Multidisciplinary Team Working

A resource for independent sector providers

June 2024

Introduction

Good Medical Practice requires medical practitioners to work with colleagues in ways that best serve the interests of patients[1]. The value of a multidisciplinary team working across cross sectors in the interests of optimising patient safety and patient outcomes[2] is well established. The use of multi-disciplinary teams (MDTs) as part of a patient's care pathway to provide team based clinical decisions based on review of clinical documentation, such as, case notes, test results and diagnostic imaging is now accepted as standard practice in many areas. In particular, this is the case in patients with complex care needs, for example cancer, where MDTs are viewed as the gold standard for care.

The Medical Practitioners Assurance Framework[3] (MPAF), refreshed in 2022, helps independent providers to strengthen assurance processes that support medical practitioners to deliver quality care to patients being treated in their organisations. The MPAF continues to emphasise the need for formal multidisciplinary team working. This would include how relevant clinical data are transferred, the multidisciplinary specialists that constitute a quorate team, how the team operates and how outcomes are audited.

Traditionally, MDT meetings happened face-to-face. But MDTs are increasingly using technology to enable them to 'meet' remotely and asynchronously. This transition to remote meeting formats was accelerated by the COVID-19 pandemic. Virtual and hybrid meetings are now much more prevalent, and present both opportunities and challenges to effective MDT working[4].

In the independent sector there also are different ways of operating MDTs. For example, external MDT meetings provided through NHS organisations on a Service Level Agreement or MDT meetings carried out within local independent providers (using traditional paper-based formats or digital asynchronous platforms).

As part of its ongoing programme of work, IHPN is committed to identifying and sharing good practice and innovation in MDT working, recognising that whilst much current guidance focuses on cancer patients, that best practice supports the use of multidisciplinary teams in other medical settings.

1. General Medical Council (2024). Good Medical Practice. Available from: https://www.gmc-uk.org/professional-standards/good-medical-practice-2024 [online]
2. Department of Health and Social Care (2021). Government response to the independent inquiry report into the issues raised by former surgeon Ian Paterson. Available from: https://www.gov.uk/government/publications/government-response-to-the-independent-inquiry-report-into-the-issues-raised-by-former-surgeon-ian-paterson/government-response-to-the-independent-inquiry-report-into-the-issues-raised-by-former-surgeon-ian-paterson [online].
3. Independent Healthcare Providers Network (2022). Medical Practitioners Assurance Framework. Available from: https://www.ihpn.org.uk/report/medical-practitioners-assurance-framework-mpaf-refresh/ [online]
4. Running virtual and hybrid cancer multi-disciplinary team meetings. An evidence-based best-practice toolkit. Developed by the RECONCILE collaboration supported by North Central London Cancer Alliance and funded through Q Exchange by The Health Foundation and NHS England. Dec 2022. https://www.nclcanceralliance.nhs.uk/news/reports-and-publications/mdt-toolkit/

Section 1

Purpose of this resource

This resource is for independent providers to use to develop, strengthen and improve their approaches to MDTs. It aims to provide support to all independent providers, regardless of their size, structure or the clinical activity that they undertake. Whilst MDTs will vary from setting to setting, using this resource as a tool to support review of MDT arrangements will facilitate consistency of approach to MDTs and help improve their quality across the independent sector.

First, the resource provides principles to help independent providers to identify when MDT meetings might be in the best interest of, and therefore should be considered for, patients being treated in their organisations.

Second, it outlines in broad terms the core best-practice principles that all independent providers need to consider when setting up and running MDT meetings, however they are provided.

Third, it shares examples of practice from across the independent sector and the NHS, both to stimulate and to support independent providers to strengthen the governance around their MDTs as well as to develop and innovate their approaches.

Where resources already exist to support independent providers with MDTs, these are signposted rather than replicated in this document.

Section 2

When is an MDT meeting necessary?

Access to an MDT can ensure that patients benefit from the range of expert advice needed for high quality care. MDT meetings are not necessary for all patients and are dependent on the patient's diagnosis and the nature and complexity of the care being provided. MDT meetings for more straightforward procedures are generally not warranted. Whilst it is not necessary, or desirable, for all patients treated in the independent sector to be reviewed by an MDT, independent healthcare organisations do need to identify when MDT meetings should be part of a patient's care pathway.

Rather than providing a list of conditions where MDTs should be considered standard practice, which would rapidly date, this resource provides two principles for independent providers to use to evaluate when patients being treated in their organisations should have an MDT review or could potentially benefit from one.

The following principles will help identify situations where collective opinion is in the best interest of the patient, the organisation and the medical practitioner:

- Is an MDT required by authoritative guidance?
- Is an MDT considered to be good practice?

2.1. An MDT is required by authoritative guidance

MDTs in some areas of care are well established and accepted as the gold standard of practice. This is typically reflected in guidance issued by authoritative national organisations. These organisations include professional Royal Colleges or societies, NHS England (for example, through the Getting It Right First Time (GIRFT)[5] programme) and the National Institute for Health and Care Excellence (NICE).

Independent providers should follow guidance produced by authoritative national organisations and MDT meetings should be held when required by this guidance. It is the responsibility of the independent provider and the consultant responsible for the patient's care to ensure that the patient has an MDT review in line with authoritative guidance.

For example, the use of MDT meetings in cancer is well established and national guidance requires all cancer patients to have appropriate MDT meetings[6]. Examples of other conditions where MDTs are recommended include, weight-loss surgery where NICE recommends an MDT approach[7] and complex spinal surgery when NICE and national guidance recommend an MDT approach[8].[9],[10].

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5. Getting It Right First Time. Available from: https://gettingitrightfirsttime.co.uk
6. In the NHS, once diagnosed and staged, cases that fit into an existing pathway (Standards of Care) can be managed without repeat discussions. NHS England and NHS Improvement (2020). Streamlining Multi-Disciplinary Team Meetings, Guidance for Cancer Alliances. [accessed online].
7. National Institute for Health and Care Excellence. Obesity: identification, assessment and management. Clinical guideline [CG189] chapter 1.10 Surgical Interventions. Last updated: 26 July 2023. [accessed online].
8. Getting it Right First Time – Spinal Surgery (https://www.gettingitrightfirsttime.co.uk/surgical-specialty/spinal-surgery/
9. National Institute for Health and Care Excellence. Spinal cord stimulation for chronic pain of neuropathic or ischaemic origin. Technology Appraisal 159. 2008 reviewed 2014. [accessed online].
10. The British Association of Spinal Surgery (BASS) https://spinesurgeons.ac.uk/[accessed online].

2.2. An MDT is considered best practice

Where an MDT review is not required by authoritative guidance but a best practice treatment pathway includes one, or it is routinely done in the NHS, independent providers should be guided by this as a default position.

This might include situations where there is no clear standard treatment pathway or there is a range of different treatment options. In cases where one of the treatment options is an 'innovative' procedure or the safety/effectiveness of a proposed treatment is unclear or unknown[11] or when a treatment option deviates from accepted practice. Complexity of the patient's condition, including having received multiple rounds of treatment already, may also suggest the need for an MDT review.

Similarly, situations where any decision to treat a patient may have significant consequences for the patient going forward, for example irrevocable procedures or when a patient has had previous significant treatment, and the benefits of no treatment versus further intervention (such as revisions) would benefit from discussion somewhat independent from the original treating consultant.

2.3. Other considerations

How decisions are taken about whether or not MDT review will be part of the patient's care should be documented so that there is clarity around why, or why not, an MDT was involved. If there are cases where an MDT meeting would ordinarily be expected but was not performed, for example, in an urgent situation, appropriate governance procedures should be in place. *See Example of Practice 1. Governance arrangements if an expected MDT meeting did not take place.*

There are also likely to be variations in the size of MDTs, as no one size will fit all. Independent providers need clarity about the focus of different types of MDTs, how they are constituted and which patients are being discussed. For example, when to use a specialist MDT as opposed to a local MDT that might be used for patients with less complex presentations. Or, where medically complex patients are being discussed for surgery or where surgery is particularly high risk or complex, it would be good practice to include an anaesthetist in the MDT discussion.

11. All independent providers should have policies in place for the use of innovative procedures or clinical trials.

Section 3

Characteristics of effective MDTs

Good practice guidance that supports the operation of MDT meetings, in particular cancer MDTs, is available from NHS England. The guidance is broadly applicable to the independent sector and has been used by several independent providers to support the development of MDTs in their organisations.

Rather than duplicate existing guidance, the core principles of the NHS guidance[12] are outlined briefly below with a focus on the challenges that are particular to the independent sector. Additional references and resources to support MDT development can be found in Section 5.
Broadly speaking the core principles that underpin effective MDT meetings are:

- The Team
- Infrastructure for Meetings
- Meeting Organisation and Logistics
- Patient Centred Clinical Decision-Making
- Team Governance

These core principles can be used to support the development of effective MDT meetings whether carried out within independent providers or outsourced, for example, through service level agreements with existing NHS providers. *See Example of Practice 2. Highly specialist MDTs*

3.1. The team

Core multidisciplinary membership of the MDT, attendance requirements, quorum, how the team is led, both in terms of the meeting itself through a chair and more generally to manage issues of governance, and escalation of concerns must be defined and recorded. There should also be expected norms for the behaviours and culture that promote team working, including an expectation that all team members actively participate, fulfil their roles in the MDT and access the necessary personal development and training opportunities in support of their roles.

For the independent sector there can be specific challenges around quoracy to overcome as MDT members with the expertise needed may not be employed by the independent provider and the teams may be structured differently depending on the clinical speciality. The leadership role, responsibilities and accountability of the MDT Chair are crucial to the effective functioning of MDT meetings and should be formally recognised by the independent provider (see also Team Governance 4.5). *See Example of Practice 3. Leadership and management of MDTs.*

3.2. Infrastructure for meetings

The infrastructure necessary for the effective functioning of MDT meetings should be defined to ensure that technology allows members access to all the relevant clinical information necessary for an effective discussion about the patient's care and facilitates the recording of decisions. As care is delivered in a more joined up and integrated way, this may include provisions for information sharing across organisations where MDTs have professionals from different sectors. Meetings might be in physical meeting rooms, virtual/hybrid meetings or asynchronous MDTs run entirely online. Patient confidentiality must be guaranteed, irrespective of the platform used for the MDT meeting. *See Example of Practice 4: Using an asynchronous MDT meeting platform.*

12. NHS National Cancer Action Team. The Characteristics of an Effective Multidisciplinary Team (MDT). 2010.

3.3. Meeting organisation and logistics

MDT meetings need to be scheduled to enable patients to be considered ahead of any planned interventions. The information required ahead of the meeting should be defined in order for the MDT to function and make appropriate recommendations. This would include, for example, information relevant to the patient's clinical risk profile in relation to treatments under discussion. The organisation and logistics of meetings may vary depending on whether the meetings are in person, virtual/hybrid, or asynchronous. *See Example of Practice 5. Running effective virtual and/or hybrid MDT meetings.*

How the meeting will be organised and the administration necessary during the meeting should be defined, including how MDT discussions are captured accurately (what is discussed and by whom, treatment options considered, what decision is made and why). This includes how the MDT meeting notes and recommendations are recorded in the patient's records and securely transmitted to the clinicians responsible for each patient's direct care and other relevant healthcare professionals. Following the MDT meeting, processes need to be in place to ensure decisions are communicated within agreed timeframes and that patients are tracked through the system to ensure that any appointments, tests or procedures recommended, are carried out. *See Example of Practice 3. Leadership and management of MDTs.*

3.4. Patient-centred clinical decision-making

As highlighted earlier, independent providers need to have systems in place to identify which patients need an MDT discussion. Patients should be aware of the MDT meeting, understand its purpose, its members and their roles. Patients should be clear about the timeframes for discussion of their case at an MDT meeting. Recommendations made at the meeting should be discussed with the patient, again within agreed timeframes, by the clinician in charge of their care in the independent sector to reach a shared decision on the patient's treatment. Independent provider's audit activities should include the impact of MDT recommendations on patient outcomes, for example, through patient reported outcome measures (PROMs).

3.5. Team Governance

Independent providers need to ensure that MDTs are appropriately resourced and available to all patients whose care requires involvement of an MDT. This will include ensuring adequate funding in terms of people (clinical and administrative), time, equipment and facilities for MDTs to operate effectively. The resourcing of MDTs should be subject to regular review, in particular as models for the provision of MDT meetings in the independent sector evolve.

MDT meetings should also be subject to clinical governance processes that enable audit of processes, documentation of discussions, communication of recommendations, actual treatment given and patient outcomes and experience (see also Patient Centred Clinical Decision Making 4.4). See Example of Practice 7. Audit and assurance of MDT meetings. This should include an escalation process for non-compliance as well as a process for sharing good practice and/or treatment complications with the MDT and more widely. Any conflicts of interest must be declared and if appropriate acted upon.

Section 4

Examples of practice

Example of practice 1 - Governance arrangements if an expected MDT meeting did not take place

As highlighted in the resource, decisions about whether or not an MDT discussion will be part of the patient's care should be documented so that there is clarity around why, or why not, an MDT meeting was held.

Independent providers should have procedures in place to cover situations where it is not possible to hold the MDT meeting that forms part of the patient's pathway of care prior to an intervention, for example, where a patient requires urgent care or their condition changes unexpectedly.

Procedures will vary between independent providers, dependent on the nature of the provider and the type of patients being treated. However, they should include a process for making a decision not to hold an MDT meeting, documentation is required to show that process has been followed and the rational for the decision. Some approaches used by independent providers include:

- The consultant in charge of the patient's care discusses the case with another consultant or the Medical Advisory Committee Chair ahead of the intervention. Those discussions are fully documented.
- The Chair of the MDT makes the decision to proceed with an urgent intervention in conjunction with another member of the MDT. That decision is formally ratified at the subsequent MDT meeting.
- If the patient's pathway includes an MDT meeting, governance processes ensure that theatre time cannot be booked unless it has happened. If a procedure were to go ahead without the MDT a retrospective MDT would review what happened.

Example of practice 2 - Highly specialist MDTs

Some patients treated in the independent sector are in need of highly specialist MDT input into their care. These patients are complex and typically seen in low numbers in independent providers. In these cases, the NHS and independent providers can make arrangements for MDTs in NHS specialist centres to review independent sector patients at their meetings.Rare/ low volume cancers which have been centralised even in the NHS are examples of this.

The National Hospital for Neurology and Neurosurgery, Queen Square has an MDT that is used to review the small number of patients from The Cleveland Clinic requiring specialist input prior to neurosurgery for cancer. Similarly, HCA Healthcare UK work with NHS Cancer MDTs for The Christie Private Care to refer and discuss all cancer patient groups except Breast, including Sarcoma, Lymphoma, and Cancer of Unknown Primary.

Examples of practice 3 - Leadership and management of MDTs

The importance of MDT leadership is recognised at HCA Healthcare UK where MDT chairs can have a standardised role/job description and access to a training scheme to help improve chairing skills where necessary. In addition, to ensure no MDT meetings are cancelled due to Chair availability, all service line MDTs within HCA UK have nominated co-chairs to take on the Chair role when needed, including signing the MDT outcome recommendations.

Robust management of the MDT process is enabled by dedicated MDT coordinators employed by HCA Healthcare UK. The MDT coordinators work closely with the MDT Chairs to ensure that the MDT processes run smoothly. For example, the offer of pre-MDT triage meetings with a small focused group of suitable clinicians, clinical nurse specialists and the MDT coordinator in advance of the MDT to review and streamline (against nationally agreed standards of care) the agenda ensuring that patients listed for full MDT discussion are suitable (e.g. the minimum core data set is available including all necessary investigations). The results of the pre-MDT triage are communicated to all MDT members and any patients not reviewed have a responsible healthcare professional assigned.

Examples of practice 4 - Using an asynchronous MDT platform

Spire Healthcare has introduced an asynchronous MDT platform that is available to consultants undertaking complex spinal surgery. The platform used is one that is currently used in Spire Healthcare for Oncology Care across the Group. Patients are added to the electronic platform by their consultant prior to surgery. Information on demographics and relevant clinical details are uploaded, a link to any relevant imaging is also included. A clinic letter can also be uploaded to the platform if required to minimise duplication of data entry.

The MDT consists of the patient’s consultant, three standing MDT panel members (two spinal surgeons and a radiologist) and the MDT coordinator. The digital platform is available for use 24 hours a day and can be accessed at the MDT panel members convenience and independently of other panel members. All members of the MDT review the patient details, proposed surgery and relevant imaging. They then complete the proforma template, which includes a section if members have additional questions. The MDT coordinator ensures that additional questions are answered and keeps the MDT on track so that discussions are concluded ahead of the patient’s surgery. If all MDT members are in agreement, then surgery is scheduled. If there is any uncertainty over the surgery that requires further discussion a virtual MDT meeting is scheduled with the panel and the listing consultant.

The system tracks all entries and is fully auditable. Once the MDT is finished, a pdf of the outcome is generated for the patient’s medical records. The asynchronous platform has been well received by consultants and is resulting in meaningful MDT outcomes, furthermore it is recognised as an effective use of time. Further MDTs are being developed based on these principles.

Examples of practice 5 - Running effective virtual and/or hybrid MDT meetings

North Central London Cancer Alliance, Q Exchange by The Health Foundation and NHS England have developed a toolkit to be used by cancer multi-disciplinary team members to support them to run and participate in effective virtual and hybrid MDT meetings. The toolkit is based on evidence from a national programme of research with cancer MDT members.

Traditionally MDT meetings have been held face-to-face. Increasingly, MDTs are now adopting remote technologies, a transition that was accelerated by the Covid-19 pandemic. Running remote and/or hybrid MDT meetings poses both opportunities and challenges. The aim of the toolkit is to optimise patient care and MDT members' experience when meetings are run in virtual or hybrid forms.
Whilst the toolkit is aimed at cancer MDTs in the NHS in England, much of the content and learning is relevant to virtual/hybrid MDT meetings for patients with other clinical conditions, and to the independent sector. It can potentially be adapted to individual MDT needs in the independent sector.

As well as the full toolkit a one-page summary of core best practice principles and checklist has been produced. The research behind the toolkit is published in BMJ Open.

Examples of practice 6 - Engaging patients in the MDT process

Nuffield Health have developed and implemented a gold standard spinal patient framework and pathway which outlines the requirements and standards for hospitals providing spinal services. This framework draws on national guidance and subject-specific best practice to aid hospital teams in providing a service that is safe, effective and results in great patient outcomes. A crucial factor in this framework is the MDT meeting process and how patients are engaged in the MDT process.

Consultants write to patients if they are to be discussed and notified of the MDT outcome. If mobility concerns are raised at the MDT meeting, the physiotherapists call the patient to discuss their home and social support situation in order for the patient to put practical solutions in place prior to surgery to enhance their recovery. If required, the spinal nurse calls any complex patients and/ or their care givers to instigate conversations regarding realistic expectations of surgery. This includes discussions about preparing physically and mentally for surgery and post-op recovery, and to initiate care planning and support for discharge.

Through engagement with the patient, a collaborative approach aims to proactively set the patient up for the best chance of success and a positive outcome from their surgery. In addition, patients feel more confident in their medical management plan as further expert clinical opinions have been sought and given.

A patient journey video is available on the hospital website Wessex Hospital Spinal Service | Nuffield Health.

Examples of practice 7 - Audit and assurance of MDT meetings

Monitoring the effectiveness and outputs of MDT meetings is an important part of the overall MDT process. As part of their audit programme, Circle Health Group have developed and implemented two audits to evaluate the MDT meeting documentation and the overall quality of the service via a quality audit tool.

The MDT meeting documentation and quality audits monitor and ensure that attendance compliance of its core members is maintained throughout the year. They also allow Circle Health Group to review the quality of the documentation and discussion, as well as the robustness and quality of the documented outcome. These audit tools allow Circle Health Group to review the number of cancer related procedures per consultant clinician per annum, associated morbidity and complications, adherence to the MDT output and mortality within 30 days of treatment. The quality review allows for the output documentation to be reviewed against published guidelines to ensure compliance.

Section 5

Resources to support MDT development

- NHS National Cancer Action Team. The Characteristics of an Effective Multidisciplinary Team (MDT). 2010. [accessed online]

- NHS England and NHS Improvement (2020). Streamlining Multi-Disciplinary Team Meetings, Guidance for Cancer Alliances. [accessed online]

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- Mughal M, Goodman J. MDT Improvement Report. UCLH Cancer Collaborative 2017. https://www.canceralliance.co.uk/application/files/3816/0622/8013/MDT_IMPROVEMENT_REPORT_-_UCLH.pdf

- Running virtual and hybrid cancer multi-disciplinary team meetings. An evidence-based best-practice toolkit. Developed by the RECONCILE collaboration supported by North Central London Cancer Alliance and funded through Q Exchange by The Health Foundation and NHS England. Dec 2022.

- Soukup T, Lamb, Sonal A et al. Successful strategies in implementing a multidisciplinary team working in the care of patients with cancer: an overview and synthesis of the available literature. Journal of Multidisciplinary Healthcare 2018:11 49–61 [accessed online].

Reference Group Members

Name	Title	Organisation
Mr Ahmed Ahmed	Consultant Surgeon	Royal College of Surgeons
Catherine Picton	Project lead and author	Policy and Healthcare Consultant
Dr Cathy Cale	Group Medical Director	Spire Healthcare
Dr Charles Ranaboldo	Chief Medical Officer	Ramsay Healthcare UK
Christopher Peters	Medical Director	Medefer
Dr Cliff Bucknall	Medical Director	HCA Healthcare UK
Dr Davina Deniszczyc	Medical and Charity Director	Nuffield Health
Dawn Hodgkins	Director of Regulation	IHPN
Dr Helen Hartley	Associate Medical Director and Chair, Association of British Insurers Patient Safety Working Group	Aviva
Dr Howard Freeman (Chair)	Clinical Director	IHPN
Dr Julia Wendon	Medical Director	The London Clinic
Linda Jones	Head of Patient Safety and Quality Governance	IHPN
Luke Soper	Medical Effectiveness Lead	Nuffield Health
Professor Mark Hamilton	Responsible Officer	Cleveland Clinic
Mary Cregg- Lock	Clinical Digital Manager and CSO	Ramsay Health UK
Professor Muntzer Mughal	Director of Surgical Oncology	Cleveland Clinic
Dr Pallavi Bradshaw	Deputy CMO and Patient Safety Committee, Association of British Insurers	AXA Health

Reference Group Members

Name	Title	Organisation
Mr Peter James	Group Medical Director	Circle Health Group
Dr Phillip Harrison	Corporate Medical Director, Governance	HCA Healthcare UK
Rachel Power	Chief Executive	The Patients Association
Dr Richard Cohen	Medical Director	Cleveland Clinic
Miss Stella Vig	National Clinical Director	NHS England
Stella Williams	Senior Specialist, Secondary and Specialist Care	Care Quality Commission
Victoria Wright	Deputy Director of Clinical Effectiveness	Spire Healthcare

Additional input and/or comments on the resource were provided by:

- Aprajay Golash, British Association of Spine Surgeons
- Mr Ben Lamb, Barts Health NHS Trust
- Fiona Booth, Healthcode
- Dr Fiona Donald, Royal College of Anaesthetists
- Dr Harpreet Sarna, Vitality
- Robyn Cutforth, NHS Cancer Programme, NHS England
- Dr Sally Pearson, NHS Resolution

Further copies can be requested from:
Email: **info@ihpn.org.uk**

Independent Healthcare Providers Network
Thomas House, 84 Ecclestone Square,
London SW1V 1PX

Email: **info@ihpn.org.uk**
or visit: **ihpn.org.uk**

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