Section 7: Pre-MDTM Preparation

Case Selection

The workload at breast MDTMs has evolved to include two broad categories of cases:

- Patients having diagnostic tests to confirm or exclude the diagnosis of breast cancer, where predominantly concordance of triple assessment results is discussed
- Breast cancer patients where care is discussed at key points in the pathway to formulate management plans e.g. initial treatment, post-operative, breast cancer recurrence, etc.

This distinction between those MDT members involved in diagnosis and in treatment should be taken into account in planning cases listed for MDTM discussion and the scheduling of attendees (see section 6).

MDT Guidelines

RECOMMENDATION:

The MDT should have guidelines for clinicians detailing discussion requirements for individual cases. These should identify those cases appropriate for routine listing for the MDTM and the required information for discussion to take place. They should also identify potential cases for any triage or streamlining processes that may be in place, where case management can occur without MDTM discussion but is appropriately recorded.

Detailed standard operating procedures (SOPs) should be agreed to aid administrative staff in implementing these guidelines.

It is important that members of the MDT have clarity regarding cases appropriate for formal discussion at the MDTM. Meetings can become overloaded with unnecessary discussions that could be managed and outcomes documented efficiently outside of the meeting without requiring formal discussion by the full MDT.

Examples of inappropriate use of MDTM time may include:

- To check the results of normal staging investigations
- For documenting reasons for patient management that differs from a previous MDTM decision (e.g. patient medically unfit for surgery, patient declining treatment, etc.)
- For straightforward radiology queries not requiring multidisciplinary input
- To deal with correspondence and queries from GPs or other tumour site MDTs

MDT guidelines, detailing cases to be routinely discussed at MDTMs, will assist efficient organisation. Placing cases into categories can assist this process e.g. pre-operative core biopsies, post-operative cases, imaging discussion cases, metastatic breast cancer cases, etc.

Meeting preparation and discussion time can also be wasted by listing cases where some or all of the results required for meaningful discussion are not available. There should be an agreed process for omitting patients from the MDTM discussion list prior to the meeting when key information is not available. This is discussed later in this section.

Section 7: Pre-MDTM Preparation

If new processes are introduced to streamline cases that previously would have had formal discussion at an MDTM, then the MDT should have guidelines that detail responsibility for checking results of investigations and ongoing case management. This is increasingly important in an era of team delivery of breast care where more than one individual from a single discipline may be involved.

Pre-MDTM Triage Meeting

A Pre-MDTM Triage Meeting can be an effective way of reducing the number of cases requiring formal MDTM discussion. A defined smaller group of MDT clinicians may meet together with the MDT Coordinator at an agreed time in advance of the meeting to determine those cases that are to be listed for formal discussion, those that can be managed without formal MDTM discussion and those cases potentially suitable for management by protocolisation (see Standards of Care).

It is essential that there are processes in place for outcomes and decisions made at such a meeting to be documented and communicated to relevant members of the MDT. Where it is decided that a patient does not require MDTM discussion there should be clear documentation of any required actions and who is responsible for them.

Some MDTs have specific processes in place solely for review of concordant benign biopsy results, which are still listed but not discussed at the MDTM unless a clinician, radiologist or pathologist requests discussion for a specified reason. Clear documentation of both processes and outcomes is again essential to such a process.

Pre-MDTM Triage Meeting

Example: Bart's Health, London (Virginia Wolstenholme)

Bart's Health had two breast MDTMs each week across two sites. Caseloads in each of the MDTMs had been steadily increasing; impacting on workload, MDTM length, time available for individual patient discussions, etc.

One of the MDTMs introduced a pre-MDTM Triage Meeting to discuss pre-operative patients held two days prior to the main MDTM. The Triage Meeting was attended by a consultant surgeon, a consultant radiologist and a consultant oncologist (or their covers) together with the MDT coordinator and took approximately 90 minutes. This was with a view to reducing the number of cases requiring full discussion at the main MDTM. Live recording of decision-making occurred.

Using the draft MDTM list, patients were triaged to ensure that all relevant information would be available for the main MDTM. If results were unavailable or it was possible to resolve issues without the need for MDTM discussion this was recorded.

Some patients that fitted into specific protocols and were not listed for discussion at the main MDTM but included on the MDTM list in a separate section for clarity.

PROTOCOLS

T1a/bN0 cancers: Seen on imaging, pathology confirmed, for breast conserving surgery and sentinel node biopsy. Consider clinical trials.

NACT: Neoadjuvant chemotherapy

Metastatic disease: biopsy to be arranged of suitable site. Staging with CT CAP and bone scan +/- brain imaging. Refer to Metastatic MDTM

T4d cancers: Clinical review, pathology confirmed, staging with CT CAP and bone scan. Refer to oncology for primary chemotherapy followed by mastectomy, no reconstruction and axillary node clearance.

Cancer recurrence: biopsy to be arranged of suitable site. Staging with CT CAP and bone scan. Refer to surgical team

A risk assessment was carried out of the new process and monitoring through regular audit was introduced.

Section 7: Pre-MDTM Preparation

RESULTS OF BART'S HEALTH PILOT REASON TO MOVE OFF MDTM LIST October 2018 - June 2019	NUMBER	%	
PROTOCOLISATION			
T1 N0 pathway	22	3.7	
NACT pathway	28	4.7	
Metastatic pathway	16	2.7	
T4d pathway	4	0.7	
Recurrence pathway	7	1.2	**Total 77 / 594 12%**
DISCUSSION NOT NECESSARY			
Tests not ready - defer	67	11.3	
Sort via email	33	5.6	
Could make a plan	141	23.7	
Double checking reports	82	13.8	
Other	17	2.9	**Total 340 / 594 57%**
TOTAL	**417 / 594**	**69%**	

On completion of the pilot, the average number of patients on the MDTM list reduced from 89 to 57. This 35% reduction in MDTM list size was achieved through a combination of protocolisation and omitting patients where discussion was either not required or delayed due to non-availability of results.

This change enabled the two MDTMs to be amalgamated and now all Bart's Health cases are triaged under a single MDTM. The benefits have included less time spent in MDTMs, shorter preparation time for radiologists and pathologists, and more MDTM time to discuss complex cases.

Streamlining MDTMs

In January 2020 NHS England and NHS Improvement issued guidance for Cancer Alliances for *Streamlining Multi-Disciplinary Team Meetings*[1].

This refers to the process of introducing Standards of Care as a routine part of MDTMs to stratify patient cases into those which require full multidisciplinary discussion in the MDTM, and those cases which can be listed but not discussed in the MDTM, as patient need is met by a Standard of Care.

A **Standard of Care** (SoC) is a point in the pathway of patient management where there is a recognised international, national, regional or local guideline on the intervention(s), which should be made available to a patient.

A process is described for:

- The development and sign off of SoCs by the relevant Cancer Alliance, the Medical Director and Lead Cancer Clinician at Trust level.
- The introduction of a process for triage agreed at Trust level with roles and responsibilities set out for: referring clinicians, those involved in reviewing cases, and the MDT Chair.
- The introduction of an audit process to ensure that all information is captured and scheduled for review at appropriate intervals

SoCs should focus on those points in the pathway where there is clear clinical consensus on the treatment or care that a patient should receive.

SoCs should be reviewed by Cancer Alliances annually or when there is a change to best practice in national or international guidance or clinical trial findings, whichever comes first. This ensures that they are up to date in relation to the latest guidance, published data and national and international opinion on standards of care.

Section 7: Pre-MDTM Preparation

With the streamlined approach, patients are to be stratified by their consultant, or triage group, at the appropriate point of referral to the MDTM, to either:

Patient on a SoC (no discussion) **OR** Patient requires discussion for any given reason

All patients remain accounted for through inclusion on the MDTM list. No patient should be removed from oversight of the MDTM or responsibility of the MDTM.

Patients listed "not for discussion" must have a completed agreed minimum data set.

If there is any doubt, any queries on a patient, or new information becomes available in advance of, at, or after the MDTM then the patient should be discussed at the MDTM; this could include psycho-social needs.

The MDTM should undertake a regular audit of patient cases not discussed in relation to the appropriateness of patients receiving a SoC and their outcome.

Streamlining workload tool: MDT-MeDiC[2]

MeDiC is an evidence-based and expert-driven tool that gauges the complexity of cancer MDT cases. MeDiC has been developed specifically to help MDTs streamline their processes aiming to improve the efficiency of their MDTMs.

MeDiC can be used to improve cancer MDM-working through case selection and prioritisation. For example, cases can be ordered by complexity with more complex cases receiving MDT discussion, and those that are less complex treated according to pre-defined guidelines and/or discussed in a smaller 'straightforward-case' MDM.

MeDiC has been validated extensively across a number of tumour types, including breast cancer, and is intended to be used by clinicians, administrators or researchers. MeDiC provides a solution for MDTs looking to streamline their meetings without compromising quality for those cases that benefit from a multidisciplinary approach.

MeDiC can be used in conjunction with other tools, such as MDT-MODe, or MDT-QuIC as part of a comprehensive MDT-streamlining strategy (see MDT Tools).

For further information on scoring, please get in touch with Tayana Soukup: tayana.soukup@kcl.ac.uk

Pre-MDTM Preparation: Generic

RECOMMENDATION:

All of the required information to allow appropriate MDTM discussion of an individual patient should be available

There should be an agreed process for omitting patients from the MDTM discussion list prior to the meeting when key information is not available e.g. if pathology results are incomplete/not available or radiology is not yet performed or reported. This could be a pre-MDTM triage meeting.

Information required for MDTM discussion for an individual patient should include clinical findings, radiological imaging and/or histology results, and other patient-centred information that may alter clinical management such as co-morbidities, history of previous cancer, significant family history of cancer, preferences, psychosocial status, etc.

Many services have agreed timelines for the presentation of pathology results at the MDTM, e.g. core biopsy histology results taken on 'x' date, result will be discussed at 'y' MDTM and the patient will have follow up arranged at 'z' clinic. Or operation on date 'a', will have post-operative histology discussed at 'b' MDTM and the patient will have follow up arranged at 'c' clinic.

Section 7: Pre-MDTM Preparation

These timelines can be assumed to apply unless the MDT Coordinator is informed in advance of the meeting, for example by pathology. It is important that these timelines are clinically relevant but achievable within the constraints of the pathology department. A balance also needs to be struck between the timely notification of unreported results, so that alternative arrangements can be made with the patient, and unnecessary postponements causing delays. Of note, specimens (particularly core biopsy samples) can be reported quite close to the time of the MDTM.

If a patient requires multiple results to allow adequate MDTM discussion, all of the results should be available before MDTM discussion to avoid multiple discussions.

Where patients have had care transferred from another health care provider for subsequent management, prior to the MDTM discussion, checks should be made to ensure that all of the relevant information (clinical, imaging, pathology, etc.) has been received and reviewed as appropriate to facilitate full MDTM discussion. Similar checks should be made when intra-hospital MDT referrals are received from other MDTs or clinicians. The specific reason for discussion and supporting information should be provided before the case is discussed.

The use of a pro forma to be completed for Breast MDT referrals can be an effective method of checking that all required information is received. This was recommended in the 2017 CRUK report *'Meeting the patient's needs: improving the effectiveness of the multidisciplinary meetings in cancer services'* [3]

"MDTs should require incoming cases and referrals to have a completed pro forma with all information ready before discussion at a meeting."

The pro forma could include:

- Patient demographics
- Diagnostic (radiological and pathological) information
- Patient fitness and co-morbidities; history of previous malignancies
- Results from a Holistic Needs Assessment, if available
- The patient's preferences (if known)
- The rationale for requiring MDT discussion

SUGGESTION:

A pro forma for incoming cases and referrals with all information completed before discussion at an MDT meeting can be valuable. This could be a requirement for external referrals and intra-hospital referrals (from another MDTM). It could also be used selectively for more complex or routinely for all case discussions.

Older Patients with Breast Cancer

Available randomised evidence confirms that use of primary endocrine therapy (PET) in preference to initial surgery in women aged 70+ years with ER+ early invasive breast cancer (EIBC) may lead to inferior outcomes.

There will be instances where diminished patient cognition, medical fitness or the presence of frailty or limited life expectancy, suggest surgery is not the preferred pathway. PET may be appropriate in these circumstances in full transparent discussion with the patient, their family and carers.

Deferred surgery following a defined period of PET for a specific reason such as tumour downstaging, medical optimisation, which is protocol based or involvement in approved clinical trials is reasonable, but the use of PET for fit patients or those with relatively minor co-morbidity outside these circumstances is discouraged.

The NABCOP project team has devised a simple, pragmatic single A4 sheet assessment aid for completion in all breast cancer patients 70 years and over, which would further inform the patient discussion at the Diagnostic MDT.

The individual component parts of this form are mandatory, returnable data items on every Trust's COSD returns from May 2020. Each MDT Lead should ensure that there are mechanisms in place for recording of

this frailty/mental test assessment form for all relevant patients.

RECOMMENDATION

Cases should be appropriate for MDTM discussion

Local breast MDT guidelines should agree which cases are appropriate for MDTM discussion and for the process for a case to be added to the appropriate meeting at the correct time

The MDTM should not be used as a forum for checking routine results.

A process for updating the recorded MDTM outcomes with additional information where further MDT discussion is not required should be considered to free up MDTM capacity.

RECOMMENDATION

Disciplines require adequate time for agreed pre-MDTM preparation

Where there is a requirement for a discipline to carry out agreed pre-MDTM preparation this must be adequately reflected in job plans, in addition to recognition of the time required for MDTM attendance. The time requirement should be determined locally.

Pre-MDTM Preparation: Pathology

Where a pathology report will not be completed in time for a scheduled MDTM, a local process should be agreed to inform the MDT Coordinator in a timely fashion so that the patient discussion can be moved to a later MDTM and re-arrangement of patient clinic appointments made. As per NHSBSP guidance, provisional/preliminary and verbal reports should not be issued as routine practice; cases should not be discussed at the MDTM if incomplete.

Current *Quality Assurance Guidelines for Breast Pathology Services in the NHS Breast Screening Programme*[4] state the following:

Multidisciplinary Team Meetings

- Attendance at routine multidisciplinary case management meetings by a pathologist providing a service to the breast screening unit is mandatory.
- Pre-MDTM case review practice is variable and should be adapted to local circumstances.
- This need not be the sole responsibility of the lead breast pathologist.
- There is no mandatory requirement for pathology slide review prior to MDT meetings, but this is regarded as good practice.
- The local MDT pathologist is best placed to select any cases they feel may benefit from slide review, based on knowledge of the Unit's breast screening data (e.g. B3 rates), experience of colleagues (e.g. new consultants or locum staff) and other local circumstances.

The same principles should be applied to symptomatic breast cases.

SUGGESTION: SLIDE REVIEW

There is no mandatory requirement for pathology slide review prior to MDT meetings, but this is regarded as optimum practice. Ideally review of slides and reports should be carried out for all biopsies and resection. Such pre-MDTM slide review does not necessarily require re-examination of every slide from a case. Slide review may be performed at a specified time before the MDTM (individually or as a group) or consistently through the working week.

SUGGESTION: SHOWING SLIDES AT THE MDTM

There is no mandatory requirement for showing histopathology (and cytology) slides at the MDT meetings, but this is regarded as good practice as it facilitates clinical understanding and clinico-pathological correlation.

Section 7: Pre-MDTM Preparation

Histopathology departments must have adequate resources and support staff to get the cases ready in time for the MDTM, e.g. to retrieve slides from file or arrange for slides to be transported to the MDTM site, arrange cases in the relevant order, etc. as well as for the histopathology slide review and attendance at the MDTM. It is the responsibility of the Trust to ensure adequate equipment is available and processes are in place to overcome any logistical challenges, if any, for slide review and for slide demonstration at the MDTM.

Pathology Pre-MDTM Preparation Survey

Pathologists were asked their views (n=144 respondents) via the Association of Breast Pathology, the Royal College of Pathologists and participating pathologists of the national EQA scheme.

The full results are shown in Appendix 4. They show that three quarters of pathologists have time allocated in their job plans for MDTM preparation. The vast majority of pathologists (96%) carry out some form of pre-MDTM case review. Three quarters of pathologists would deem it good practice to review both slides and reports if time were made available in their job plan and/or logistical issues were overcome.

Pre-MDTM Preparation: Radiology

The principles for pre-MDTM preparation for radiologists are set out in *Cancer Multidisciplinary Team Meetings – standards for clinical radiologists*[5].

RECOMMENDATION:
There should be prior review of all images by an individual with appropriate expertise and with sufficient time to provide an unhurried professional opinion for the MDTM.

The exact time requirements will vary according to the number and size of MDTMs per week and should be determined locally.

The MDT coordinator should ensure that all imaging and reports are available to the imaging team preparing the MDTM in advance of the meeting.

For more complex cases (e.g. reviews of treatment response in metastatic disease) the specific reason for discussion and supporting information should be provided to the MDT coordinator in advance of the MDTM. The use of a standard pro forma can facilitate this process.

It is unreasonable to expect the imaging team to comment on outside images without sufficient time to review the images and the reports. This should also be the case with videoconference MDTMs where imaging from networked Trusts is routinely reviewed. Ideally diagnostic quality images need to be transferred for review to the 'hub' by an agreed deadline prior to the MDTM. Viewing radiology images via teleconference for illustration purposes is accepted practice, but should not be used for diagnosis.

Sometimes patients will be discussed at MDTMs whose images have not been previously available for review. The number of patients to be discussed without prior review must be kept to an absolute minimum.

For patient examinations not reviewed prior to the MDTM, there are a number of possible courses of action for the MDTM radiologist:

- To decline to review the examinations
- To review briefly the examinations and pass comment, but also agree to provide a written summary report to the relevant clinician and the MDTM coordinator at some stage after the MDTM
- To decline to review the examination during the MDTM, but agree to provide a written summary report to the relevant clinician and the MDTM coordinator at some stage after the MDTM
- Postpone discussion of the patient to the next MDTM after review of imaging

The MDTM radiologist should record, at the time of the MDTM, whether they have given an opinion on an examination that substantially differs from the initial report (such as an opinion that affects clinical management). In such circumstances a supplementary report should be issued.

Section 7: Pre-MDTM Preparation

Pre-MDTM Preparation: Clinical Nurse Specialists

The 2017 CRUK report *Meeting the patient's needs: improving the effectiveness of the multidisciplinary meetings in cancer services*[3] stresses that information about the patient that does not relate specifically to their cancer is often pivotal in planning their treatment e.g. psychosocial circumstances, information on their comorbidities, their views on treatment options, etc.

"This information is often not included in discussions: just 14% of discussions observed involved such information.

Interviews of MDT attendees found that Clinical Nurse Specialists (CNS) were generally regarded to be the most qualified to provide this information. However, in over 75% of the meetings observed, nurses did not speak at all. Research has also shown that, in some cases, nurses and other allied health professionals feel marginalised and report that their contribution of patient-centred information is ignored.

The inclusion of patient-centred information can also have a significant impact on clinical care, and taking such information into account in an MDT discussion maximises the chance of the recommendation being appropriate for that patient. Past research has found that 10-15% of MDT recommendations are not implemented, the patient preferring more conservative treatment, since the discussion had not considered information such as their comorbidities or their preferences."

RECOMMENDATION:

Local mechanisms should be agreed for Clinical Nurse Specialists (CNS) to be able to input patient centred factors (psychological, social or physical) into the MDTM discussion and decision-making process.

Relevant patient-centred information that may alter clinical management such as co-morbidities, preferences, psychosocial status, etc. should be available to facilitate MDTM discussion and decision-making. The CNS is often the major source of such information.

Local mechanisms should be in place to ensure that this information is best utilised.

Ideally individual patient information should be prepared in advance of the MDTM and presented by the relevant CNS at the appropriate point in the MDTM. The agreed local process for MDTM case discussion should routinely allow the opportunity for such information to be inputted by a CNS.

However, with the current move to modernise MDTMs (e.g. timetabled attendance of individual CNS at MDTMs, no formal MDTM discussion of some patients placed on agreed management pathways, etc.) this may not be practical or feasible.

Local mechanisms should be agreed to ensure input of this information to the relevant MDTM discussion or streamlining decision-making process. This should ensure that patients with more complex needs are both identified for MDTM discussion and have the relevant information available for that discussion. Options for achieving this may include the use of a pro forma to be completed in advance by the CNS detailing relevant information to be inputted to the decision-making process.

Pre-MDTM Preparation: Surgery

Specific preparation time may be required for surgeons in advance of the MDTM if they take a lead role in presenting cases or participate in a pre-MDTM triage meeting.

However, it is essential that relevant information is clearly documented and available for MDTM discussion and decision-making.

This will include:

- Clinical findings and opinion in triple assessment cases.
- Additional relevant information in newly diagnosed cancer cases such as co-morbidities, history of previous cancer, significant family history of cancer, preferences etc.

Section 7: Pre-MDTM Preparation

- Details of surgical procedures. These may be of particular importance in discussions relating to surgical excision margins. Clear documentation of margins where there is no additional tissue to re-excise aids MDTM discussion.

Pre-MDTM Preparation: Oncology

No specific preparation time is likely to be required for newly diagnosed breast cancer cases or post-operative patients as these will usually be presented to the oncology team by other disciplines for discussion of neoadjuvant or adjuvant treatment options respectively. Newly diagnosed cases of metastatic disease are also most likely to be presented to the oncology team by other disciplines.

The likeliest scenarios where oncologists would need to prepare or provide information in advance of the MDTM are:

- Neoadjuvant treatment cases requiring MDTM discussion and review of imaging to determine post treatment surgical options.
- Metastatic breast cancer cases where discussion is required regarding treatment response. This would usually be selective on request by the oncologist (e.g. for equivocal results, difficult treatment decisions, trial assessments, etc.).
- Ad hoc discussion of complex cases.
- The specific reason for discussion (e.g. specific imaging or histology requiring review) and supporting information should be provided to the MDT coordinator in advance of the MDTM. The use of a standard pro forma can facilitate this process.

Pre-MDTM Preparation: Research/ Trials

The MDTM is a valuable opportunity to highlight and document the potential eligibility of a patient for available clinical trials.

This can be facilitated by a member of the research team screening the list of patients to be discussed at the MDTM in advance to identify potential patients.

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Version	2

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