Merseyside and Cheshire NHS
Cancer Network

Guidelines for governance and communication between local and specialist multi-disciplinary teams

Version 7 January 2010

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1. Introduction

As the Improving Outcomes Guidance has been implemented in the Network, a number of specialist multidisciplinary teams (MDTs) have been set up for the less common cancers, covering a wider geographical footprint where specialisation is required.

While the treatment of these cancers by the experts of the specialist MDT allows for excellent cancer care, this is operationally more complex and it is important that even greater attention is given to good communication and that it is clear who is responsible for the patient's care at any given time to allow for good governance.

This document aims to lay out principles for good communication and good governance for patients discussed at specialist MDTs within the network and should be read in conjunction with the network's Key Worker Policy.

A list of SMDTs is contained in appendix 1.

2. Referral to the specialist MDT

It is the responsibility of the local MDT to refer patients to the specialist MDT using criteria agreed within network guidelines. Each of the specialist MDTs should design and distribute a referral form for its patients which should be emailed or faxed to the SMDT co-ordinator. The patient's GP should also be informed that a referral to the SMDT is being made (for example within the clinic letter). The proforma should include patient details, clinical history, diagnosis, stage, grade, the reason for discussion, the MDT minimum data set and the performance status of the individual being referred. It should also have details of fax, email and telephone contacts for the specialist MDT, and also the fax back number, email

address and the address of the local MDT making the referral. In addition the patient's home telephone number and mobile phone number should be included.

The referring clinician may also dictate a letter which may be helpful to the SMDT. Pathology slides can be sent with referral to the SMDT if a second opinion is necessary, using the network agreed pathology proforma.

The MDT co-ordinator of the local MDT is responsible for ensuring that the referral is made in a timely manner (normally regarded as being within one working day) and x-rays and pathology specimens and other supporting documentation is provided. There is a generalisation that the specialist MDT will need a minimum of three days notice to discuss a particular patient and to allow time for review of the pathology and radiology.

3. The meeting

The MDT co-ordinator should ensure that the patient's x-ray file is sent to the radiology department in good time to be loaded onto PACS for review by the radiologist prior to the meeting and to be available for the MDT.

The SMDT co-ordinator is responsible for generating and distributing the MDT list to core and extended team members. It is the responsibility of the MDT co-ordinators to establish the video link and ensure the IT suite is functional throughout the meeting.

The chair will ensure that an action plan is formulated by consensus agreement and is recorded at the meeting. It is the responsibility of the SMDT co-ordinator to transcribe the action plan to the electronic format and for this to be reviewed by the chair.

4. Patients 'unseen'

It is recognised that not infrequently patients will be discussed by the specialist MDT without having been seen by a specialist MDT clinician, and that a final

decision on the appropriateness or exact nature of treatment may well be dependent on a clinic visit to the specialist MDT, and the final MDT decision may be modified. Any changes in decision should be effectively communicated to the referring hospital and the GP, and where necessary the patient should be re – discussed by the specialist MDT.

5. After the meeting

After the SMDT, the MDT co-ordinators should liaise with the clinical nurse specialist (CNS) to ensure that all clinical plans are carried out. Details of available trials that have been considered will also be included. Where appropriate the patient is contacted by the CNS to arrange an outpatient clinic appointment

6. Communication from the specialist MDT to the local MDT and GP

Following discussion at the SMDT it is the responsibility of the chair to ensure that a comprehensive opinion is communicated using a proforma.

The completed proforma (patient details, clinical history and action plan) will be distributed by the SMDT co-ordinator within one working day to the following:

- Electronic copy to core and extended team members
- Faxed copy to GP
- Copy to referring clinician
- Local key worker

In some cases, the chair may also dictate a letter to the referring consultant with a copy to the GP and other relevant clinicians, summarising the treatment options to be recommended.

7. Communication with the patient

Where the SMDT is making decisions without having met the patient, or if the patient is handed back to the local MDT, responsibility for their care remains

with the referring consultant who also continues to have responsibility for the communication to the patient and the organisation of their ongoing care.

Patients who are referred back to the local MDT for further management will be contacted by the local MDT clinical key worker to inform them of the outcome and arrangements will be made for them to be seen the following week (or earlier) by an appropriate core member of the local MDT so that the SMDT decision can be explained and the patient given chance to ask questions.

If it is intended that the SMDT provides treatment, patients will be contacted by the key worker as agreed at the meeting to inform them that their case has been discussed and that they will be seen the following week (or earlier) by an appropriate member of the core team. Where possible, patients will be seen in a joint clinic with the oncologist and surgeon.

The MDT action plan, relevant case files and imaging files will be prepared by the relevant MDT team and forwarded to the clinic. This process will be co-ordinated centrally by the specialist nurses.

The specialist MDT makes major decisions regarding treatment and further management and should therefore have a very low threshold for seeing patients. Therefore any patients who wish to be seen by the SMDT should be offered an appointment. This is an important part of the SMDT's role, ensuring that sensitive information is communicated directly to patients and relatives, providing them with opportunity to ask questions in person.

It is, however, recognised that many patients will not wish to attend the host hospital for an appointment or this may be inappropriate. In this instance the responsibility for communication and ongoing care lies with the referring consultant, outlined above.

8. Disagreement between the local and specialist MDT

In those instances where there is a disagreement between the local consultant or local MDT and the specialist MDT there should, in the first instance, be a telephone conversation between the consultant in the local and specialist MDT and if concerns remain then the specialist MDT should see the patient for a final decision.

9. Governance arrangements

It is important that there are clear governance arrangements and that both patient, relatives, medical and nursing staff in primary, secondary and tertiary care are all clear who is responsible for the patient's care at any given point of the pathway.

When a patient is referred from primary care to secondary care they are assigned to a particular consultant who has responsibility for their care. This remains the case unless the patient is referred on to and seen by another consultant. The same situation pertains to the patients being discussed at the specialist MDT.

For those patients referred for SMDT discussion by the local MDT, but the patient is not actually seen, the responsibility for the patient's care remains entirely with the local MDT and local consultant. It is the responsibility of the local MDT to ensure that the patient is told of the specialist MDT decision in an appropriate and sensitive manner.

10. For those patients seen by a consultant from the specialist MDT

Clinical responsibility for the patient remains with the referring clinician until a named doctor from the SMDT writes to confirm that they are taking over their care. They will remain responsible for this care until referral back to the local MDT.

11. Patients requiring further investigation at the request of the specialist MDT

If further specialist investigation is required following discussion at the SMDT, it is good practice for the patient to be offered an appointment to enable the SMDT to explain the test and the reason for this in person. This is both courteous and allows for clear communication.

It is however recognised that specialist investigation may be needed quickly without time to see the patient in advance. Under these circumstances it is reasonable for the specialist MDT clinical key worker to contact the patient directly to explain why further tests are needed, what these will entail and when and where these will be carried out.

12. Patients treated by the specialist MDT

Patients treated centrally by the specialist MDT are usually having complex major surgery and it is vital that good quality discharge information is communicated by fax/electronically to the local MDT, GP and local key worker within 24 hours following treatment. A copy of this discharge summary should also be given to the patient. The discharge summary should have clear contact details for the key worker, consultant and on call team at the specialist MDT.

Similar standards of communication should also apply to those patients having radiotherapy and/or chemotherapy.

Appendix 1 (revised October 2011)

Specialist MDT	Host Trust	Lead Clinician
Pancreatic Specialist Urology – radical surgical procedures Testicular Level 3 & 4 Haematological cancers - myeloma - acute leukemia - lymphoma Sarcoma Early rectal Anal Skin lymphoma Neuroendocrine	Royal Liverpool and Broadgreen University Hospital	John Neoptolemos Phil Cornford Judith Carser Patrick Chu Richard Clark Andrew Pettit Q Yin Paul Rooney Paul Rooney Richard Azurdia/Andy Pettitt Sobhan Vinjamuri
Oesophago-gastric cancers Thoracic (mesothelioma)	Liverpool Heart and Chest Hospital	Nathan Howes Martyn Carr (surgical) Martin Walshaw (MDT Lead Clinician)
Paediatric Oncology	Alder Hey	Lisa Howell
Specialist Gynaecology	Liverpool Women's	John Kirwan
Brain/CNS	Walton	Andrew Brodbelt
Head and Neck Hepatobiliary (primary and secondary liver tumours) Oesophago-gastric cancers	Aintree	James Brown Hassan Malik Richard Sturgess
Skin Plastics	St Helen's & Knowsley	Elaine Hindle Phil Brackley
Specialist Urology – radical surgical procedures Penile*	Wirral Hospitals	Nigel Parr
Teenage and Young Adults (16-24 years)	Clatterbridge Centre for Oncology	Nasim Ali
Oesophago-gastric cancers	Betsi Cadwaladr University Health Board	Jonathan Pye

* SMDT hosted at Christie

Appendix 2

PATHOLOGY REVIEW FOR SECTORISED MDTs

1) Selection of cases for review

All cases referred to a Cancer Centre for consideration of treatment should ideally have the diagnostic biopsies (and, where relevant, cytology specimens) reviewed by a pathologist who is a core member of the MDT. In practice, the proportion of cases needing review will vary for each cancer site, depending on the workload of the MDT and the complexities of diagnosis. Each MDT should therefore establish its own criteria for selection of cases for review.

2) Selection of reviewers: the role of the 'specialist'

MDT membership is the responsibility of the host trust. Each MDT will need at least two review pathologists to allow for cover. It is important that sufficient time be allocated and funded within job plans for this role.

Reviewers are expected to satisfy the criteria for 'specialist cellular pathologists' as suggested by the Royal College of Pathologists[1], or to work towards that status. In particular, their CPD and EQA activities should reflect their specialist role. They should participate in a relevant specialist EQA scheme, where one exists.

3) Transport of review material

For some MDTs, presentation of histology by the original pathologist from a remote site by video-linking may be acceptable. In addition, it may soon be possible to review cases by viewing digitised images sent electronically. Nevertheless, for the forseeable future it will remain necessary to move some slides physically between laboratories. Transport of review material will comply with guidelines issued by the Royal College of Pathologists[2].

Slides and (if appropriate) blocks for review will be requested from the originating laboratory, usually by the specialist MDT coordinator. Requests must be in writing to create an audit trail. They may be sent by fax, to a secure location; e-mail is only acceptable if sent between NHS.net accounts. Courtesy suggests that the original pathologist is made aware of a request for review, unless that would delay the process, and ideally the reviewing pathologist should know in advance which cases to expect

Material must only be sent between laboratories (and not, for example, to clinicians' secretaries), using inter-hospital transport or courier, and must be signed for both on dispatch and receipt. The number of slides and blocks sent must be documented. Each case must be accompanied by a copy of the original report. Receipt of the material will be confirmed by faxback. When review is complete, material will be returned using the same system. Use of a standard referral form may be useful to encourage consistency in communication.

Cases must be received in time to allow review before the relevant MDT meeting; the exact timescale will be a matter for each MDT to agree, but will typically be at least three days before the meeting. (It should be noted that, if additional work is needed or further material is requested from the source laboratory, even cases

received by the deadline may not be ready for discussion at the anticipated meeting.) Cases should be entered onto the reviewer's laboratory information system to reinforce the audit trail, and identified as review specimens by appropriate coding to facilitate workload monitoring and clinical audit.

4) Communication of review diagnoses

The reviewing pathologist should issue a formal pathology report to the specialist MDT, even when no discrepancy is identified, and a copy should be sent to the referring pathologist. (If the review is in entire agreement with the original report then the review report should be brief, perhaps merely confirming the diagnosis and referring to the original report for more detail.) The patient record on the referring laboratory's information system should be updated to include the outcome of the review, and a supplementary report should be issued to local clinicians to ensure that the team responsible for the patient's follow-up is aware of the final pathological diagnosis. Communicating the review diagnosis also affords an opportunity for education and audit.

Clinically significant discrepancies should be logged and audited by both the original pathologist and the reviewer, and this could be incorporated into the annual workplan of each relevant tumour-specific CNG. Sensitivities around discrepant diagnoses are likely to be minimised where reviewers are recognised by their colleagues to possess specialist expertise, but the often subjective nature of the diagnostic process should be acknowledged. If there is a major diagnostic discrepancy, it is usually helpful for the reviewer to discuss this with the referring pathologist before the MDT.

References

1. 'The recognition and roles of specialist cellular pathologists.' Royal College of Pathologists, June 2006. http://www.rcpath.org/resources/pdf/G004-SpecialistCellularPathologists-Jun06.pdf

2. 'Guidelines on inter-departmental dispatch of samples from patients sent to another hospital or centre for assessment and/or treatment.' Royal College of Pathologists, September 2006. http://www.rcpath.org/resources/pdf/G016-GuidelinesOnInter-departmentalDispatchOfSamplesV2-July06.pdf

Appendix 3

Standards for the Recording of Second Opinions or Reviews in Radiology Departments

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