

# **Multidisciplinary Team Review Sharing Paper**

**August/ September 2003**

## **Aim**

The aim of reviewing MDT functionality and structures is to understand existing practices, in line with Cancer Accreditation/ Peer Review Standards identify gaps in the services and systems and by doing so, service, and improve its efficiency, developing systems to ensure that all cancer patients are included in the MDT process.

## **Objectives:**

The objectives of the review are to

- Provide a clear understanding and picture of the MDT functionality and structures currently in place
- Identify areas for improvement
- Make recommendations based on evidence collected
- Provide an action plan for development and investment for the future

## **Background**

### ***Calman-Hine report 1995***

The establishment across England and Wales of Multidisciplinary Teams (MDT) to focus on patients needs from diagnosis onwards was a chief recommendation of the Calman-Hine report 1995. The MDT role is to provide coordinated care and communication between professionals providing treatment and expertise. Some areas had already established such teams before the report being published, but the nature of the meetings varied were some patients were discussed as individuals whilst others meetings consisted of general discussions around cancer treatment and care.

### ***NHS Cancer Plan 2000***

The Cancer Plan set out the first comprehensive national cancer programme for England. Its four aims are

- To save more lives
- ***To ensure people with cancer get the right professional support and care as well as the best treatments***
- To tackle the inequalities in health
- To build the future through investment in the cancer workforce

The ultimate goal of the cancer plan is that by 2008 no one should wait longer than one month from an urgent referral for suspected cancer to the beginning of treatment except through a good clinical reason or through patient choice.

The MDT's role within this objective is to ensure the patient's progress smoothly along their journey in a timely and appropriate manner, ensuring that convenient high quality care is offered and the patient always remains central to this process.

### ***Improving the quality of cancer services 2000***

According to the Health Service Circular (HSC), Department of Health (DOH)

#### ***“National Standards for Cancer Treatment: Objectives***

##### ***Multidisciplinary Team***

- *To ensure that all aspects of diagnosis, treatment and care are provided by designated specialist, working together effectively in multidisciplinary teams*
- *To ensure that care is given according to recognised guidelines (including guidelines for onward referrals) with appropriate information being collected to inform clinical decision-making and to support clinical governance/ audit.*
- *To ensure that mechanisms are in place to support entry of eligible patients into clinical trials, subject to patients giving fully informed consent.”*

## **National Service Framework Assessment No. 1 NHS Cancer Care in England and Wales 2001**

Commission for Health Improvement (CHI) and the Audit Commission (AC) undertook a review of cancer services aimed at the public as well as professionals. The review addressed progress in implementing recommendations from the Calman-Hine Report and made many further suggestions for change in practice, such as more team working for those providing treatment and care.

Annex 1: Summary of Evidence on implementation of the Calman-Hine Report shows that: -  
“Multidisciplinary consultation and management essential – varies by cancer and areas of the country – some patients receive these benefits.”

## **Manual of Cancer Services Standards 2001**

For the first round of accreditation/ peer review in 2000 the MDT standards appeared in section 2 of the manual of cancer services standards, with thirty detailed generic and tumour specific measures appertaining to the running of effective MDT's. These Standards are currently being reviewed with the advent of the new tumour specific cancer standards, in preparation for re-accreditation 2004. The draft Urology Standards have been nationally distributed for consultation purposes and these will form the basis of the generic standards for all tumour sites. To this end one amended standard highlighted is that MDT meetings should take place weekly the impact of this could necessitate major service redesign within the current service.

## **National Cancer Waiting Times 2001 - 2005**

The monitoring of the cancer waiting times targets has been introduced by the DOH to support service improvement within the cancer arena.

This process requires data on patients who have achieved the targets but also detailed information regarding patients who have breached the targets.

The targets are: -

- Maximum one-month wait from urgent GP referral for suspected cancer to first definitive treatment for children's cancer, testicular cancers and acute leukaemia by 2001.
- Maximum one month from diagnosis (DECISION TO TREAT DATE) to first definitive treatment for breast cancer by 2001
- Maximum two-month wait from urgent GP referral for suspected cancer to first definitive treatment for breast cancer by 2002
- Maximum two-month wait from urgent GP referral for suspected cancer to first definitive treatment for all cancers by 2005
- Maximum one-month wait from diagnosis (DECISION TO TREAT DATE) to first definitive treatment for all cancers by 2005

In addition, there is also the existing two-week waiting time standard:

- Maximum two-week wait for an urgent GP referral for suspected cancer to date first seen for all suspected cancers.

## **Process of the review**

- The Cancer Service Improvement Facilitator (CSIF) visited all MDT meetings and made observations concerning different aspects of the meetings: -
  - Actual start, end times recorded for a period of two months and compared with the timetabled times
  - Recording of delays such as patients carried over to next meeting because of resources not being available i.e. notes, x-rays and results of investigations.
- All core MDT members received questionnaires (Appendix 1) for completion, these questionnaires were analysed and findings placed into recurring themes
- Distribution of a questionnaire to MDT Co-ordinators/ Facilitators as part of a piece of work carried out by the CSIF's across all the trusts in the network (North Trent). (Appendix 2 - results for the network.)

- The arrangement of interviews for the Lead Clinicians, Pathologists and Radiologists to give the opportunity to discuss the review on a one to one basis with the CSIF; thus highlighting issues pertinent to site specific MDT's.
- Review of the workload involved in preparing for MDT meetings
  - Study MDT facilitation staff working practice was undertaken for four weeks consecutively, this information has been analysed by use of templating (Appendix 3)
  - Consultant Histopathologist's time spent regarding MDT meetings collected to inform the review (Appendix 4 - template)
  - Medical Laboratory Assistants Role in preparation for MDT meetings again studied to inform the review (Appendix 5 - procedures used in preparing for the MDT meetings.)
- Audit of patient case-notes and recorded outcomes of MDT discussion (Appendix 6 – Audit Proforma)
- Investigation of Information Technology (IT) Systems to support MDT working, clinical data collection and waiting times data collection
- Full review of accommodation for MDT Support Team and Meeting room
- Review of MDT Support Staff workload to ensure administration staffs are carrying out administration tasks and Clinicians' time is used effectively. Develop a plan for redesign, development of role and future resources/ investment required

### ***Ideas for redesign***

- Introduction of standardised referral system for patients to be discussed at MDT meetings
  - Investigate IT solutions
  - Protocol for referral of patient's by Non core members of the MDT Need to raise awareness of the need for all cancer patients to be discussed at a MDT
- Standardising of documentation to enable effective record keeping, rapid feedback and essential data collection
- Planning of MDT meetings  
 For example, categories for discussion in each tumour site could be identified and treated differently to ensure the most appropriate and effective use of time. The Urology team at CNDRH has developed such a system, and has the following categories: -
  - (a) **Note-review** – No histology or radiology required – casenotes to be reviewed by Consultants (another Consultant to that treating patient)
  - (b) **Full Discussion** – All elements (radiology, histology and casenotes) required.
  - (c) **Pathology discussion** – notes and histology required.

This type of structure for MDT meeting should allow the meetings to be planned in a way, which allows different disciplines to attend separate parts of meetings

- Review the timetable for MDT meetings, especially look at Meetings scheduled for Mondays
- In line with the draft, standards for accreditation a phased move towards weekly MDT meetings must be undertaken. This is to ensure MDT discussions can take place in a timely manner within the patient's journey, thus not creating unnecessary delay of treatment. This is essential if we are to meet the 2005 NHS Cancer Plan target of 31 days from Referral to Diagnosis and 31 days from Diagnosis to treatment. During the review, it will have become obvious, which MDT meetings need to be moved to weekly meetings first thus carrying the change out in a phased approach.
- Development of a job description for the Clinical Nurse Specialist roles in MDT meetings, this is in line with the draft standards for accreditation.
- Ensure fail-safe mechanisms are in place to make sure all patients are referred for discussion.
- MDT meeting lists should be signed off by the MDT Chair two days before meeting to ensure all preparation can be carried out effectively, safely and in a timely manner.
- Patient information such as the leaflet used by Gynae/Oncology MDT (Appendix 6) should be available for all patients' in all tumour sites.
- Mapping of data collection across all tumour sites to avoid duplication of collection
- MDT Co-ordinator/ Facilitators to record if actions completed following a MDT discussion

## **Conclusion**

It is hoped that in sharing this document it will provide guidance to other Health Communities embarking on the review of Multidisciplinary Team functionalities and structures; thus preventing wheel reinvent and facilitating sustainable change.

If you would like more information on any part of the review process, please do not hesitate to contact us.

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## 8. References:

- |   |          |   |
|---|----------|---|
| Commission for Health Improvement<br>Audit Commission | 2001     | National Service Framework Assessments No. 1, NHS Cancer Care in England and Wales<br>ISBN 0117029084   |
| Department of Health                                  | 1995     | Expert Advisory Group on Cancer. A Policy Framework for Commissioning Cancer Services: A Report to the Chief Medical Officers of England and Wales. (The Calman-Hine Report) London |
| Department of Health                                  | 2000     | The National Cancer Plan. London  |
| Department of Health                                  | 2000     | Manual of Cancer Standards  |
| Department of Health                                  | 2003     | Draft Urological Cancer Standards. Cancer Action Team. London.  |
| NHS Breast Screening Programmes (NHSBSP)              | 2003     | The Right Results – Guide to the Correct Processing and Issuing of Results. NHSBSP Publication No. 55 Sheffield<br>ISBN 1844630013  |
| Department of Health                                  | 2000     | HSC 2000/021 Improving the quality of cancer services. NHS Executive London   |
| Department of Health/<br>Information Authority        | NHS 2003 | Cancer Waiting Targets – A Guide Version 2<br><a href="http://www.doh.gov.uk/cancer/waitingtimes">www.doh.gov.uk/cancer/waitingtimes</a>  |

# Appendices

## Appendix 1 – Copy of Core MDT Members Questionnaire questions

### Multidisciplinary Team (MDT) Review Questionnaire

Job title: - \_\_\_\_\_ Tumour site involved: - \_\_\_\_\_ Any \_\_\_\_\_

#### The referral (8 Questions)

1. Do you have a system for patients to be referred for discussion at the MDT meeting within your service? Please describe the process in detail. i.e. people involved, time frames, details recorded or required.
2. What is the cut off time for patients to be added to the list?
3. What do you think the cut off time should be for patients to be added to the list?
4. How do other specialties refer patients for discussion on your MDT meeting?
5. How do you feedback to the consultant treating the patient discussed – does Consultant requesting discussion always attend the meeting?
6. Or – Do you take the patient's care over if referred from another team?
7. Are you aware of patients with cancers in your 'tumour site' who are not discussed at any MDT meeting?
8. Do you have fail-safes already in place to ensure all patients are listed for MDT meetings?
9. Do you inform patients when they are to be discussed and why?
10. Can you suggest any improvements we can make to the system to improve referral on discussion list for MDT meetings?

#### The meeting (19 Questions)

1. How often does the MDT meeting occur in this tumour site?
2. How often do you think the MDT meeting should happen, if you are to meet the waiting time targets?
3. What day of the week does the meeting take place?
4. What time in the day does the meeting take place?
5. What time of day would be preferable and why?
6. Where does the meeting take place?
7. Do you know who are the core team members?
8. Do you know who are the non-core team members?
9. If you cannot attend the meeting do you send your apologies?
10. Do you use any discussion format tools? i.e. MDT Proforma, Tumour site specific IT systems
11. Are there patients discussed for whom you feel you do not need to be in attendance?
12. What type of patients are these and how could they be categorised?
13. From your observations is there any part of the meeting, which could be improved?
14. What type of data do you collect during the MDT discussion?
15. What part do Nursing and Allied Professionals play in the MDT discussion?
16. Does a Social Worker attend the discussion?
17. If not when do you discuss social issues?
18. Would it be helpful if a list of patients to be discussed and the reason for discussion was sent out before the meeting?
19. Would it be helpful to have a separate Diagnostic MDT meeting and Therapeutic MDT meeting?

#### Post meeting (4 Questions)

1. How do you ensure that decisions agreed upon are implemented?
2. If notes recorded about the outcome of the patient discussed at MDT meeting was placed in the notes, would you and others find this useful?
3. Is there any other way in which the discussion outcomes could be communicated to others?
4. In the Cancer Plan is a priority for GPs to be kept informed about patients Treatment Plan and discussions that have taken place. How would you envisage this could be facilitated?
  - a. Does this happen and how?
  - b. If not how would you envisage doing this?

Additional Information:

## Appendix 2 – Network MDT Co-ordinators Questionnaire Results

### MDT Co-Coordinator Review Questionnaire

Please State:

Total Replies 21

The trust where you work:.....

The MDT tumour site you are responsible for.....

1)	Do you know what cancer accreditation/ peer review is?	Yes	No	15	6
2)	Do you know about the manual of cancer services standards? If Yes	Yes	No	14	4
	a. Do you have access to it?	Yes	No	14	4
3)	Do you know who the MDT lead clinicians are? If Yes	Yes	No	20	0
	b. Do you have a list of them?		Yes	No	3
4)	Do you know who are the core members of your MDT? If yes	Yes	No	21	0
	c. Do you have a list of them?		Yes	No	0
5)	Do you know who the non-core team members are? If yes	Yes	No	16	4
	d. Do you have a list of them?		Yes	No	4
6)	Did you know that each member should have cover? If Yes	Yes	No	16	5
	e. Do you have a list?		Yes	No	9
7)	Did you know that MDT meetings should not be cancelled?	Yes	No	17	4
8)	Do you keep a register of attendance?	Yes	No	21	0
9)	Do you have a formal referral system for patients to be discussed at MDT meeting?	Yes	No	13	8
10)	Do you have a cut off time for patients to be added to the list? If Yes	Yes	No	18	3
	a. Does this give you sufficient time to prepare the list?	Yes	No	13	8
11)	Do you use discussion format tools e.g. MDT proforma's, a tumour site specific I T Systems?	Yes	No	16	4
12)	What type of Data/Information do you collect during the MDT meeting?				

#### *Doncaster*

Diagnosis and dates, outcomes for patients e.g. treatment type, and follow up clinics etc, histology/radiology and whether to be discussed again at MDT.

Diagnosis, investigations, cancer care plan.

Patient's age, clinical information, past medical history (if any), results of investigations done, Radiologist/Histopathologist comments, diagnosis, management decision, and outcome

Diagnosis and Outcome

Patient outcome decision, arrangements for follow up.

#### *Rotherham*

Record minutes of complete meeting discussion

Upper GI database assistant collects data. I collect attendance of core members.

Attendance figures, number of new cancers

*Sheffield*

Diagnosis/Treatment plan

Previous history of the patient, what they have already had done and what is going to happen to them next.

*Barnsley*

Histology reference patient history/treatment plan/outcome/dates of appointments and procedures

Results of histology/CT Scan/X-Ray Decisions regarding future treatment and consultations.

Results and outcome recorded in minutes. Attendance register

Results outcome attendance.

Information for action – follow up minutes. Database work

*Chesterfield*

Stage, diagnosis, and treatment plan

Diagnosis and planning decision for the patient

Treatments plan appointments, referrals to other specialists, and outcome of surgery.

Treatment plan, diagnosis, prognosis.

Breast Cancer National Data

Diagnosis, stage and treatment planning decision

13) Do you use electronic systems or manual systems?

*Doncaster*

Both

*Rotherham*

Electronic  
Manual

*Sheffield*

Both

*Barnsley*

Electronic  
Manual

*Chesterfield*

Both  
Electronic & Manual

14) What time of day are the meetings and does this give you enough time to prepare?

*Doncaster*

8.30pm, not always

Tuesday morning at 9.30am and No

Both morning MDT's so have to prepare the day before.

Mornings and afternoons, just have enough time but often running around at last minute for inpatient notes etc.

AM and PM, we usually have to prepare for the meetings the day before when possible.

*Rotherham*

Lymphoma 13.00 hrs – OK colorectal 09.00 hrs – always rushed.

Friday PM) alternative Fridays) – yes but a lot of last minute data collection/notes for inpatients

Doncaster posted Friday for Wednesday.

*Sheffield*

Afternoon (1.30pm) so yes I have enough time to prepare.

Lunchtime (Normally)

*Barnsley*

12.00 – 12.30

AM & PM – yes there is enough time to prepare.

Tuesday 9.15 Lung, Wednesday 9.00 colorectal and upper GI, Thursday 12.30 Breast (Just enough time lots of last minute tasks)

Lunchtimes and early morning. There is enough time to prepare but the time before the early morning meetings is very hectic.

4.00pm – Yes the most part.

*Chesterfield*

Lunchtime and there is time to prepare.

Usually afternoons, but some meetings are early morning.

Usually at lunchtime, this gives us the morning to make the final preparations.

15) Who ensures that decisions agreed upon are carried out?

*Doncaster*

Gynae it is Dawn the Gynae cancer co-ordinator for Upper GI the relevant consultant and myself.

Lung – Staff Nurse  
Skin & Lymphoma consultant

This is usually taken care of in clinic that happens the same day as the MDT's. In addition, the consultants and secretaries monitor the patients carefully.  
The relevant consultant and myself

Me

*Rotherham*

Decisions are minuted, highlighted, and sent out to all MDT members promptly. CRC specialists and oncology nurses arrange new investigations decided on appointments that are arranged at meetings.

Mr Lambert – UGI Surgeon.

Lead Clinician

*Sheffield*

I remind the doctor who has agreed to contact the patient to carry the relevant information out.

Consultants/Nursing Staff

*Barnsley*

Clinicians

Consultant

Consultant re: surgery etc  
MDT to re: appointments etc and pass on to appointments clerk.

The doctors in clinic who have been present at the MDT

Myself and the Gynae CNS

*Chesterfield*

Mainly the consultant who the patient is with. Some are carried out by others but this is agreed in the meeting.

Consultants, MDT staff

Consultants.

16)	Are notes recorded on a proforma?	Yes	No		
	If Yes			15	3
	a. Are they put in the patient's case notes?		Yes	No	
	If No			9	9
	b. How are decisions recorded?				

*Doncaster*

Outcome Summary Sheet

*Rotherham*

Minutes

Dictated on tape and typed up.

*Sheffield*

Outcomes are documented in the patient's notes and also letters are produced on plan of action.

*Barnsley*

Minutes/Database  
Kept as minutes in MDT office  
Minutes.  
Decisions are minuted and some consultants write in the notes.  
Manually recorded in notes

*Chesterfield*

The clinician writes in the notes and stamps to say the patient has discussed at the meeting.  
Consultant writes in notes MDT Co-ordinator records on MDT lists.  
In patients, case notes and by MDT staff.

c. Are they entered into the patient's case notes?

*Doncaster*

Yes  
Hand-written entry only by consultant.

*Rotherham*

Yes on clinical Pages by consultant.  
No – In minutes notes are stamped with UGI stamped and dated.  
Yes

*Barnsley*

Yes  
No – Only date recorded and discussed at MDT in notes.  
Data recorded in notes and brief note by doctor – sometimes.  
Only one consultant puts a copy of the minute's proforma into the notes.  
Yes.

*Chesterfield*

Yes

17)	Are the discussion notes circulated to the core members?	Yes	No	14	3
18)	Do you send any discussion outcomes to the GP's?	Yes	No	6	12
19)	From your observation is there any part of the meeting, which could be improved?				

Please state:

*Doncaster*

The preparation of the meetings needs to be improved, which we are hoping to look at in the near future. There is a lot of work that could be done in this area.  
I only attend the head and neck MDT (not breast) and I feel that it already runs smoothly so do not think any improvements need to be made.  
Yes, definite outcomes. The preparation of the meeting could be improved and we are looking into this at present.

*Rotherham*

I feel that the service for UGI MDT could be improved if there was a person in post specifically working for the UGI MDT. It would be a good idea to have the MDT co-ordinator continuing the database assistant role, so it is a continuation from the meeting and straight onto the database system.  
Also, I find that some consultants ask for patients to be discussed at the meeting and then are either stuck in clinic/theatre, so it would be a good idea to make sure there is a H/O or Reg. available to discuss the patients.  
Yes, Timings – Attendance of specialists. More input of new patients via consultants. Have to chase them and check through Histology reports. Not valued need re-grading at Rotherham.  
Providing we have full attendance no. Doncaster sometimes patients are added late and due to travel time i.e. post getting all information can be tight.

*Sheffield*

No comments.

*Barnsley*

Upper GI radiologist present and pathology reported.  
Head and Neck split with Doncaster.  
Dermatology – Increase Oncology clinics.  
Prompt start – One person needs to chair meeting to keep everyone focused, get people to move on when necessary.  
Breast OK – Use good referral source, proforma's, recorded in patient's notes, outcomes and results recorded on minutes.

Colorectal and upper GI – currently trying to streamline attempting to use proforma's.

Recorded in patient notes.

However, minutes are too lengthy – consultants dictate after MDT.

Lung – Will attempt to streamline – only just started to get involved in lung MDT.

Official referral would be a great help also proforma for entering outcome (working on this) Need to ensure ----- for care members at the moment this is impossible.

Results and outcomes should be stated more clearly so everyone is absolutely sure of what is happening. Certain core members do not attend and often their input would be useful, if only for the occasional patient.

### *Chesterfield*

No not for the Breast MDT meeting.

Chesterfield is quite up to date with collection of information data collection etc. Perhaps ease on collecting notes, X-Rays could be better but this is a standard complaint. The consultants at Chesterfield do clearly outline the treatment plan for each patient, which is after prompting by MDT staff.



#### Appendix 4 - Consultant Histopathology time record

DATE	NAME OF MDT	CHECK REPORT PREP TIME (mins)	PREP TIME FOR SLIDE REVIEW (mins)	OTHER PREP TIME (mins)	COMMENTS	TOTAL

## Appendix 5

<b>'Audit of review of MDT Discussion Documentation'</b>	
<p><b>Hospital Number:</b></p> <div style="border: 1px solid black; width: 250px; height: 40px; margin: 10px 0;"></div> <p><b>MDT Date:</b></p> <div style="border: 1px solid black; width: 250px; height: 40px; margin: 10px 0;"></div>	<p><b>Tumour site:</b></p> <p>Breast <input type="checkbox"/></p> <p>Urology <input type="checkbox"/></p> <p>Gynaecology <input type="checkbox"/></p> <p>Lung <input type="checkbox"/></p> <p>Colorectal <input type="checkbox"/></p> <p>Upper GI <input type="checkbox"/></p> <p>Skin <input type="checkbox"/></p> <p>Head &amp; Neck <input type="checkbox"/></p> <p>Comments:</p>
<p><b>Legibility:</b></p> <p>Totally illegible <input type="checkbox"/></p> <p>25% legible <input type="checkbox"/></p> <p>50% legible <input type="checkbox"/></p> <p>75% legible <input type="checkbox"/></p> <p>Fully legible/clear <input type="checkbox"/></p> <p>Comments re abbreviations:</p>	<p><b>Diagnosis:</b></p> <p>Full written diagnosis <input type="checkbox"/></p> <p>50% written diagnosis <input type="checkbox"/></p> <p>No apparent written diagnosis <input type="checkbox"/></p> <p>Comments:</p>
<p><b>MDT decision as indicated on MDT Database :</b></p> <p>Treatment plan – 0% <input type="checkbox"/></p> <p>Treatment plan – 25% <input type="checkbox"/></p> <p>Treatment plan – 50% <input type="checkbox"/></p> <p>Treatment plan – 75% <input type="checkbox"/></p> <p>Treatment plan – 100% <input type="checkbox"/></p> <p>Comments:</p>	<p><b>Overall Comments:</b></p>

Patient Information

# Multi-disciplinary Team and joint Gynaecological

*Oncology clinic*



Chesterfield and North Derbyshire  
Royal Hospital  
NHS Trust

You have been referred to a 'fast-track' specialist gynaecology clinic, so you can be seen and have any tests arranged and performed as swiftly as possible. You may have already undergone some investigations either by your own GP or hospital. You may have undergone surgery for treatment of suspected gynaecological malignancy.

The multi-disciplinary team (MDT) is made up of consultant specialists from gynaecology, radiology, pathology and a senior gynaecology nurse. The team is supported by a visiting specialist from Weston Park Hospital, Sheffield. The MDT meet regularly throughout the month to review your test results and recommend the most appropriate and effective treatment for you.

Although you will not meet all the specialists at any one time you will be seen by Mr P Tromans, Consultant Gynaecologist, or his colleague, Mr J M McDonnell, together with Jean Bown or Margaret Davies, Gynaecology Nursing Sisters. You may be introduced to Dr Pledge, Consultant Clinical Oncologist during the course of your clinic attendance.

This is an anxious time for you and your family. Hopefully you will be reassured by your visit to this clinic and know that a team of professional healthcare personnel have your best interests at heart.

Chesterfield and North Derbyshire  
Royal Hospital  
NHS Trust

Calow, Chesterfield, Derbyshire, S44 58L. Tel: 01246 277271

**Appendix 7 – Examples of useful documents from other hospitals relating to MDT meetings and discussions**

**SOMERSET COLORECTAL CANCER SERVICES**

**GP DETAILS**

Name of GP:

Practice Address:

**PATIENT DETAILS**

Patient NHS number:

Consultant Surgeon: Mr Eyre-Brook / Mr Vickery / Mr Welbourn  
Other (Please state):.....

Clinical diagnosis: .....

Information given to patient:

Carcinoma:	Certain	Yes / No
	Strongly suspected	Yes / No
	A significant risk	Yes / No

Intended treatment plan:                      Investigations:.....

Pre-Op Radiotherapy:.....

Surgery: .....

Adjuvant chemotherapy: .....

Palliative treatment: .....

Comments

**Colorectal Nurse Specialist Involved: Yes / No ([Forsyth\\_n@tst.nhs.uk](mailto:Forsyth_n@tst.nhs.uk))**

Contact Numbers: Tel: 01823 342452 Fax: 01823 344732

Stoma Nurse Specialist ([Catto\\_j@tst.nhs.uk](mailto:Catto_j@tst.nhs.uk))

## MDT patient template

<b>Patient identifier label</b>	<b>Date of MDT meeting</b>
---------------------------------	----------------------------

Has patient been informed of diagnosis?                      Yes                       No

Consultant:		
Diagnosis:		
Histology:		
Investigations awaited: (e.g. staging CT, MRI)		<u>Date:</u>
Significant co-morbidity:		
ASA grade:		
<b>MDT discussion:</b>		
Further investigations:		
Plan of action:		
Person responsible for action:		