

## Is Your MDT Fit for Purpose?

A UKLCC sponsored session at  
*International Lung Cancer Conference*  
At Liverpool Convention Centre  
Thursday 10<sup>th</sup> July 2008

*The United Kingdom Lung Cancer Coalition (UKLCC) is a powerful new partnership of leading lung cancer experts, senior NHS and Department of Health professionals, charities and healthcare companies.*

*The UKLCC is the nation's largest multi-interest group in lung cancer and this is the first time all the interested parties have joined together to give people with lung cancer a true voice.*

*The UKLCC is supported via funds and in-kind support provided by the partners, who are bound by a funding and governance policy.*

*This symposium aimed to review the current status and impact of MDT working in lung cancer care in the UK by inviting a range of speakers to give their perspectives and recount their experiences of MDTs. Using the presentations and feedback from the audience, the session aimed to build up a detailed picture of the ideal lung cancer MDT.*

*The views on MDT working explored in the session will be fed back to the Department of Health and the Cancer Action Team to input into their strategy to improve the standards of MDTs working nationally.*

### **Chair**

Dame Gill Oliver (Chair, UKLCC and Trustee Roy Castle Lung Cancer Foundation)

### **Speakers**

Mick Peake, Chair of UKLCC Clinical Reference Group

Cheryl Cavanagh, MDT Lead, Department of Health, Cancer Action Team

Trevor Rogers, Consultant in General Medicine, Doncaster Royal Infirmary

Robert Rintoul, Consultant in Respiratory Medicine, Papworth Hospital, Cambridge.

## **Chair's introduction**

*The session was introduced by Gill Oliver, who emphasised the need for current improvements to MDT working to make an impact on the lives of people with lung cancer. The UKLCC aim to double 1-year lung cancer survival rates in the UK by 2010. The Chair lamented the underfunding of lung cancer research but stated that lung cancer MDTs have a valuable role to play in that research by their contribution to clinical trial accrual rates.*

## **What is the evidence that MDT working has improved outcomes in lung cancer?**

*Mick Peake*

That MDTs have a significant and positive impact on patient care has now become an accepted fact. The majority of studies that provide this evidence, focus on the nature of MDT working.<sup>1-4</sup> In addition, there are studies on specific issues such as access to radiotherapy<sup>5</sup> and the impact of surgery.<sup>6</sup>

Some studies show an increase in resection rate as a result of MDT working<sup>6,7</sup>, others improvement in survival rates.

The Papworth study carried out by Laroche and coworkers, showed that following on from the introduction of systematic MDT working, resection rates rose from 10% to 29% in first year - settling at around 25% and the interval between first referral and surgery was halved.<sup>7</sup>

A Scottish study of patients with inoperable stage III or IV disease compared survival in two groups of patients before and after the introduction of MDT working.<sup>3</sup> There were no differences in age, sex and extent of deprivation between the two groups. Results showed a significant improvement in survival when the patients were managed by an MDT: median survival in 2001 was 6.6 months compared with 3.2 months in 1997 ( $P < 0.001$ ).<sup>3</sup> The study by Price echoed these findings in an improved 1-year survival rate of 23.5% with MDT working compared with 18.3% pre-MDT working.<sup>5</sup>

An audit in Oxford found that MDT working led to improved bronchoscopic accuracy for both central and peripheral tumours. In Leicester, the inclusion of thoracic surgeons in the MDT in 1997 followed by a wider service reorganization in 2000 have contributed to a rise in average 5-year survival of patients with lung cancer from 4.97% to 7.48%. Across the UK, relative survival rates in lung cancer increased dramatically between 1991 and 1993 as MDT working became standard practice in many health authorities with up to a four-fold difference in survival rates.<sup>9</sup>

In summary, MDT working has meant that most patients are now seen by a specialist and discussed at an MDT meeting. The National Lung Cancer Audit (originally called LUCADA) which has been rolled out since the 1990s, found that four-fifths of patients are seen by an MDT.<sup>10</sup> There are shorter waiting times, improved diagnosis and better tracking and coordination of care. Nurse support and improved treatment in some areas are further pluses as well as increased political resource. Most importantly of all these are translating into improved survival.

Key data are being gathered to provide evidence of effective interventions and working practices and enrollment in trials is increasing. The National Lung Cancer Audit has gathered information from over 23,000 patients with lung cancer to find out where there are gaps in treatment provision and regional discrepancies between standards of care. It is hoped the results will improve the quality of care for patients, leading to better outcomes.

However, there is still work to be done. The audit also showed that only 48% of patients received chemotherapy in 2006. How can we achieve aims like this through MDT

working? What makes a good MDT? And how do we assess the quality of MDT working?  
And how do we bring about change where it is needed?

### References

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## Summary of Peer Review findings on Lung Cancer MDTs and how the DH Cancer Action Team plans to approach MDT development

*Cheryl Cavanagh*

Cancer Action Team (CAT) is a national team that supports the NHS and facilitates the implementation of the NHS Cancer Plan which was introduced in 2000. It works closely alongside the Cancer Policy Team in the Department of Health and the Cancer services Collaborative "Improvement Partnership". The CAT also works closely with the strategic health authorities and cancer networks.

The results of the first round of the Peer Review Programme in 2001 were regional. The feedback was judged to be beneficial and the review programme was carried out nationally between 2004-7. The principles of the programme are national consistency, peer-on-peer review (so surgeons review other surgeons for e.g.) and integration with the review of other systems (screening for e.g.). Each peer review is reported in the public domain. The 2004-7 review was of all 34 cancer networks and site-specific groups.

The aim of the review is to ensure safety of services and improve quality and effectiveness which will, in turn, improve patient and carer experience. The review should also encourage the dissemination of good practice.

Thirty-four lung network site specific groups (NSSGs) were reviewed and 175 MDTs (and it is a point to consider whether this is too many MDTs).

The highest compliance with all the NSSG measures in the review was 79%. Of these network groups, 97% meet regularly and 91% follow clinical guidelines.

MDR measures include attendance, membership and patient experience surveys. Overall compliance with MDT measures was 73%. However, MDTs tended to do less well with some of the more detailed guidelines.

In terms of membership, 64% of MDTs had full core membership with thoracic surgeons and palliative care clinicians being the members most commonly missing. Three teams had four core members missing. Full membership for extended teams including social workers and psychiatrists were quite poor.

Attendance at meetings was also quite low with only 39% of core members or cover attending half of meetings.

Issues that need to be resolved include whether we need specialist MDTs and whether members of MDTs incorporate that in their job plan. Low levels of implementing audit findings were also found. The audit found lots of good practice for clinical nurse specialists resulting in nurse-led clinics, home visits, provision of evening appointments for relatives and good support for patients. However, that in turn meant there were many teams with high workloads where further CNS support was needed. It is hoped that the financial restraints of 2006/7 are now easing.

Independent evaluation has shown that there is strong support for the continuation of the review programme. In future the emphasis will switch to outcomes rather than process as measure become available and there will be a greater focus on self-assessment: visits will be the exception rather than the rule.

MDT development goes hand in hand with the Cancer Reform Strategy. Mike Richards spent 4 years putting MDTs into place. The next task is to make them work well. This encompasses examining structure and processes as well as softer issues like team working and leadership. This examination leads to the need for identifying additional support and interventions to be provided where required. We need to consider what differences there are between different MDTs and how we can encompass those differences in the evaluation process. Any comments on how to move forwards would be greatly appreciated.

### **Strengths and Weaknesses of Lung MDTs as they are now: two personal views**

*Trevor Rogers, Doncaster Royal Infirmary*

Trevor Rogers described his MDT as not small and not standard but a good, functional and conventional MDT. The team amalgamates the areas of Doncaster, Bassetlaw and Mexborough, i.e. three hospitals with a relatively high incidence of lung cancer. In 2007, there were 324 new cases of lung cancer.

In terms of MDT structure, they are lacking a core palliative care physician and had a half-time coordinator who is responsible for the database and sending letters. They do have a respiratory physician and a clinical nurse, deemed by Trevor Rogers to be fundamental to the smooth running of clinics.

The MDT team comprises:

- MDT co-ordinator
- 1 histopathologist
- 2 lung specialist interventional radiologists (cross-cover)
- 6 respiratory physicians (4 at DRI, 1 Mexborough, 1 Worksop)
- clinic nurse
- 2 thoracic surgeons (cross-cover)
- 1 clinical & 1 medical oncologist (cross-cover)
- 3 LCNs
- Palliative care NS

The MDT allows referral to the local cancer centre in Sheffield, 25 miles away and thoracic surgery to take place either locally or in Sheffield. This enables patients to be offered the most appropriate treatment to them. But the large number of patients in the MDT area does mean that an MDT in Doncaster is needed. Formerly, treatment choices might be influenced by the proximity of certain options and the patient's willingness to travel. The addition of a local thoracic surgeon to the team in Doncaster was much needed. Now parallel surgical, oncology and medical clinics are possible.

The MDT offers colleagues a chance to swap notes, although they have been criticised for being too friendly and not encompassing a plurality of opinion.

Evidence of this MDT's efficacy was shown in survival rates with 3-year survival increasing from 5.5% to 12% in Bassetlaw over the four years after the inception of MDT working.

An examination of the resection rates shows a dip after the introduction of MDT working but further examination shows this variation in efficacy may be due to locum surgeons and variation between individual surgeons.

The MDT also provides a forum for respiratory physicians working alone to discuss difficult cases. The MDT has high trial recruitment and a pathologist for mesothelioma referrals.

When considering a super MDT, the addition of tertiary centre reference pathologists would be a bonus but meetings would last 6 hours, which may not benefit individual attention given to patients. Patients would also have to travel.

*Robert Rintoul, Papworth Hospital, Cambridge*

This MDT still works within the former West Anglia cancer network arrangements. Referrals from local district general hospitals and other centres come through to Papworth. There are about 700 referrals a year with the majority from local centres. There are two MDT meetings at Papworth: the first looking at surgical thoracic patients and the second at all referrals going to biopsy.

There are essentially two MDTS: one meeting in the morning to discuss surgical and thoracic matters with around 5 to 15 cases and the other in the afternoon to discuss referrals going for biopsy. In total around 80 patients are discussed.

In terms of members, the MDT comprises the following:

- 3 Lung cancer chest physicians

- 4 Lung Oncologists (2 medical)
- 3 Thoracic surgeons
- 3 Lung pathologists
- 3 Lung radiologists
  - 2 CT-PET trained
- 5 Specialist nurses (1 NCRN)
- 1 Palliative Care Consultant (or SpR)

The MDT does enjoy having specialist cases to manage and the level of specialisation means the patient benefits. The meetings are generally amicable with the occasional bit of sparring. Often there is more than one surgical viewpoint. Their patients are usually referred from district general hospitals so also get discussed at the MDTs at these hospitals too. Everyone who is treatable comes through an MDT and the results of PET scans etc come with them, making good use of resources.

In addition to the specialisation, another strength of the MDT is that patients are managed in consistent fashion according to national guidelines.

As many patients as possible are put into clinical trials. This is due in part to the involvement of the specialists in clinical trials and to the routine consideration of each patient for trials.

One issue at Papworth is an increase in meetings to have fewer patients to discuss. This means having a two-day meeting. Administrative support is also an issue so that clinicians can receive accurate clinical data and performance status data. The administrative issues range from uploading information prior to the MDT meeting to the inconvenience of burning CDs in a peripheral hospital.

Finally, increasing reliance on an MDT can mean clinical staff abdicate responsibility when they are unsure what to do. MDT decisions are only recommendations.

We should consider whether all lung cancer patients should be seen by a specialist MDT and if this would lead to a favourable reduction in the overall numbers of MDTs.

## Debate

*The debate on MDT working and structure was then opened up to the floor. The following are the comments from both the audience and the panel.*

### Measuring efficacy in MDTs

- *Efficacy of MDTs is variable. Some have made no difference to practice.*
- *There are lots of MDT coordinators but no classification of the role. Often the coordinators are nurses who gather information but it doesn't have much impact on core data*
- *Do we record what both SpRs and oncologists say? So much is dependent on performance status (PS) and we should be examining consistency in our assessment of PS.*
- *It is important that the Peer Review process takes account of discrepancies in MDT make-up. Local cancer networks are crucial and can hold an MDT together.*

### Other observations

- *The MDT meeting is a useful way of driving partnership.*

- *Putting patients into clinical trials is a valuable thing but we need to make sure that it is an appropriate trial.*

#### Capacity

- *The biggest issue in MDTs is the capacity of the services. If diagnosis takes place in a timely manner, then the problem of capacity rears its head.*
- *Doncaster MDT employing a thoracic surgeon meant that capacity could increase.*
- *There was wide variation in the audience in terms of how quickly test results came back, which would affect efficiency and capacity:*
  - *Some histology results were available the next day*
  - *Biopsies can be batched and a half day set aside to do the pathology for the week*

#### Structure and size of MDTs

- *The choice is hub and spoke or increase the number of hubs and reduce or eliminate the number of spokes.*
- *Need to consider how many times the MDT makes a clinically relevant change to the patient's treatment*
- *An MDT in a specialist hospital might consider pathology reports and CT scans from local MDTs and ask how often they make a clinically relevant change. Robert Rintoul noted that at Papworth they do often make a different decision to the one made in the local hospital and this needs to be handled sensitively.*
- *People don't want to travel to a hospital far away. Need the best treatment at a local hospital*
- *Does peer review work? The centralisation of MDTs makes them unwieldy and inefficient. It is impossible to concentrate throughout a lengthy MDT meeting: better to have a short one at a smaller MDT.*
- *If we have super MDTs, all the information we might know about a patient at local level, such as details of home and social background. An ordinary MDT can still have good surgeons and good resection rates, as in Norwich.*
- *For a super MDT in a specialist hospital, it is important to keep in touch with general hospitals and you can involve local clinicians by meeting them or videolink.*
- *Super MDTs can mean that smaller hospitals lose all their 'interesting' cases to specialist MDTs and that can make one's clinical life less challenging and means that junior doctors lose out on learning from such cases.*
- *Are there checks in place to monitor the link between MDT decision and outcome for the patient as part of the review programme?*
  - *There are the beginnings of evidence including a study from Addenbrookes/Papworth and one from Norwich.*
  - *Making time to monitor and collate this information is a fine balancing act between expertise and locality-based services. Lung cancer is an increasingly complex medical field with growing needs for surgery, scanning and so on. That alone needs commitment from clinicians.*

**Dame Gill Oliver thanked the speakers for their contributions to the debate and closed the meeting**

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