We need to fix the ‘MDT problem’, now.

Without the right technical support, MDTs may unravel

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It is now ten years since the surgeon Ian Paterson— the infamous butcher of Solihull — was suspended from medical practice; four and a half years since he was jailed; and nearly two years since the Paterson Enquiry published its report. A few days ago Paterson was refused the legal opportunity to challenge his convictions.

In all that time, many things have changed for the better. In my work improving safety in hospitals in both the UK and China I have noticed an increased willingness to challenge healthcare colleagues – including senior doctors – in order to protect patients from preventable harm.

Trust-level boards in the NHS have also tightened their governance structures – and the appraisal system for doctors has become further embedded. But Ian Kennedy, the author of the first Kennedy review, in 2013 wrote in early 2020 that there remain stubborn and difficult cultural and political problems throughout the NHS – implying that a similar tragedy could still happen.

The recommendations of both reports concentrated rightly on the need for cultural and systemic changes but the government enquiry also demanded better compliance with MDT meeting standards:

The guidance at the time was from 2019 that emphasised streamlining. The guidance also assumed that the MDTMs should be held as a single meeting, with the whole team in attendance.

But, a consequence of these recommendation has been an increased number of Multi-Disciplinary Teams (MDTs) to cover many of other challenging clinical decisions.

The CQC inspection framework now includes MDTs for End of Life Care, tumours and weekly MDTs for people with complex needs.

Lack of time and staff availability for this is a real problem. Admittedly videoconferencing has improved, but this is still *a lot of meetings*.

Smaller providers in the independent sector (where a lot of the NHS recovery work will no doubt be done) are unable to find the competencies unless they have good relations with their local trust.

MDTs are under increasing pressure and are already seeing an erosion of their power to assure safe and appropriate care. Anecdotally, non-attendance by key MDT members is a significant quality issue for many hospitals. This is not a problem of engagement — all MDT members and are willing to provide input — but staffing pressures and the complexity of rostering makes holding these MDT meetings near-impossible.

So how do we stop this degradation? How can hospitals better manage the burgeoning requirement for MDTs?

One possible answer is to change the emphasis from a single meeting to a managed series of

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recorded opinions and decisions. If properly supported by the right workflow technology, we can move away from the 'single-point' MDT *meeting* (MDTM) to a 'multi-point' MDT *process* (MDTP) which could allow better and more auditable decisions to be made. Where significant differences of opinion exist, then a meeting can be called – but the MDT members could act independently and in parallel using a suitable recording and monitoring system.

How exactly might that work?

An MDT Process

Here is an outline of an MDT process that uses *asynchronous review* rather than a fixed, formal meeting:

1) A patient is created in a dedicated, secure MDT patient list (could be 'sent' from or looked-up in an EPR, or manually entered).

2) Required referral summary uploaded to a secure patient-specific document storage area. This includes expected or planned treatment or questions to be answers.

3) Supporting documents (e.g. scans, letters, other notes) are uploaded to the same location

4) Actions are assigned to relevant members of the MDT, requesting their opinion on the case.

5) Documents are reviewed by each member of the MTD, in their own time, who provide written summaries of their opinion.

6) If the result is equivocal, then an ad-hoc meeting is called for detailed discussion.

7) Summary output information is entered into the system.

8) The result of this is then agreed by the MDT leader, printed out or emailed back to the referrer.

9) The patient is discharged from the team

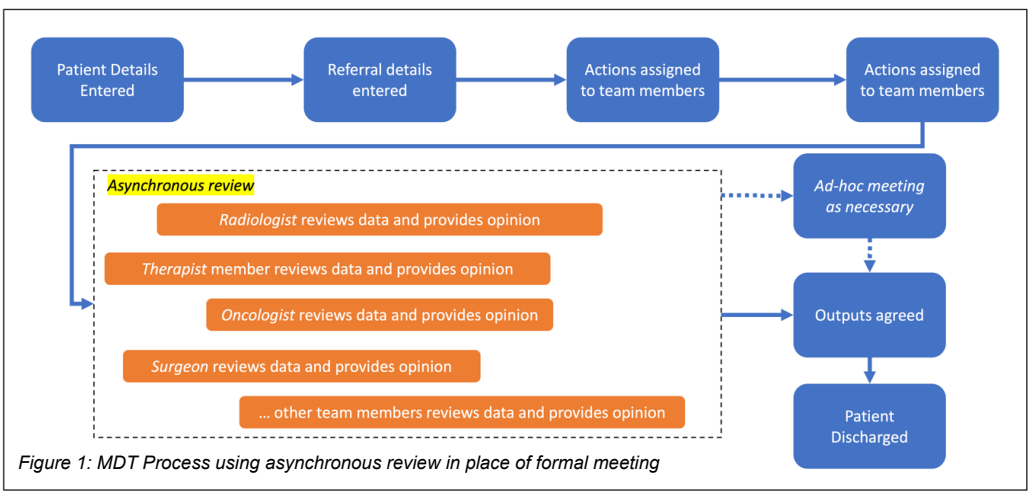

Figure 1: MDT Process using asynchronous review in place of formal meeting

With such a system in place, MDTs could be batched by individuals, making their life easier and very possibly providing a way of resisting the bullying tactics used by Patterson all those years ago.

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