Introduction

The development of multidisciplinary team (MDT) working has been a key feature of cancer services over the last ten years. The NHS Cancer Plan states that every cancer patient should receive clinical management that has been considered by a multidisciplinary team.

The project teams within the Cancer Services Collaborative have worked on improving the function of the multidisciplinary team, as there are a number of key challenges that have needed to be addressed in many places. In particular, these challenges include:

- Agreeing appropriate membership for the MDT and ensuring that all team members attend the meetings
- Ensuring that the care of every patient is discussed at MDT meetings
- Developing effective systems for collecting and presenting the information that is needed for decision-making at the meetings
- Recording the decisions that are made
- Setting up systems to check that the decisions of the MDT are acted upon
- Speeding up and simplifying the referral process between team members
- Involving primary, secondary and tertiary care providers as part of a single team delivering cancer care
- Introducing systems to ensure palliative and supportive care is provided in line with patient needs.

Some teams have begun to take multidisciplinary team working to a more advanced level. This includes making changes such as:

- Agreeing evidence-based protocols for care delivery and ensuring that care is delivered accordingly
- Using the MDT meetings to discuss more complex cases that fall outside the protocols
- Monitoring outcomes information and using this to refine and further develop protocols
- Examining the existing care roles within the team and identifying how these can be redesigned to best meet patient needs.
The case studies that have been included for each theme show how the teams went about developing multidisciplinary team working within their own organisations and networks.

A recent study of a random sample of 72 multidisciplinary breast teams in England examined data on team composition, working methods, perceived effectiveness and clinical performance. The study established that MDT working is positively related to a range of measures of effectiveness, including the quality of clinical care. It also emphasised the importance of the distinction between management and administration – which needs a clear team head, and clinical decision-making – which is most effective in MDTs with a shared leadership style. The findings of this study also indicate that working in teams may be beneficial to the mental health of members. This type of data should help to develop optimal methods of MDT working to maximise clinical effectiveness.

Reference
1: Improved organisation

The key improvements at this stage of the patient journey ensured that multidisciplinary team (MDT) meetings were effectively organised. Typically, this involved making sure that appropriate staff could attend and did attend, that all information was available, and that the decisions made were recorded. The timing of the meeting was often reviewed and changed to reduce delays along the patient journey.

The changes

**King's College Hospital, London** (case study MDT 1.1 (BrC 4.5), page 5)
- A core team of staff that need to attend the MDT meeting was identified. Arrangements were made for cover during leave. Decisions and management plans are entered onto a laptop computer during the meeting and downloaded onto a database afterwards. Copies are circulated to team members.

**University Hospital Lewisham, London** (case study MDT 1.2 (BwC 6.1), page 7)
- A combined lower and upper gastrointestinal MDT meeting now takes place once a week. All patients are discussed, and the combined nature of the meeting makes for best use of the core team.

**Glenfield Hospital, Leicester, Leicestershire** (case study MDT 1.3 (LC 3.2), page 9)
- Improvements to the multidisciplinary team meeting have enabled it to become a major forum for discussing difficult diagnostic management issues, and for giving feedback on treatment outcomes.

**Bromley Hospital, Bromley, Kent** (case study MDT 1.4 (LC 3.1), page 11)
- Co-ordination of the multidisciplinary team meeting has ensured that all patients are discussed and that all information (notes, films, reports and so on) is available.

**Royal Victoria Infirmary, Newcastle-upon-Tyne, Tyne and Wear** (case study MDT 1.5 (BrC 4.4), page 13)
- The meeting is attended by key people, has secretarial support and an electronic record-keeping system. The whole team is involved in making decisions for the patients and information is circulated to all members.
Medway Maritime Hospital, Gillingham, Kent (case study MDT 1.6 (LC 3.3), page 15)

- The MDT meeting was reorganised to ensure representation from oncology and radiology. Input from surgery was gained through a ‘zonal’ MDT meeting at the Maidstone Cancer Centre, where patients from more than one cancer unit are discussed.

Ipswich Hospital, Ipswich, Suffolk (case study MDT 1.7 (LC 3.4), page 17)

- A pro forma was developed to collect information before and during multidisciplinary team meetings, and membership of the MDT was extended.

Leicester Royal Infirmary, Leicester, Leicestershire (case study MDT 1.8 (OC 3.3), page 19)

- The membership of the MDT has been expanded to include the radiologist and palliative care specialist. Meetings are now held weekly rather than fortnightly and attendance has improved from around 80% to 90%. As a result, clinical care has improved and the referral time from surgery to first appointment with the oncologist has been reduced from up to three weeks previously to three to four days now.

Queen Elizabeth the Queen Mother Hospital, Margate, Kent (case study MDT 1.9 (OC 3.2), page 21)

- A fully-integrated MDT, that includes all disciplines, has been developed. The MDT has regular weekly meetings. Patients now receive treatment plans with input from all team members according to agreed protocols.

Leicester General Hospital, Leicester, Leicestershire (case study MDT 1.10 (PC 3.1), page 23)

- Greater commitment to attend MDT meetings was obtained from relevant professionals, and an information sheet was developed to aid communication and ensure that all patients were discussed.

Kent and Sussex Hospital, Tunbridge Wells, Kent (case study MDT 1.11 (BrC 4.3), page 25)

- The oncologist could not always attend the whole MDT meeting because of time pressures. This meant that he was not involved in the discussion of some patients. To resolve this, his workload was reduced by changing the follow-up for radiotherapy patients. He now only sees these patients once, before they are referred back to the surgeon.
Improved organisation

Starting point
There were concerns about the efficiency and effectiveness of the multidisciplinary team (MDT) meeting.

Improvement made
A core team of people who should attend the weekly MDT meeting was identified, with two representatives of each area (for example consultants, histopathologists, and radiologists) to ensure cover for absences. A register of attendance has been introduced.

A pathology list is compiled by the breast unit secretary each Monday and entered on to a database. This is then distributed electronically (via an intranet) to the pathology and breast screening departments to provide details of the patients to be discussed.

A laptop computer is used to record decisions and management plans during the meeting. This is then downloaded onto the database by a member of the breast team immediately after the meeting. The breast unit secretary sends copies of the decisions made and management plans to all attendees.

Challenges in implementing this change
The main challenge has been ensuring duplicate attendance (two representatives cross-covering for each other in each area) at the meeting. This was dealt with by talking to the relevant departments and holding meetings with them.
Impact of this change
The service has become more efficient and accurate as a result. Information is immediately available about what has been discussed and when.

Next steps
There are plans to give responsibility for recording information during the meeting, and disseminating it afterwards, to one named individual. It has not yet been decided who will be responsible for this.

Change principles
B2: Develop systems for team-based review, information sharing and decision-making for the care of every patient.
D6: Plan and co-ordinate staff annual leave.

Further reading
Improved organisation

Starting point
Patients with cancer were discussed in a variety of gastrointestinal (GI) meetings. The multidisciplinary team (MDT) meeting took place on alternate weeks due to the time pressures on key consultant staff. Consequently, there were delays before decisions and treatment plans could be discussed. The MDT discussed only patients with lower GI cancer. There was no record of the key information from the meeting and decisions made, as there were no protocols or forms for recording this information.

Improvement made
The MDT meetings now take place once a week and combine upper and lower GI cancers. These measures mean that:
- Decisions are made more quickly and are shared with the patient before discharge
- Patients with upper and lower GI cancers are discussed within the same forum, promoting seamless care and making best use of the core team
- Decisions are recorded by the cancer data manager on a pro forma, including information about past medical history, diagnosis and management plan.

Challenges in implementing this change
This change required the co-operation of the entire team, and a high degree of co-ordination by the lead clinician’s secretary. This has led to a consensus that an MDT co-ordinator is required.
Impact of this change
All bowel cancer patients are now discussed at the MDT meeting.

Next steps
There are plans to record MDT decisions onto a laptop during the meetings so that they feed directly into a database.

Change principles
B2: Develop systems for team-based review, information sharing and decision-making for the care of every patient.

Further reading
Improved organisation

Starting point

The multidisciplinary team (MDT) meeting was normally held at 8 am on Monday morning. Attendance varied, although a core group was maintained. The meeting lacked structure or direction and not all patients were registered or discussed; however, the potential for improvement of the meeting was recognised.

Improvement made

A project team was put together. The MDT meeting was moved from Monday to Friday, enabling patients seen during the week to be discussed, and is now chaired by the lead lung cancer clinician. A secretary co-ordinates the meeting and all patients for discussion are notified to him/her the day before. All lung cancer patients are registered at the meeting and it has become a major forum for discussing difficult diagnostic management issues. The meeting provides feedback on treatment outcomes so that the team can monitor the progress of patients.

The MDT developed a pro forma which is completed for each patient and returned to the secretary with the patient’s notes before the meeting. The secretary then collates the following information on each patient for the meeting: name; hospital number; reason for MDT referral; diagnostic problem; treatment decision; registration only; and follow-up.

All decisions made at the MDT are recorded on the pro forma and a copy is filed in the patient’s notes. A copy can be used as a referral to the next stage in treatment. A provisional appointment for the next step of the patient’s journey is also made at the MDT meeting.

If the MDT decides to refer a patient for a surgical opinion a consultation with
the surgeon is arranged, wherever possible, for the day of the patient’s first follow-up visit. Patients referred to oncology are seen within seven days, at the next available outpatient clinic.

**Challenges in implementing this change**

Electronically inputting patient details to collect and monitor data and generate referral letters presented some problems as the database was not ready on the launch date. The changes also required additional secretarial time, which has resulted in the need for an MDT co-ordinator being identified.

**Impact of this change**

All patients with suspect or diagnosed lung cancer are now registered and discussed at the MDT meeting.

**Change principles**

A5: Simplify the process by which patients progress from one care provider to another.
B2: Develop systems for team-based review, information sharing and decision-making for the care of every patient.
B4: Measure variation from agreed protocols and compare with outcomes information.

**Further reading**


Improved organisation

Starting point
The referral process to the multidisciplinary team (MDT) meeting was not defined. This resulted in not all patients being discussed. The meeting itself lacked structure and there was a shortage of relevant information about patients (for example, notes and investigation results). Patient care decisions were not documented and sometimes unclear. There was no follow-up on the outcome of previously referred patients.

Improvement made
A secretary now acts as a single point of co-ordination for the MDT and all patients are referred to the meeting using a pro forma. The secretary produces an agenda which includes the reason for inclusion of a patient and sends a copy to the histopathology department. The secretary also ensures that the following information on each patient is available at the meeting:
- Medical notes – clinical information gathered on a pro forma during the first outpatient appointment
- X-ray films
- Investigation reports; and pathology reports.

Notes and X-rays for patients who are currently in hospital will be on the ward with the patient, but the secretary ensures that information about the essential investigations to be discussed is available.

The meeting has been structured so that patients requiring input from only part of the team are discussed towards the end. This allows some members (for example, histopathologists) to leave the meeting after new diagnoses have been discussed.

The meeting is also held before the chest oncology clinic so that patients can be seen...
and given their diagnosis, their treatment explained and referred on to the oncologist within the same clinic if necessary.

The meeting reviews staging for patients who are relapsing and refers them to the visiting surgeon via a direct-access clinic. Difficult diagnostic cases are reviewed by the team, as are patients who are relapsing and require further treatment.

**Challenges in implementing this change**

Extra funding was needed for the additional secretarial time (seven hours per week, which helps with all aspects of service improvement, not just organising the MDT), which ensured that the MDT functioned effectively. This increased staff morale and reduced the administrative burden of the meeting on clinical staff.

Initially, the use of the pro forma to refer patients was seen as a negative step, representing more paperwork for the clinicians. However, the form was designed with substantial input from clinicians to ensure that only appropriate data were requested. This meant that clinicians could see the value of the information they were collecting because it was used to give feedback on the progress of patients after treatment. It meant that information collected could be used as part of the patient record and data collection process. All data required for the regional minimum data set can be collected on these pro forma.

**Impact of this change**

The effectiveness of care given has been increased. All patients undergoing bronchoscopy and needle biopsy of the lung are discussed at the MDT, regardless of the consultant in charge of the case.

**Next steps**

The next step is to ensure that all patients’ details are brought to the MDT meeting (including all ward patients as well as clinic patients). The MDT record could be faxed to the GP as this gives the diagnosis and treatment plan and saves the time of staff in faxing separate information to the GP. It will soon be possible to collect MDT information live electronically, using a field which resembles the paper record.

**Change principles**

A5: Simplify the process by which patients progress from one care provider to another.
B2: Develop systems for team-based review, information sharing and decision-making for the care of every patient.
**Improved organisation**

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**Starting point**
Although a multidisciplinary team (MDT) meeting was running, it was not being appropriately planned and documented and was therefore ineffective.

**Improvement made**
At the Royal Victoria Infirmary, key people attend the MDT meeting, which now has appropriate secretarial support. Decisions and actions agreed are recorded on an electronic database, which is also used for circulating information to relevant people.

To achieve this improvement all the breast teams were brought together and agreement reached on the key people who should attend the MDT meeting (as well as cover arrangements for absences). Funding for secretarial support was discussed and agreed. The requirement for a database was also discussed, with agreement that there would be use of a laptop, and a projector in meetings. The session also acts as a forum for discussing other issues, such as clinical trials.

Work is being done with North Tyneside General Hospital and Wansbeck General Hospital to set up a similar database to support their MDT meetings.

**Challenges in implementing this change**
One of the main problems encountered was in arranging the initial meeting to ensure everyone could attend. There were other challenges in agreeing the type of database needed and in finding secretarial support.

Secretarial support covering two sessions was organised to gather the information needed to set the meeting up, record the meeting and to disseminate information.
Impact of this change

The whole team is now involved in making sure that the correct decisions are made for each patient. All information is recorded and circulated to appropriate people. Patients leave each clinic appointment with a clear view of their treatment pathway, removing much uncertainty and anxiety.

Next steps

Plans are in development to make sure that the patient’s GP receives a copy of the information discussed at the MDT meeting. Expansion of this work to other hospitals in the area is also under way.

Change principles

B1: Encourage primary, secondary and tertiary care providers to see themselves as part of a single team delivering cancer care.

B2: Develop systems for team-based review, information sharing and decision-making for the care of every patient.

Further reading

Improved organisation

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Starting point
Multidisciplinary team (MDT) meetings sometimes had insufficient information available for discussion. The timing of the meetings made it difficult for representatives of radiology or oncology to attend, with a consequent reduction in their input. The trust covers multiple sites and patients at Medway Maritime Hospital were not receiving a surgical opinion at the meeting.

Improvement made
A project team was put together. The time and day of the MDT meeting was altered to accommodate representatives from oncology and radiology. Key personnel present at the meeting now include the lead clinician, the chest physician, the oncologist, the radiologist and the pathologist, allowing appropriate discussion of all patients and their treatment plans.

A pro forma was designed to collate the necessary information for the discussion of possible treatment options for patients, to document decisions made at the meeting and to highlight agreed treatment plans. Information is also recorded on the meeting’s attendance and the patients discussed.

To address the inadequate surgical representation at the Medway MDT meetings, the lead cancer clinician takes X-rays and information on Medway patients to a ‘zonal’ MDT meeting at the Maidstone Cancer Centre attended by the thoracic surgeon. The ‘zonal’ MDT meeting discusses patients from cancer units who need a surgical decision at the cancer centre. Several oncologists and radiologists from the cancer centre now take part in the ‘zonal’ MDT meeting, ensuring that patients receive appropriate care with input from all members of the team.
**Challenges in implementing this change**
Finding an appropriate time for the MDT meeting, when all essential personnel could attend, took some discussion, as did preparation of the pro forma. Funding needed to be found to free up clinician time for the ‘zonal’ meeting, but this enabled the clinician from Medway Maritime Hospital to attend the meeting at Maidstone Hospital.

**Impact of this change**
The MDT meeting is now attended by all key personnel, is properly documented and complies with cancer standards (the COG guidelines, British Thoracic Society guidelines and national accreditation).

**Next steps**
The are plans to monitor, evaluate and roll out learning.

**Change principles**
B1: Encourage primary, secondary and tertiary care providers to see themselves as part of a single team delivering cancer care.
B2: Develop systems for team-based review, information sharing and decision-making for the care of every patient.

**Further reading**
Improved organisation

Mid Anglia Cancer Network
Ipswich Hospital, Ipswich
Population served: 350,000
Number of newly diagnosed lung cancers per year: 150
Cancer centre

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Starting point
Multidisciplinary team (MDT) meetings were relatively unstructured, with no pro forma to document the meeting and collect information. Only the chest physicians, a surgeon, an oncologist and a nurse specialist attended the meetings.

Improvement made
A pro forma has been designed to collect information before and during MDT meetings. It records details of the patients being discussed, their next appointment date (or ward number if an inpatient), case information and action to be taken. The form also records the date of the meeting and the attendees. The form is updated during the meeting by one of the junior doctors.

Membership of the MDT meeting has been extended to include a radiologist and a pathologist.

Challenges in implementing this change
The change required a secretary (or administrator) to be responsible for collecting the information for cases being discussed, and a junior doctor (who was present anyway) to update the form during the MDT meeting. The work involved in getting the patient’s notes and X-rays together and producing the pro forma takes approximately one morning a week. It was also necessary to get agreement for a radiologist and a pathologist to become core members of the MDT and attend meetings. This was achieved through discussions with the lung physicians and the relevant departments.
Impact of this change

All patients are now discussed at every MDT meeting and any action taken is recorded and followed up. The extension of the core team has led to fuller discussion of individual cases. The overall co-ordination and operation of the meetings has been improved.

Next steps

A newly-recruited member of the palliative care team will soon start attending the MDT.

Change principles

B1: Encourage primary, secondary and tertiary care providers to see themselves as part of a single team delivering cancer care.
B2: Develop systems for team-based review, information sharing and decision-making for the care of every patient.
B6: Introduce systems to ensure palliative and supportive care is provided in line with patient needs.

Further reading

Improved organisation

Leicestershire Cancer Network
University Hospitals of Leicester NHS Trust
Leicester Royal Infirmary, Leicester
Population served: 1 million (Trust)
Number of newly diagnosed ovarian cancers per year: 80 (Trust)
Cancer centre

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Starting point
There were delays in agreeing treatment plans for patients after surgery and a lack of communication of information to GPs. Delays were making patients more anxious. Not all professional groups were attending the multidisciplinary team (MDT) meetings and there was often a delay in GPs receiving information about treatment plans.

Improvement made
MDT membership was reviewed and expanded to include a radiologist and a palliative care representative. Meetings are now held every week instead of fortnightly. A pro forma has been developed by an MDT co-ordinator in consultation with the rest of the MDT. This is completed by the co-ordinator and the consultants, and sent out to a patient’s GP within 48 hours of the weekly meeting.

Challenges in implementing this change
There was a need to obtain commitment to attend the meeting on a weekly basis. This was achieved by including all MDT members in the discussion. There were only a few dissenting voices and a compromise was agreed that the time of the meeting would be altered and that members should attend at least every two weeks. In practice there has been excellent attendance (80–90%) at every meeting.

Impact of this change
Before the improvements it took up to three weeks from surgery to first consultation for chemotherapy and up to three weeks to complete investigations. Now, patients are seen,
on average, within three to four days of surgery. Investigations are completed and chemotherapy commenced within two weeks, depending on the patient’s choices and clinical condition. The number of patients being discussed at the MDT has increased to 100% (Figure MDT 1.8a).

Next steps

The pro forma will be evaluated from both primary and secondary care perspectives and will be rolled out to the remaining gynaecological cancers. The co-ordinator role is currently combined with the role of data manager to support the team on both sites. The MDT forum will also be used for discussing and reviewing protocols.

Change principles

B1: Encourage primary, secondary and tertiary care providers to see themselves as part of a single team delivering cancer care.

B2: Develop systems for team-based review, information sharing and decision-making for the care of every patient.

B6: Introduce systems to ensure palliative and supportive care is provided in line with patient needs.

Further reading

Improved organisation

**Starting point**

There was no real team approach to the management of patients, and continuity of care was an issue. Although patients received excellent care, it was on a ‘piecemeal’ basis. Patients did not receive a definitive plan of treatment, and patients’ care could not be pre-planned. There was a lack of specialist nurse input, and patients were not given as much support as they required because the resources were not in place to provide this support.

**Improvement made**

A fully integrated multidisciplinary team (MDT) that included all disciplines was established. All team members are now fully involved in, and informed about, decisions taken. The MDT was set up following careful negotiation with all parties and all disciplines. The meeting time was arranged around availability, making sure it worked around the resources that were most thinly spread (for example, the oncologist’s time).

The establishment of the MDT facilitated the process of streamlining the patient pathway and adopting a ‘gold standard’ to work towards. Treatment plans are now devised according to agreed protocols, with input from all team members. All patients have a diagnosis and definite treatment plan within four weeks of referral to the specialist team.

The need for a clinical nurse specialist was identified and a gynaecological oncology nurse took on more work and was seconded to the team to work as an oncology support nurse, initially on a trial basis. An additional nurse is being recruited. A clear definition of the roles and responsibilities of the members of the MDT was vital in ensuring the success of this oncology support nurse post, and ensuring its effective use.
Challenges in implementing this change

Setting up the MDT meeting was difficult because of the time constraints of each professional and finding a common, regular meeting slot. But this was overcome through discussion and goodwill. It was also important to establish workable, agreed protocols. When the new nurse role was set up it was important to ensure that this was used effectively and that the role being undertaken was accepted. Strong leadership was required to prevent internal tensions and develop co-operative and collaborative working.

Impact of this change

Patients are now discussed within the confines of the weekly MDT meetings. Treatment/care plans are now agreed across disciplines, whereas previously patients were managed by ward rounds and monthly pathology meetings (and corridor meetings). There is continuity of care and the MDT is totally aware of the management process and of who is treating the patient. The continuation of the patient’s pathway is planned before she is discharged.

The oncologist is now fully committed and involved in the MDT; previously, involvement was limited. Chemotherapy is now discussed with the patient before she is discharged following surgery. Previously, chemotherapy may have only been discussed at an additional appointment post-discharge. There is now an established, named pathologist who is responsible for specimens from ovarian cancer patients. In the past, specimens were sent to general pathology and limited discussion on each patient took place. A hospice physician attends the MDT meetings so that patients who may need palliative/hospice care are seen earlier, symptoms are managed better and the patients’ experience is improved. Previously, there was often late referral for hospice care.

Patients for whom hospice care is appropriate are identified more effectively, often earlier in the pathway. As a result, the patient receives better support. All gynaecological oncology patients are now seen by a specialist gynaecological oncology nurse. This provides excellent continuity for the patient.

Change principles

B3: Deliver care according to evidence-based protocols agreed by the team.
B5: Redesign care roles to best meet patient needs along the patient journey.
B6: Introduce systems to ensure palliative and supportive care is provided in line with patient needs.

Further reading
Improved organisation

Leicestershire Cancer Network
Leicester General Hospital, Leicester
Population served: approximately 1 million
Number of newly diagnosed prostate cancers per year: 230
Cancer centre

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Starting point
Not all professional groups were attending the multidisciplinary team (MDT) meeting neither were all patients being discussed. The information required to make an informed decision was not always available.

Improvement made
The MDT meeting was reviewed and a new information sheet was developed to aid communication and ensure professionals knew which patients were to be discussed at meetings. MDT membership was expanded to include radiology, pathology and Palliative care.

Resources necessary for this change included the time of the professionals involved (at least one hour every fortnight) and a small amount of funding for printing the information sheet.

Challenges in implementing this change
One challenge was in getting commitment to attend the fortnightly meetings. This was overcome by including all team members in the discussions on the format of the meeting and the design of the information sheet. The sheet was originally introduced on a trial basis with ongoing review to help promote its use.
Impact of this change
There has been an increase in membership and the majority of patients are now being discussed at the meeting. The meeting is also being used to discuss clinical issues.

Next steps
Attendance at the meetings will be monitored and the information sheet revised if and when necessary. Alternative ways of using the group are being considered (for example learning opportunities).

Change principles
B1: Encourage primary, secondary and tertiary care providers to see themselves as part of a single team delivering cancer care.
B2: Develop systems for team-based review, information sharing and decision-making for the care of every patient.
Improved organisation

Starting point
Attending the multidisciplinary team (MDT) meetings was difficult for the oncologist because of time pressures. As a result, he was frequently late and not present to discuss all patients.

Improvement made
The follow-up of patients who have had radiotherapy has been changed. Patients are now seen only once by the oncologist, six weeks after treatment, and they are then referred back to the surgeon for a baseline mammogram at six months. After that, they are seen annually with mammograms for five years, before being discharged back to the GP.

No new resources were used, but communication between the two sites was essential.

Challenges in implementing this change
One challenge was in ensuring communication between the oncologist and the surgeon. Another was in updating the team on the latest research being carried out on follow-up procedures. Regular team meetings ensured that these challenges could be tackled.
**Impact of this change**

Before, patients were seen every three months by the surgeon and the oncologist. Now they will be seen annually after an initial six-month assessment by the surgeon. The full impact on the oncologist’s time will not be apparent for several months, as those already on follow-up still need to be seen. He is, however, much better at making the MDT meeting on time, and there is still a need for him to attend.

**Next steps**

Over the coming years, it will be essential to monitor any recurrences and how they present to ensure that this method of follow-up is the best for the patient (as shown by the literature research).

**Change principles**

A8: Design follow-up systems to meet patient needs.
B3: Deliver care according to evidence-based protocols agreed by the team.
D5: Find ways to increase capacity.
2: All patients treated and discussed according to protocol

Multidisciplinary team working can ensure that the care each patient receives is consistent. These changes centre around making sure that every patient is discussed, that they are treated according to agreed, evidence-based protocols, and that outcomes information is reviewed and protocols developed and enhanced as a result.

The changes

**Bromley Hospital, Bromley, Kent** (case study MDT 2.1 (PC 3.2), page 29)
- Relevant information is gathered before the MDT meeting by a urology nurse and secretary. A pro forma was developed in order to enhance record-keeping at the meeting.

**Birmingham Women’s Hospital, Birmingham, West Midlands** (case study MDT 2.2 (OC 3.1), page 33)
- All patients’ treatment plans are now discussed or noted at MDT meetings with all core team members present. This ensures that patients receive the most clinically effective treatment.

**Royal United Hospital, Bath** (case study MDT 2.3 (BwC 6.2), page 35)
- Colorectal nurses forward a list of bowel cancer patients to the meeting leads for discussion at the MDT meeting. This ensures that all patients are discussed at the meeting. All decisions taken at the meeting are noted, and referrals to oncology are produced automatically from those notes.

**Ipswich Hospital, Ipswich, Suffolk** (case study MDT 2.4 (OC 3.4), page 37)
- The MDT now meets weekly and all new patients’ histories are presented and discussed. Care is managed by the team according to agreed clinical protocols.
Multidisciplinary team working
**Starting point**

The urology/oncology multidisciplinary team (MDT) meeting was held twice-monthly before morning clinics. Patients were discussed without case notes, test results and without key people involved in their care present. Patients’ management and treatment plans were not documented, nor were referrals made to all colleagues present. Meetings were disorganised, with poor time-keeping. The poor co-ordination of the meetings and the lack of relevant clinical information prolonged decision-making well into clinic time. The lack of case notes also limited discussions about patients’ management and delayed the filing of histology reports given to the urologists during the meeting. There was no nursing or radiology representation.

**Improvement made**

A urology/oncology multidisciplinary pro forma was developed for the MDT meeting to document patients’ diagnoses, investigations, and management and treatment plans. This was then filed in the patients’ notes.

The urology nurse specialist and the palliative care consultant now attend the meeting. Prostate biopsy results are available for discussion.

To achieve these changes, initial meetings were set up with clinical, nursing and administrative staff to discuss areas that needed improvement and to explain the Cancer Services Collaborative project. The project manager observed the process of the MDT meeting and it was agreed that the format could be improved.

Now the urology nurse and secretary co-ordinate the meeting by compiling a list of patients for discussion from urologists and prostate biopsy results faxed from the receptionist in the X-ray department. The list is then faxed to the secretaries in the
histopathology department to retrieve slides for discussion at the MDT meeting. This list of patients acts as an agenda at the meeting.

The case notes, pathology reports and test results for each patient to be discussed are available at the meeting. Registrars complete the pro forma during the MDT meeting.

**Challenges in implementing this change**

Ensuring that case notes arrived on time for the MDT meeting was a challenge. Liaising with the medical records department improved the situation. Chasing notes wasted a lot of the urology nurse specialist’s time, but this situation was improved with additional secretarial support.

The urologists found it time-consuming and distracting to complete the pro forma while listening to cases being presented. It was agreed that registrars should complete the pro forma and file them in patients’ case notes. The urologists needed to be convinced about the benefits of the pro forma, and its usefulness will be regularly reviewed as they become more accustomed to it.

Another challenge was to ensure that all key professionals had an opportunity to comment on all drafts of the pro forma. Meetings were set up to check and discuss the usage of the pro forma and proved to be beneficial.

**Figure MDT 2.1a (PC 3.2a): Percentage of patients managed in accordance with clinical guidelines**

<table>
<thead>
<tr>
<th>Month</th>
<th>Percentage of patients managed in accordance with clinical guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan</td>
<td>0</td>
</tr>
<tr>
<td>Feb</td>
<td>10</td>
</tr>
<tr>
<td>Mar</td>
<td>20</td>
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<td>Apr</td>
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<td>May</td>
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<td>70</td>
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<tr>
<td>Sep</td>
<td>80</td>
</tr>
<tr>
<td>Oct</td>
<td>90</td>
</tr>
<tr>
<td>Nov</td>
<td>100</td>
</tr>
</tbody>
</table>

*MDT pro forma introduced and specialist staff attend MDT meeting*

** Notes available at MDT meetings
Impact of this change

Benefits of the change include:
● A well co-ordinated meeting
● Notes available with test results
● Management decisions documented on a pro forma and filed in the patients’ notes
● Better time-keeping, resulting in clinics starting on time.

Figure MDT 2.1a (opposite) shows the implementation of the new guidelines.

Next steps

An electronic database is to be developed, using the pro forma.

Change principles

A7: Improve communication between care providers across the patient journey.
B2: Develop systems for team-based review, information sharing and decision-making for the care of every patient.
Multidisciplinary team working
All patients treated and discussed according to protocol

Starting point
Weekly multidisciplinary team (MDT) meetings have been held for the past five years. All core members (gynaecological oncologist, medical oncologist, clinical oncologist, histopathologist, radiologist, clinical nurse specialist, palliative care specialist) were invited every week. However, attendance at the MDT meeting was not accurately or regularly recorded. Palliative care representation was often missing. Examination of patients’ notes revealed that not all treatment plans were being discussed or noted by the MDT, and that they were not all agreed by the MDT. Variances in clinical practices that are governed by guidelines and/or protocol were not always recorded. Decisions were recorded ad hoc and, in some cases, decisions were not recorded at all. Auditing treatment plans following decisions was not common practice.

Improvement made
Updated guidelines and management protocols were circulated to all members of the MDT. All patients’ data were collected, collated and recorded electronically by the data manager at all stages of care. A pro forma that records discussions and decisions about treatment, and acts as an audit tool, was developed by the MDT.

All patients with histologically confirmed gynaecological cancer are now either discussed or noted at the MDT meeting. All treatment plans are recorded on a copy of the pro forma in the patient notes as well as being stored electronically. The data manager and the MDT compare the treatment outcomes against the plans six to eight weeks after decisions have been made. All variances are recorded and collated to enable annual review and updating of guidelines and protocols. All variances are reviewed at an MDT meeting.
Multidisciplinary team working

After treatment options have been discussed at an MDT meeting, patients are offered an informed choice of approved options.

**Challenges in implementing this change**

Initially, it was difficult to motivate the MDT to want to change its meetings. Individual members of the team were challenged to prove that the treatment they offered was clinically effective. The results of the examination of patients’ notes were presented to the MDT, and the team was informed that there was no record of who had attended the meetings. The team became convinced of the need for change to fulfil the requirements of clinical governance and to be able to provide evidence to the Commission for Health Improvement that patients received clinically effective care at all stages.

The appointment of a data manager was essential in helping the team to co-ordinate the changes in procedure. Treatment information is collected by the nurses, especially where variances exist, and the data manager collects all the other information: for example, first outpatient appointment, referral for investigation and date of surgery.

**Impact of this change**

All patients’ treatment plans are discussed or noted at MDT meetings where all of the core team members are present. This ensures that every patient receives the most clinically effective treatment. All decisions are noted and recorded, and all treatment plans are audited at six weeks. The data manager notes on the pro forma whether the patient has been ‘noted’ as following the protocol, or discussed at the MDT. She puts this on the database and at six weeks the system flags up those who have not been discussed. She checks on the pro forma if the treatment has been followed through or what the variances in treatment have been, and the reasons why. This is recorded on the database.

**Change principles**

B3: Deliver care according to evidence-based protocols agreed by the team.
B4: Measure variation from agreed protocols and compare with outcomes information.
C4: Involve patients in decisions about their care at every stage of the journey.

**Further reading**

All patients treated and discussed according to protocol

Starting point
Not all patients were discussed at the multidisciplinary team (MDT) meeting and not all treatment decisions were noted for patients. Referrals for oncology were written up in letter form after the meeting.

Improvement made
All bowel cancer patients are now discussed at MDT meetings. A list of patients is forwarded, by the colorectal nurses, to the pathologists who arrange the meeting. Discussion and decisions taken at the meeting are all noted on an index sheet and filed in the notes.

The referral to oncology, containing all the appropriate information, is prepared by the colorectal nurse specialist.

Challenges in implementing this change
Ensuring that the complete list of patients was compiled and sent to the pathologists who organise the meeting was important. Although it is potentially a time-consuming task to compile the list, it is a vital one to ensure that all patients are discussed at the MDT meeting.

Impact of this change
Before this change, only a random selection of patients were discussed at the MDT meetings. All patients are now discussed.
**Change principles**

A5: Simplify the process by which patients progress from one care provider to another. B2: Develop systems for team-based review, information sharing and decision-making for the care of every patient.
All patients treated and discussed according to protocol

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Mid Anglia Cancer Network
Ipswich Hospital, Ipswich
Population served: 350,000
Number of newly diagnosed ovarian cancers per year: 30
Cancer centre

Starting point
Patient care was not discussed or managed by a multidisciplinary team (MDT). Instead, care was managed through the traditional consultant-directed model. Consultant skills were not always being used appropriately.

Improvement made
Weekly MDT meetings have been instigated at which all new patients are presented and discussed. The meetings are attended by the consultant gynaecological oncologist, nurse specialist, histopathologist, radiologist and the oncologist. Patients’ care is managed through the MDT according to agreed clinical protocols. These protocols were agreed through consultation with individual trusts and across the network.

Challenges in implementing this change
There were difficulties in finding a suitable time and venue for meeting, but this was overcome through negotiation. Information technology and administrative support were required to project scans and pathology slides. This support was already available and no extra funds were required, but as more MDTs are set up, demand on resources will undoubtedly increase.
**Impact of this change**
Care is now managed according to clinical outcomes guidelines.

**Next steps**
There will be continual review of the situation.

**Change principles**
B2: Develop systems for team-based review, information sharing and decision-making for the care of every patient.
B3: Deliver care according to evidence-based protocols agreed by the team.

**Further reading**
3: Improving referral between members

Referral mechanisms between care providers are often protracted and time-consuming. Changes have been made to simplify and speed up referrals. Improved communication between team members has improved the co-ordination of care delivery.

The changes

**Frenchay Hospital, Frenchay, Bristol** (case study MDT 3.1 (BrC 4.1), page 41)
- Waiting times were reduced by booking patients electronically for breast care oncology appointments immediately after the MDT meeting. Typical reductions were from 11–24 days to 2–11 days for chemotherapy, and 11–22 days to 3–18 days in the case of radiotherapy.

**Glenfield Hospital, Leicester, Leicestershire** (case study MDT 3.2 (BrC 4.2), page 43)
- There was a delay of about two to three weeks between the MDT’s decision that a patient needed an oncology referral and the oncology department receiving the referral. Redesigning the MDT registration form to double-up as an oncology referral letter has reduced the delay.
Multidisciplinary team working
Improving referral between members

Starting point

There were no specific arrangements in place for processing breast care oncology appointments made from the clinic. Waiting times for oncology varied from 11–24 days for chemotherapy and 11–22 days for radiotherapy. This increased patient anxiety and some appointments were missed.

Improvement made

A system for pre-planning an oncology appointment from the breast care unit immediately after the clinical discussion is now in place. There is direct access to a reserved appointment slot.

There had been full multidisciplinary team (MDT) discussion and agreement on the need for improved booking arrangements. The breast care unit administrator proposed new arrangements for the unit to have direct access to a reserved number of oncology appointments which would be used for other patients if not required for breast care. The proposals were discussed with the oncology department and new arrangements agreed. They were piloted via Plan, Do, Study, Act (PDSA) cycles (a systematic series of small-scale tests) and are now a permanent arrangement. There is increased patient certainty and choice.

There is a data collection system which now includes the patient’s NHS number and GP details. After the MDT meeting the administrator books patients into the reserved slots electronically. The referral (including full patient and GP details) is faxed to oncology the same afternoon.

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The patient is seen by a breast surgeon after the MDT meeting, to be told of the treatment required (according to the histology) and is given the oncology appointment at the same time.

The Medical Data Input system (MDI) has been adapted to generate letters to the oncologist, GP and patient electronically, giving details of the patient’s tumour and adjuvant treatment. This means that the patient has written information about his or her tumour and reasons for adjuvant treatment. Each letter is unique to the patient and is generated individually.

**Challenges in implementing this change**

There were no specific challenges apart from introducing ‘fast track’ access for breast care patients.

**Impact of this change**

Waiting times for oncology were reduced to 2–11 days for chemotherapy and 3–18 days for radiotherapy. Monthly measures show that satisfaction with the service has increased for both patients and professionals. This is reinforced by comments from patients directly to the breast care nurse.

**Next steps**

An MDT meeting is planned for the diagnosis stage (after mammography and cytology) as well as for staging.

**Change principles**

A6: Book appointments for care further along the journey as soon as the need is identified.
A7: Improve communication between care providers across the patient journey
Improving referral between members

Starting point
The time taken between the multidisciplinary team’s (MDT) decision to refer and receipt of the referral letter in the oncology department was delaying the first oncology appointment. Processing and receiving the letter typically took between two and three weeks.

Improvement made
The MDT registration form was redesigned in duplicate to double as an oncology referral letter and delivered the same day to oncology by the co-ordinator. In addition, an electronic link has been set up between histology to oncology to provide online transfer of results.

Resources needed to implement these changes included the project team’s time, and the time taken to map the patient journey. Ongoing communication by letter was also needed to maintain momentum.

Challenges in implementing this change
The associate lead clinician chaired the MDT working group, and the changes were implemented swiftly, without objection. The team could also see the dramatic difference the change would make.
Impact of this change

Before, there were a variety of referral systems, which were not co-ordinated and led to lengthy delays. Now, there is a standardised pro forma (produced as a carbon duplicate) providing a referral letter and a copy for the case notes.

Next steps

It is planned to keep the project team going (rather than closing it down, as would be expected), in order to provide continuous support to the clinical team. There will be ongoing evaluation through the project team, and formal evaluation after six months. It is hoped that a clinical trials co-ordinator will be included in the MDT and will attend all MDT meetings.

Change principles

A5: Simplify the process by which patients progress from one care provider to another.
4: Improving communication with primary care

Specific changes have been made to ensure that primary care professionals are notified of decisions made at multidisciplinary team (MDT) meetings quickly and effectively.

The changes

**Medway Maritime Hospital, Gillingham, Kent** (case study MDT 4.1 (LC 3.6), page 47)
- A ‘serious diagnosis’ pro forma is faxed to the GP immediately after the outpatient consultation.

**Ipswich Hospital, Ipswich, Suffolk** (case study MDT 4.2 (LC 3.7), page 49)
- The lung cancer nurse specialist informs the GP within 24 hours of the patient’s diagnosis and gives details of onward referral.

**Glenfield Hospital, Leicester, Leicestershire** (case study MDT 4.3 (LC 2.18), page 51)
- A ‘serious diagnosis’ pro forma is faxed to the GP immediately after the outpatient consultation.
Multidisciplinary team working
Improving communication with primary care

Starting point

GPs were receiving confirmation of diagnosis by letter 48–72 hours after patients had received their diagnosis in clinic. GPs were unaware of decisions made at the multidisciplinary (MDT) meeting until 48 hours after the patients’ outpatient appointment. Patients were returning to their GP before the GP had been informed of their diagnosis.

Improvement made

A ‘serious diagnosis’ notification pro forma was developed. This is now faxed to the GP informing the GP of the patient’s diagnosis. If this is not possible (for example, when the patient is seen very late in the day) the clinical nurse specialist or medical secretary will phone or fax the GP with the information the following morning.

Challenges in implementing this change

Problems with faxing GPs have been frequent and there were difficulties accessing the fax machine after 5 pm. Use of the fax to send information to the GP needed to adhere to Caldicott principles of safety and confidentiality of patient information. Phoning through of the diagnosis has been more effective in practice.
Impact of this change
GPs now have the appropriate information to deal with patient enquiries before receiving the formal notification of diagnosis. This procedure has also established links between primary care and the lung cancer clinic, improving multidisciplinary communication between primary and secondary care.

Next steps
Identify other areas to improve communication with primary care.

Change principles
A7: Improve communication between care providers across the patient journey.

Further reading
Improving communication with primary care

Mid Anglia Cancer Network
Ipswich Hospital, Ipswich
Population served: 350,000
Number of newly diagnosed lung cancers per year: 150
Cancer centre

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Starting point
GPs were not informed of a patient’s diagnosis within 24 hours of the diagnosis being made.

Improvement made
The lung cancer nurse specialist now faxes the GP (Box MDT 4.2a shows example) within 24 hours of making the diagnosis to inform them of the patient’s diagnosis and any onward referral details.

Box MDT 4.2a (LC 3.7a): Contents of fax to GP
Your patient . . . . . . . . . . . . attended the chest clinic today to see Dr . . . . . . . .
They have received a diagnosis of . . . . . . . . . . . . . . . . . . . . . .
An appointment has been made for them to see . . . . . . . . . . . . . . . .
We will be supplying you with further, more detailed information. We are sending you this urgent letter because we are aware that the patient or their family may contact you for advice.
Challenges in implementing this change

The nurse specialist is present when the patient is told of the diagnosis, and therefore has the relevant information to fax to the GP on the day that the patient is told of the diagnosis. However, this change requires good co-ordination and teamwork in order to ensure that the nurse specialist is informed of the diagnosis as soon as possible if she is not present at the diagnosis.

Impact of this change

GPs have been pleased to receive basic information so promptly. The change ensures that the GP has appropriate information should the patient wish to see the GP about their diagnosis before the formal letter arrives. This has also established links between primary care and the lung cancer clinic, which aid multidisciplinary communication between primary and secondary care.

Next steps

The process will be tightened up to ensure that no referrals are missed.

Change principles

A7: Improve communication between care providers across the patient journey.

Further reading

Improving communication with primary care

Leicestershire Cancer Network
University Hospitals of Leicester NHS Trust
Glenfield Hospital, Leicester
Population served: 1 million (Trust)
Number of newly diagnosed lung cancers per year: 600 (Trust)
Cancer centre

Starting point
GPs were unaware of decisions made at the outpatient appointment for over 48 hours afterwards. GPs had no information to communicate to their patients during this delay.

Improvement made
A ‘serious diagnosis’ pro forma is faxed to the GP after the outpatient appointment, giving information about the patient’s diagnosis. The contact number of the cancer nurse specialist is included, should the GP require further information.

Challenges in implementing this change
A minor challenge was in paying about £60 for a fax machine.

Impact of this change
GPs now receive appropriate information before the formal letter to help deal with any immediate patient concerns. This procedure has also established links between primary care and the lung cancer clinic, improving multidisciplinary communication between primary and secondary care.
**Next steps**

The pro forma will be extended to cover breast cancer, and there are plans to introduce an electronic version. Eventually, the multidisciplinary team (MDT) pro forma, with clinical details, will be faxed to the GP after the MDT meeting.

**Change principles**

A7: Improve communication between care providers across the patient journey.

**Further reading**

5: Information capture

Timely and accurate information is vital for the effective management of patients and for the ongoing improvement of care delivery. Teams have made changes to ensure that all necessary information is collected and available when it is needed.

The changes

**Birmingham Women’s Hospital, Birmingham, West Midlands** (case study MDT 5.1 (OC 3.6), page 55)
- The appointment of a data manager has improved the collection of data. The manager tracks patients through the system. The availability of valid evidence has clarified which areas need change.

**Hammersmith Hospital, London** (case study MDT 5.2 (OC 3.5), page 57)
- An assessment record and protocol for surgical inpatients has been developed, which acts as a guide to patient management, and promotes consistency in care and the implementation of evidence-based practice.
Multidisciplinary team working
Information capture

Birmingham Cancer Network
Birmingham Women’s Hospital, Birmingham
Population served: 1.2 million
Number of newly diagnosed ovarian cancers per year: 120
Cancer centre

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Starting point
Oncology data were collected only on an ad hoc basis. There was no clinical oncology information system and no system in place for tracking patients from the initial referral through to the final follow-up point, or death. Patients were referred to the cancer centre by letter or fax. However, the only records of the existence of patients were the hospital information systems, and the PAS and HISS systems (which do not link up and only collect minimal data which are not specific to a patient’s cancer pathway). The essential information required by the Cancer Intelligence Unit (CIU) was collated in an ad hoc manner and many times the data sent to the CIU were inaccurate or incomplete.

Improvement made
The trust appointed an A&C grade 5 data manager with funding from the oncology budget for the gynaecology programme. The data manager collects and records all cancer patient data from the patient’s initial point of contact with the trust. All CIU information is now collected, collated, extrapolated and sent to the CIU every week. Histopathology turnaround times are now recorded. The clinical effectiveness of treatment plans and the attendance and business of MDT meetings are recorded and audited. These improvements in data collection allow accurate reporting of the impact of any changes made. For example, it is now possible to report accurately on how many patients are referred using the rapid-referral pro forma, the route of referral, how long – on average – it takes for suspected cancer patients to be seen by a specialist, and the time to definitive treatment.
Challenges in implementing this change

For the first six months of the project there was no data manager to collect and collate essential clinical oncology information. Instead, the project manager had to trawl through patients’ notes by hand. Following the appointment of a data manager who knew how to set up and manage a series of databases, the challenge of implementing this change was significantly reduced.

Impact of this change

The case for improving data collection and use of data throughout the project was clarified for members of the MDT with evidence from tracking patients through the system showing cancer-related demand. Data relating to all patients with suspected or confirmed cancer are collected and no patients fall through the net. The data manager relays all patient-related information to the support nurse team. This means that support can be offered to all cancer patients from the initial referral up to the final follow-up point, or death. The data manager is now a vital member of the MDT.

Next steps

We are now working with the Birmingham Cancer Centre and the CIU to develop a Birmingham-wide clinical oncology information system.

Change principles

A4: Create systems for tracking patients along the care pathway.
B4: Measure variation from agreed protocols and compare with outcomes information.
Information capture

West London and Environ Cancer Network
Hammersmith Hospital, London
Population served: 1.1 million
Number of newly diagnosed ovarian cancers per year: 43
Cancer centre

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Starting point
Patients admitted to the trust/hospital had a set of medical notes and a nursing care plan, but once in hospital, information was sometimes documented in different files, or in different parts of medical notes, depending on which member of the multidisciplinary team (MDT) saw the patient. Communication between professionals was therefore hindered. Often, the assessment of an individual patient by different members of the MDT overlapped, and the patient could be asked the same question by several different individuals. The information gathered would often be documented in different sections of the medical notes, or in separate files.

Improvement made
Two new records were developed: an assessment record and an inpatient surgical record. The assessment record commences at the first outpatient appointment and includes all assessments made preoperatively. The inpatient surgical record commences on the day of hospital admission and continues until the patient is discharged; it is designed to be used by all members of the MDT for documenting patient information.

The assessment record and the inpatient record were developed to describe the key aspects of treatment that most ovarian cancer patients will receive. It also acts as a guide to management, helps promote consistency in care and implement evidence-based practice, and is a risk management tool.

A meeting was held with members of the steering group (comprising the clinical lead, project manager, gynaecology department manager, clinical nurse specialist, clinical oncologist, chemotherapy day unit sister, women’s health outpatient sister, ward sisters, a GP and another consultant) to determine the format of the assessment record and
protocol. Nursing and medical staff were trained on how to use the assessment record and protocol. The replacement of the history sheets and the nursing care plan with the assessment record and protocol was agreed with the director of nursing, head of information and the directorate manager for cancer. Piloting of the assessment record and protocol took place within the gynaecology department and ward. The protocols were found to reduce nursing documentation time; they encouraged the nurses to document variations in care and reasons for agreed treatments not being carried out rather than simply noting what they had done for the patient.

**Challenges in implementing this change**

This change required considerable communication between the consultant, nursing staff in the outpatient department, doctors and the ward nursing staff. It took time for the nurses to get used to recording information in the new way. Doctors sometimes forgot to document treatment in the protocol. The nursing staff now ensure that the doctor caring for their patient writes in the protocol.

**Impact of this change**

The care that patients receive is now documented in a single record that encourages and enables multidisciplinary working. The ability to monitor and audit the delivery of care has been greatly improved. Patients do not have to repeat the same information to multiple team members.

**Next steps**

So far patient numbers are small, but changes are being made to the protocols as a result of ongoing audit.

**Change principles**

A4: Create systems for tracking patients along the care pathway.
B2: Develop systems for team-based review, information sharing and decision-making for the care of every patient.
B3: Deliver care according to evidence-based protocols agreed by the team.