patient's views. In such cases, it should be the responsibility of the lead clinician to work with the MDT chairs and coordinators to ensure notes are available to be discussed in meetings.

Peer review of MDTs would support improved performance

While NHS England encourages MDTs to follow guidance to ensure consistency in ways of working (such as the 2019 Cancer Alliance guidance on *Streamlining Multi-disciplinary Team Meetings*),[2] the lack of systematic evaluation or peer review of MDT meetings both within and across NHS Trusts was raised by many interviewees. Clinical outcomes are regularly reviewed, but there is no formal process for assessing the effectiveness of MDTs themselves, leading to variation in the way meetings are conducted.

The *National Cancer Peer Review Programme,* which ran until 2015, previously offered a structured approach to evaluating cancer services, including MDT meetings.[9] It consisted of peer assessments and quality reviews to enable trusts to benchmark against national standards. However, with its discontinuation, many MDTs have lost the opportunity for regular, external review and constructive feedback. The absence of such a programme has created a gap in the ability to ensure consistent, high-quality MDT functioning across the NHS.

Reintroducing a peer review process within Cancer Alliances would facilitate the sharing of best practice between MDTs. By participating in cross-Trust assessments or peer discussions, teams could learn from one another's experiences and innovations. Successful strategies in one MDT – such as improved meeting structures or effective communication techniques – could be adopted more widely, raising the overall standard of care.

Recommendations to improve MDTs

Based on our research and discussions, MSD believes that the implementation of the following recommendations at local, regional and national levels would have the greatest impact towards strengthening MDT working and improving their functionality, benefitting both clinical efficiency and patient outcomes:

1 Meeting guidance

NHSE and DHSC should work with Cancer Alliances to review and refresh the 2019 *Streamlining Multi-Disciplinary Team Meetings* guidance for Cancer Alliances to ensure that advances and best practice examples are included. This must also be distributed to all MDTs to ensure all services are aware of and take steps to implement the guidance.

2 MDT leadership and training

- NHS Trusts should ensure all HCPs involved in MDTs receive appropriate training regarding their roles and responsibilities.
- NHSE and DHSC should work with professional organisations to develop training modules on meeting facilitation and leadership to reduce variability across services and therapy areas.

3 MDT coordination

NHSE and DHSC should work with professional organisations to ensure the roles and responsibilities of MDT coordinators are embedded within job descriptions and are made clear to all MDT members.

4 Assistance technology

NHSE and DHSC should review the use of technologies and digital platforms to facilitate MDT meetings and optimise working across different systems.

5 Patient voice

NHS Trusts should ensure patients' treatment preferences and wishes are discussed with the patient and their family / carers. Preferences and wishes should be recorded, prior to being presented during MDT meetings.

6 Evaluation and review

NHSE and DHSC should work with Cancer Alliances to reintroduce peer evaluation of MDT meetings to routinely review functioning and efficiency, and encourage sharing of best practice across MDTs.

While this exercise has highlighted issues in the organisation and effectiveness of MDT meetings, which are potentially impacting the speed at which patients are accessing treatment, every interviewee noted their optimism that MDTs can be strengthened and variation reduced to deliver better patient care. We believe the specific areas covered in this report are where the greatest improvements could be sought – providing an opportunity for the Government, NHSE and local health leaders to work together to deliver timely access to treatment for those who receive the devastating diagnosis of cancer.

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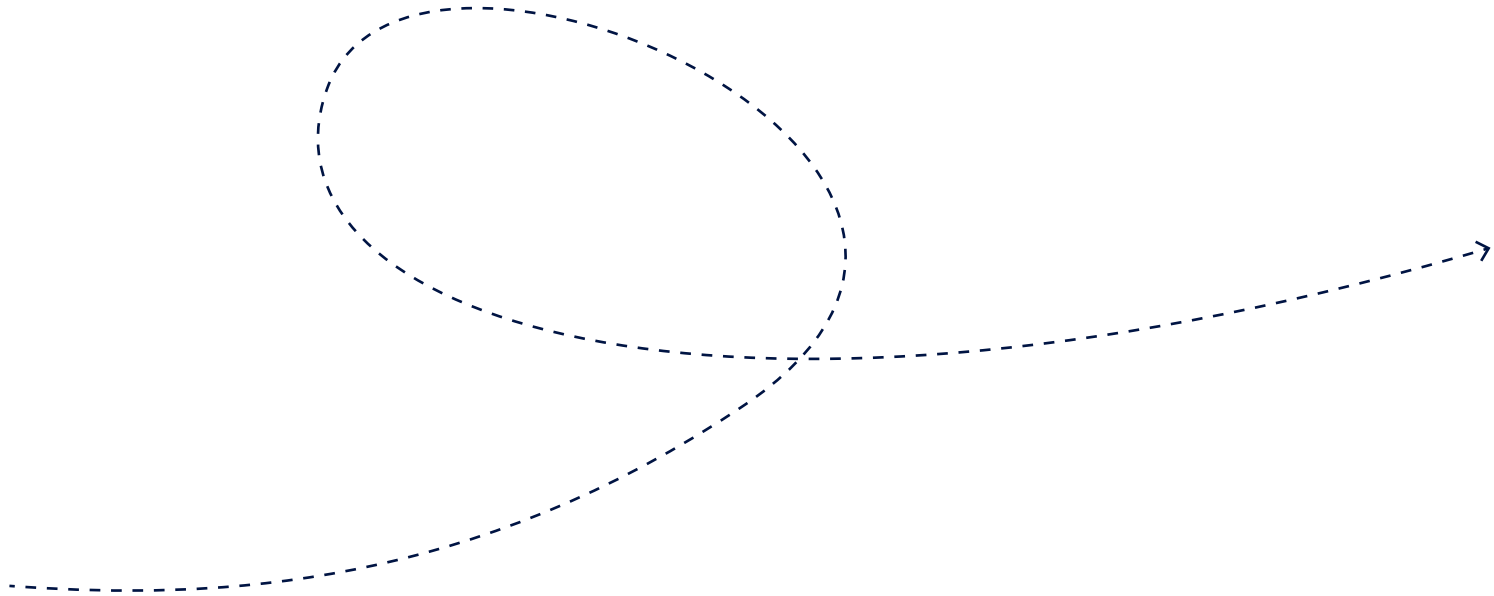

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