

# Streamlining Multi-Disciplinary Team Meetings

Guidance for Cancer Alliances



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# Executive Summary

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This guidance has been developed to enable cancer multi-disciplinary teams (MDTs) to respond to the changing landscape in cancer care, as recognised in the NHS Long Term Plan and the Independent Cancer Taskforce Report.

The guidance sets out how MDT Meetings (MDTMs) can continue to provide effective clinical management by remaining focussed on discussion of those patient cases which require full multidisciplinary input. This approach aims to support MDTMs in three ways:

- Firstly, it should help to ensure there is adequate time for discussion of cases where it is needed, by allowing more focus on complex cases in the MDTM.
- Secondly, streamlining should ensure that valuable diagnostic and clinical time is used most effectively by creating more flexibility in management of the MDTM.
- Thirdly, the policy will increase the transparency and consistency of care by agreeing the treatment or care any patient should expect to receive across Cancer Alliances.

The key principle to achieve MDTM streamlining is that all patients remain listed and recorded at the MDTM, however patients will be stratified into two groups: Those cases where full discussion at the MDTM is required, for example due to clinical complexity or psycho-social issues, and those cases where a patient's needs can be met by a standard treatment protocol (or *Standard of Care*), and so do not require discussion at the MDTM.

MDT Streamlining will be supported by agreeing *Standards of Care (SoCs)* across Cancer Alliances. These SoCs will set out the treatment or care patients should expect to receive. Introducing MDT Streamlining is not mandatory however it is recommended that Cancer Alliances work with Trusts locally to identify how this approach could benefit patients, clinicians, and MDTMs.

The principles set out here are not a one-size-fits-all approach and should be considered in relation to patient need, local circumstance, and by tumour site. Where Trusts introduce streamlining this guidance must be followed.



# Introduction

Care by a multi-disciplinary team (MDT) has long been the gold standard for patients with cancer. Signalled by the Calman-Hine report in 1995 and mandated by the National Cancer Plan in 2000, the pledge that all patients with cancer would have their care reviewed by an MDT has now become a central part of the cancer pathway. However, much has changed in the cancer landscape since 2000 and we need to ensure that MDT working continues to provide the best service for patients.

We now provide more sophisticated and personalised treatments to a higher volume of patients, with increasingly complex cases. For MDT Meetings to derive their full benefit they need to be able to operate effectively and provide full multi-disciplinary input where it is needed, yet a study by Cancer Research UK in 2017 found there was not enough time in the MDT Meeting to discuss more complex patients, with around half of patients discussed for two minutes or less.<sup>1</sup> For these reasons the Independent Cancer Taskforce Report recommended that NHS England should encourage providers to focus specialist time in the MDTM on those cases which do not follow well-established clinical pathways.<sup>2</sup> This work remains central to ambitions of the NHS Long Term Plan to improve access to specialist expertise in cancer care.<sup>3</sup>

This guidance sets out how MDTMs can streamline to focus time on more complex cases through the introduction of *Standards of Care* (SoCs). A Standard of Care is a point in the pathway of patient management where there is a recognised intervention (or interventions) that should be made available to a patient. The MDTM will maintain oversight of all patient cases, but where a patient's need is met by a Standard of Care the case would be listed but not discussed at the full MDT meeting.

This approach aims to improve clinical management for all patients referred to the MDTM by improving consistency and transparency of pathways, creating adequate time for discussion of patient cases where it is required, and ensuring the best use of clinical and diagnostic time. Standard of Care pathways will be applied in the wider context of personalised care, and clinical teams will always ensure that, when planning treatment for any patient, their individual circumstances and wishes are always paramount.

<sup>1</sup> Cancer Research UK, "Meeting Patients' Needs, improving the effectiveness of multidisciplinary team meetings", January 2017.

<sup>2</sup> Independent Cancer Taskforce Report, "Achieving World-Class Cancer Outcomes, a Strategy for England 2015-2020", July 2015.

<sup>3</sup> NHS England and NHS Improvement, "The NHS Long Term Plan", January 2019

An extensive engagement process informed the principles outlined in this guidance. This includes consultation on the key principles, work with patients and patient groups, and engagement with professional groups and Arms-Length Bodies. This guidance has also been informed by the results of a three-month evaluation, designed by CADEAS and undertaken with the support of ten Cancer Alliances. This policy follows from resources produced to support effective MDT working including the 2010 *NCAT* report which outlined a framework for establishing effective processes in the MDT,<sup>4</sup> and the MDTFIT improvement tool.<sup>5</sup> Indeed, work to enable streamlining as set out here has already begun in some Cancer Alliances.<sup>6</sup>

MDTs are ultimately responsible for ensuring that time in the meeting is spent most appropriately to deliver the right outcomes for patients. This may be the status quo in some MDTMs, and in others it may require further consideration of how time is distributed to patient cases. MDT streamlining as set out in this guidance is not a one-size-fits-all approach. However, where clinically appropriate this can be a useful tool to support pathway improvement for patients and optimise use of clinical time.

The development of this guidance owes a significant debt to the late Professor Martin Gore, whose commitment and enthusiasm drove this work forward.

NHS Cancer Programme, August 2019

<sup>4</sup> National Cancer Action Team, "The Characteristics of an Effective Multidisciplinary Team (MDT)", 2010

<sup>5</sup> <https://www.mdffit.co.uk/>

<sup>6</sup> UCLH Cancer Collaborative, "MDT Improvement Report", Prof Muntzer Mughal and Jacob Goodman, April 2017

# Successful Implementation of MDTM Streamlining

MDT Streamlining as set out in this guidance refers to the process of introducing Standards of Care as a routine part of MDT Meetings 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 (SoC). A 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) that should be made available to a patient.

The following steps will support successful implementation of MDT Streamlining.

1. The Cancer Alliance should work with site-specific clinical leads to identify MDTs in which to begin work on agreeing and introducing SoCs.
2. SoCs should be developed and signed off by the relevant Cancer Alliance tumour pathway board, or equivalent, in collaboration with the clinical lead for that tumour site. These should draw on existing standards where possible.
3. The Medical Director and lead cancer clinician at a Trust should sign off the SoCs before they are implemented at Trust level. This is to ensure clinical oversight and buy-in to facilitate practice change.
4. The MDTMs to which streamlining applies should be agreed at both Alliance and Trust level and done in agreement with all those involved in the pathway.
5. A process for triage should be agreed at Trust level with approval from the Medical Director before SoCs are introduced, with roles and responsibilities set out for: referring clinicians, those involved in reviewing cases, and the MDT Chair. This may require adaption of job plans.
6. An approach to audit should be set out for each MDT before streamlining begins, to ensure that all information is captured and scheduled for review at appropriate intervals, including consideration of how patient representatives can contribute to audits.
7. Successful implementation of Streamlining will require buy-in from all those involved in the patient pathway. Strategic oversight of implementation should be maintained and supported by Cancer Alliances which will ensure consistency across the geography. Clinical leads, operational managers, administrative staff, and patient representatives – as part of Alliances or tumour pathway boards - will need to collaborate to support practice change, ensuring that all those involved are clear about roles and responsibilities. Alliances and Trust leadership should work together to begin introducing streamlining when Standards of Care have been approved; this may include Executive Director sponsorship and oversight.

# Developing Standards of Care for Streamlining

Central to implementing MDTM streamlining is the introduction of SoCs. Providers and Alliances will already have predetermined SoCs in place for the diagnosis and treatment of (suspected) cancer patients. For the purposes of MDTM streamlining, these agreed standards must be formalised and strengthened to identify which patients do not require discussion at the MDTM.

Existing SoCs should be drawn on where available and it is strongly encouraged to share SoCs between Alliances and Trusts to minimise duplication and promote consistency.

## **Definition: 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) that should be made available to a patient.
- There may be two or more recognised SoCs for a stage of disease or clinical scenario; a 'watch and wait' policy could be a standard of care.
- SoCs are identified and drawn up by tumour site specialist MDTs with the Cancer Alliance Tumour Pathway Board. They must be referenced, signed off by the Cancer Alliance, and apply across the geography of an Alliance.
- Development of 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.

## Developing National Standards of Care

The NHS Cancer Programme will be working with professional bodies and Cancer Alliances to coordinate development of an initial set of Standards of Care. These will be shared through the Cancer Alliance Workspace online. Each SoC must be approved for adoption locally by the Cancer Alliance tumour pathway board, or equivalent, in collaboration with specialists in that tumour type, e.g. from the specialist MDT in that patch. This does not preclude further input, or oversight, from relevant bodies such as Clinical Quality Groups to support development and rollout. This should also include discussion with patient representatives using local mechanisms.

## Developing Standards of Care in Cancer Alliances

Cancer Alliances should utilise the Cancer Alliance Workspace online to coordinate and share further Standards of Care for adoption locally. This is central to promoting good practice, consistency in care, and avoiding duplication of effort between Cancer Alliances.

Where further local SoCs are developed, the following steps must be completed for the SoC to be signed off by the Cancer Alliance:

- Identify the point in a predetermined SoC where referral to the MDTM is required and incorporate NHS England's rapid cancer diagnostic and assessment pathways, as well as local diagnostic protocols where applicable, to support the Faster Diagnosis Standard.<sup>7</sup>
- Clear clinical parameters for the application of the SoC, e.g. histological sub-type, stage and grade of disease, and therefore a patient does not require full discussion at MDTM. They should also give consideration to situations where a SoC would not apply with clear inclusion and exclusion criteria.
- SoCs should include processes for managing interactions of networked MDTMs and explicitly state to which MDTMs they apply; in some situations, they may apply to both local and specialist MDTMs. This is not a one-size-fits-all approach.
- The SoC identified must be based on national or international standards, guidelines and protocols, and best practice as determined by the Cancer Alliance tumour pathway board. The clinical guidelines used in generating the predetermined standards of care must be referenced.<sup>8</sup>

<sup>7</sup> Further diagnostic protocols, where clinically recognised and referenced, may also be applicable.

<sup>8</sup> This information should already be available as part of the MDTM's operational policy in the treatment pathways and guidelines as per Quality Surveillance indicators.



Each SoC must be approved for adoption by the Cancer Alliance tumour pathway board, or equivalent, in collaboration with specialists in that tumour type, e.g. from the specialist MDT in that patch.<sup>9</sup> This should include discussion with patient representatives using local mechanisms.

Examples of recognised Standards of Care within the NHS include NICE Guidance and NHS England rapid cancer diagnostic and assessment pathways. Tumour types will vary in the number of recognised SoCs for different stages of disease and clinical scenarios. As such streamlining is **not** a one-size-fits-all approach and will not necessarily apply to all patients.

When looking to introduce Standards of Care, findings from the real-world testing of this guidance indicated that Cancer Alliances may wish to start with MDTs with the following characteristics:

- Tumour sites with well-established pre-defined treatment pathways, where there already exists clear consensus.
- Local rather than specialist MDTs, where there may be a greater case mix, including fewer clinically complex cases which may require discussion.
- Sub-specialist pathology and radiology expertise is already available to support triage of patients 'not for discussion' at the MDTM.

## Updating Standards of Care

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.

Trusts should not amend the SoC as approved by the Cancer Alliance without explicit approval from the relevant Cancer Alliance Tumour Pathway Board (or equivalent).

This is an ongoing process and it is expected that MDTMs will continually identify, approve and embed an increasing number of SoCs for different stages of disease and clinical scenarios.

<sup>9</sup> This does not preclude further input, or oversight, from relevant bodies such as Clinical Quality Groups to support development and rollout.

# Implementing Standards of Care in the MDTM

Standards of Care must be introduced with support of the full MDT. With the streamlined approach, patients will be stratified by their consultant, or triage group, at the appropriate point of referral to the MDTM,<sup>10</sup> to either: Patient on a SoC (no discussion), or; patient requires discussion for any given reason, e.g. patient preference. All patients remain accounted for through inclusion on the MDTM list.

## Process for implementing streamlining

The following steps will enable SoCs to be embedded in MDTMs:

- All patients on a Cancer Alliance agreed predetermined Standard of Care must be listed at the full MDTM. No patient should be removed from oversight of the MDTM or responsibility of the MDTM.
- Patients listed “not for discussion” must have a completed minimum data set available (see section 6 below) which has been implemented as agreed by the Cancer Alliance tumour pathway board.
- 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 physiological or psycho-social needs. Ability to refer the patient ‘for discussion’ is a safeguard for patient care.
- 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.
- Implementing streamlining may require changes to processes across clinical, administrative, and management roles. It is important to engage all staff to raise awareness and collaborate to help the work to embed effectively.

<sup>10</sup> Where available, referral to the MDTM should align with NHS England’s rapid cancer diagnostic and assessment pathways.

# Pre-MDTM review of cases

## Approach to reviewing cases prior to the MDTM

Patients on a Standard of Care should not require discussion at the full MDT Meeting. For patients to be safely listed, there should be a clear process to collate essential information, and a minimum dataset must be available for each patient which pertains to the relevant tumour type.

The minimum data set must have been reported and be available to the treating doctor. The decision to place a patient on the MDTM list will be made by the treating doctor or appropriate MDTM member as agreed locally. The responsibility for providing accurate information to the MDTM lies with the referring clinician in all cases. This information supports the recommendation of the MDTM, with any treatment decision made by the responsible clinician and patient.

The SoC should be reviewed prior to the MDTM. This may be a named appropriate person, or some MDTMs may wish to create a 'triage group' for deciding which patients do not require full discussion at the MDTM. The MDT Chair should work closely with the coordinator and MDTM members to agree an optimal way to gather and review information in advance of the MDT Meeting. The preferred means of reviewing patient cases 'not for discussion' in advance of the MDTM should be agreed with the Medical Director at the Trust and the method may vary between tumour sites.

The purpose of a triage group should be focussed on identifying whether patient need is met by the SoC or requires full MDT discussion. If such groups are formed their functionality and utility should be regularly reviewed and justified. The referring clinician maintains responsibility for their patients and the patient list should be made available for the MDT to review in good time before the meeting.

## For a patient to be assigned for no discussion at the MDT Meeting the following conditions must be met

- They have been seen, or the clinical circumstances otherwise assessed, by a core MDT member consultant or clinical nurse specialist (CNS)
- The minimum core data requirements have been met
- The pathology has been reported by designated persons for that tumour type
- Images have been reported by designated persons for that tumour type. Where imaging is outsourced, the reporting must be carried out by individuals agreed as suitable by the MDT.
- All other tests relevant to the decision-making have been completed
- Patient preference stated (if known) and any special circumstances have been taken into consideration. Patients should be referred to the MDTM for discussion where preference contradicts a SoC pathway.
- The SoC has been reviewed by an appropriate person or triage group, there is clarity that it is appropriate, and all of the above have been fulfilled.

## Minimum core data requirements

The following information must be accounted for in order to list a patient not for discussion at the MDTM:

- Diagnosis date (specify mode of diagnosis);
- Stage (specify investigations);
- Performance status;
- Histopathological and/or cytological diagnosis;;
- Co-morbidities;
- Availability of, and suitability for, clinical trial/s;
- Relevant genomic/genetic testing<sup>11</sup>;
- Patient preference (if known) and/or any special circumstances have been taken into consideration;
- MDTM recommendation and treatment pathway;
- Any additional tumour-specific tests needed to inform diagnosis.

These data items are from the Cancer Outcomes and Services Dataset (COSD).

<sup>11</sup> Where a genomic test is likely to have a material impact on treatment planning, the patient should normally be discussed either at a genomic MDT or other MDT meeting.

## National data collection for MDTM streamlining

At present, the Cancer Outcomes and Services Dataset (COSD) records every MDTM as well as care plan. As Standards of Care are introduced to facilitate streamlining of the MDTM, this process should also be captured in COSD.

An indicator will be introduced to version 9 of COSD. In the interim, for version 8 of COSD, if a patient is not discussed at the MDTM, this cohort of patients should be recorded using field **CR3190 (Attribute 1300)** and **CR3160** with the phrase: "*Patient on predefined Standard of Care*".

## Locally agreed protocols

The minimum data should be supplemented by specific data items as required by cancer site, these may include:

- Molecular profiling as related to a particular cancer tumour
- Specific imaging protocols for a tumour site to ensure consistency of imaging across referral pathways
- Other fitness assessment parameters, e.g. frailty assessment, as per SoCs.

### Clinical trials

Research is central to improving the health and care of the population. All patients, whether they are discussed in the full MDTM or their need is met by a Standard of Care, should be considered for clinical trials. This should remain of central importance as MDTM streamlining is implemented.

Each MDT must have access to an up-to-date list of clinical trials available, and cases not being discussed must be screened for potential suitability in liaison with one of the NIHR's 15 Local Clinical Research Networks.

## Personalised care

The NHS Long Term Plan sets the ambition to offer personalised care to all cancer patients and transform follow-up care, giving people choice and control over the way their care is planned and delivered. MDT Streamlining should support the drive for personalisation and ensure that shared decision-making in care, and personalised care and support planning, are routine for all patients.

Personalised care and support planning (based on a Holistic Needs Assessment) ensures focus on what matters to the individual and their strengths, needs and preferences. Resources to support these conversations are available online on the NHS England and NHS Improvement website, and GMC guidance sets out expectations on including patient preferences into the decision-making processes around care.

Teams should ensure that they consider the needs of patients with protected characteristics, including those groups of people who are not usually provided for by healthcare services, such as rough sleepers, vulnerable migrants, and people living in the most deprived areas and geographies, i.e. rural areas, as we know where people live impacts on how much they engage with treatment and care.

# Case studies

## Breast Cancer MDTM at Bart's Health NHS Trust

Bart's Health had two Breast MDTMs occurring weekly at across two sites. Caseloads in each of the MDTMs had been steadily increasing, impacting on workload, MDTM length, and in turn the time and quality of information available for individual patient discussions. To improve the management of the MDTM caseload, one of the MDTMs piloted the use of prospective treatment protocols.

In the pilot, a triage panel made MDTM recommendations in cases where protocols applied, consisting of an MDT Coordinator, Radiologist, Oncologist, Surgeon and CNS. This was with a view to reducing the number of cases requiring full discussion where a protocol could apply, reduce those requiring re-discussion due to incomplete data, and provide a forum to resolve issues without the need for MDTM discussion. The panel met for an hour on average, two days prior to the weekly MDTM, and the triage outcome was recorded live on CRS.

On completion of the pilot the average number of patients on the list in the MDTM reduced from **89 to 57**. This **35%** reduction in list size was through a combination of both protocolised patients and other MDT streamlining, e.g. patients not discussed due to incomplete data. It enabled the two MDTMs to be amalgamated and now all Bart's Health referrals are triaged under a single MDTM.

*"The triage MDM process has been excellent from a radiologist point of view as it has generally saved an hour of prep time and also gives the presenting radiologist more time to concentrate on those cases that are on the main meeting."* **Bart's Radiologist.**

## Urology MDTM at Southport and Ormskirk Hospital NHS Trust

The Trust has a weekly urology MDT – including renal, prostate, and bladder cases. The MDM discusses 20-30 cases per week, with the caseload steadily increasing and the MDTM now running for one and a half hours. In an effort to improve management of the caseload, the MDTM piloted the use of prospective treatment protocols for bladder cancer, with a view to protocolisation in further tumour sites.

To begin implementation, options for piloting were discussed with the MDTM and the clinical lead completed a standard of care (clinical protocol) for bladder. The Cancer Manager was involved in discussions and the triage process agreed, with the standard of Care running alongside the MDT for a period to test its suitability.

Key tips for implementation included: ensuring quality of data for decision-making in triage; engage the whole MDT from the beginning; allow time in job plans; start small and build on the improvements, e.g. testing protocols by having them run alongside. Triage was completed one or two days before the weekly MDTM with the decision recorded and processed by the MDT Coordinator and Urology nurse. Where patients did not require discussion at the MDTM, outpatient appointments and investigations were booked and documented. With typical referral numbers, it was expected that **around 15% of cases would be triaged** each week – equating to around 10 minutes of time released for members of the MDTM.



# Audit

For safe and effective introduction of predetermined Standards of Care, the audit processes set out in the sections below must be embedded before SoCs can go live.

## Streamlining and national guidelines

Where MDTs introduce streamlining as set out in this guidance they will remain compliant with the relevant quality surveillance indicators relating to scheduled treatment planning MDT meetings.

The national requirement is now for individual scheduled treatment planning MDT meetings to be quorate on 95% or more occasions. There is no longer a requirement for a minimum attendance by individual members. The detail of required roles and what constitutes a quorum is set out nationally in the Quality Surveillance quality indicators and Service Specifications, where applicable.

Trusts should continue to work to the latest national standards in reviewing and investigating deaths of patients; this is set out in guidance from the National Quality Board, and MDTs should continue to monitor 30-day mortality at the appropriate mortality meetings and maintain oversight of relevant data.

## Local audit of SoCs at the MDTM

Audit of MDTM outcomes and processes is central to the assurance of standards. Regular audit of cases to the MDTM should also take place so that the new way of working can be reviewed for learning purposes; audit subjects outlined in the Annex are compulsory to facilitate learning between Alliances, Cancer Centres and MDTMs within the same Centre. Teams must ensure that, as any changes are brought into effect, the quality of data collection and input is maintained as this remains critical for the Cancer Registry and other data collection.

Findings should be reported to the Cancer Alliance Tumour Pathway Board (or equivalent) and Clinical Directors and used for a continual cycle of improvement to pre-determined Standards of Care and processes. This should include a conversation with patient representatives to the pathway board to discuss findings. MDTs may want to identify a data lead to support collation of audit data.

## Frequency of audit

MDTMs should review a sample of patient data **quarterly**, covering both patients on predetermined Standards of Care, and those referred for discussion at the MDTM.

This will not replace pre-existing arrangements for annual operational meetings for MDTMs. Process and outcomes of the audit should be documented.

The regular audit of patient cases can be phased to less frequent 6 or 12 monthly audits if the following conditions are met:

- It is a clinically-led decision by members of the MDT when the process of streamlining has become routine practice;
- It includes consideration of acceptable audit findings;
- It is done in agreement with the Medical Director and Lead Cancer Clinician.

## Topics for inclusion in audit

Audit meetings should cover both clinical and operational functioning of the streamlining MDT Meeting. Topics for inclusion are outlined in the Annex. Teams should ensure that they consider the needs of patients with protected characteristics, including those groups of people who are not usually provided for by healthcare services, such as rough sleepers, vulnerable migrants, and people living in the most deprived areas and geographies, i.e. rural areas, as we know where people live impacts on how much they will engage with treatment and care.

### **The MDT Meeting as a learning opportunity**

The introduction of Standards of Care to MDT Meetings provides an opportunity to contribute to the MDT as a place for learning. There are a number of ways that streamlining could be utilised, including: Scenario-based team meetings linked to audit; a quarterly 'learning' MDT where a sample of listed cases are included for discussion; presentation of clinical audit by an information or data lead, and; inclusion of, for example trainees or CNS's, in the pre-MDT triage process.

# Next Steps and Implementation

This guidance is intended to provide a permissive framework for Cancer Alliances and Trusts to assess how patient care and operational management of MDTMs could be enhanced through streamlining MDTMs. It sets out approaches to streamlining, implementation of Standards of Care, and audit of new processes.

On publication, Cancer Alliances should work with Trusts and clinicians in their patch to identify appropriate tumour sites and MDTs in which to begin streamlining. Included in this guidance are helpful tips on how this should be approached. It is suggested that sites begin to introduce streamlining in first selected sites within six months.

To support implementation, the NHS Cancer Programme will be working with professional bodies and Alliances to coordinate development of an initial set of Standards of Care. These will be shared through the Cancer Alliance workspace online. Cancer Alliances should utilise the Workspace to coordinate and share development of further Standards of Care for adoption locally. This is central to promoting good practice and avoiding duplication of effort between Alliances.

Cancer Alliances should closely monitor uptake and outcomes of MDT Streamlining while it embeds in Trusts across 2019/20. Alliances will play an ongoing role in monitoring the uptake and outcomes of streamlining MDT Meetings. The content for audit meetings as well as data from COSD should be considered for an annual report to the Cancer Alliance Board, which can also help to inform the roll-out of the Faster Diagnosis Standard and timed pathways.

# Annex

Quarterly audit meetings should cover, but not be limited to, the following topics:

## i. Clinical model

Topic	Definition
Completeness of minimum data set	Review sample and consider if any issues arising in data quality for designation of patient cases to Standards of Care, or for discussion.
Changes needed to minimum data set	Assess any additions or amendments needed to the minimum data set, e.g. tumour specific data.
Suitability of Standard of Care for cases either assigned for discussion, or not for discussion, at the MDTM.	Upon a re-examination, would any patients be assigned differently? For any scenario where a case could have been assigned differently, consider whether this may have changed the treatment recommendation.
Adherence to the Standard of Care	Proportion of patients where decision at pre-MDT meeting followed through, and assessment of any changes to decision.
Clinical trials considered for patients on Standards of Care	Assess any change in consideration for, or uptake of, clinical trials for patient not discussed vs those discussed at the MDTM; assessment of proportion of patients considered for clinical trials overall.

## ii. Operational model

Topic	Definition
Impact on staff time, in particular: radiology and pathology	Assessment of impact on staff time for those involved in triage or pre-MDTM review, and consider options to manage
Efficiency of triage process and assignment to Standards of Care	Review set-up of pre-MDT process: how is this working? Do any changes need to be made?
Proportion of patients on Standards of Care	Percentage of patients assigned to standards of care compared to overall caseload to assess scope of streamlining
Impact of streamlining on MDT Meetings	How is streamlining impacting on time for those patient cases which require discussion? What impact on total length of the MDTM?