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BHS SURGICAL STANDARD

MDT meetings for low volume, high complexity procedures

Background

For low volume, high complexity arthroplasty cases, the MDT is more than a governance or case discussion meeting. The process is fundamental to the planning of patient care. The MDT should involve clinicians with a width of experience and from multiple sub-specialties. These guidance points should be read in conjunction with the Appendix.

Attendance

1. All practitioners with an active interest in complex hip surgery should attend. Surgeons, radiologists and administration/audit support are a minimum, with microbiologists/infectious disease physicians present for infection cases.

Frequency of meetings

2. Meetings should take place weekly at a defined time. There should also be facility for 'hit squad' MDT to support emergency problems. Attendees must be allocated time in their job plan to attend.

Location

3. To be decided by the chair. Must possess IT facilities to enable remote attendance.

Surgeon commitment

4. Prior to the meeting, the surgical team should provide a standardised case summary which can be made available to all in advance of the meeting.

Role of the chairperson

5. This should be defined in the MDT 'Terms of Reference'. Specific responsibilities in maintaining good governance of the MDT process are included in the appendix.

Administrative Support

6. Administrative support is fundamental to the whole process and requires dedicated funding. Responsibilities include invitations, distribution of pre-meeting information, agenda, publication of minutes and communication with MDT members.

Model Agenda

7. All pre-operative complex cases should be discussed. Quality Control review of all post-op X-Rays with a scoring system. 'Any other business' should be included to facilitate the ability for surgeons to present urgent cases for discussion.

Terms of Reference

8. To be agreed locally and ratified by all members of the team. For review on annual basis at a minimum.

Network Lead Responsibilities

9. This include maintenance of professional standards, to act as network-wide governance lead, to ensure engagement of all relevant parties in the process and prepare an annual MDT report (to include auditable standards).

AUDITABLE STANDARDS

1. Number of meetings/frequency
2. Percentage of all revisions presented
3. (Pre-op discussion v. quality assurance review – should approach 100%)
4. Individual attendance of members
5. Complexity scoring
6. Quality assurance scoring
7. Terms of reference sign off percentage
8. Admin support whole time equivalent quota
9. Infection cases discussed with ID/micro?

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MDT meetings for low volume, high complexity procedures: APPENDIX

Introduction

The Multi-disciplinary team meeting approach to complex and revision arthroplasty has been universally accepted across the UK over the last decade. The purpose is to provide the necessary governance for patient care in the most complex cases and to support the operating surgeon in decision making and advice, as well as providing a timely means of onward referral if required. Publications from Nottingham and Stanmore have reported on the efficacy of this medium in advising/supporting surgeons, planning complex surgery and providing a mechanism for quality control and reflection. Secondary gains have included enhanced cost effectiveness and avoidance of surgery following colleague advice. More and more, dual surgeon operating is becoming accepted practice and the MDT is an excellent venue to decide on and plan this.

Whilst we all agree that the MDT is now an integral part of our working life, there is much variation in how we conduct the meeting and report output. The Hip Society seeks to support surgeons in this regard by publishing a set of standards that we hope all would strive to emulate. Whilst the following guidelines are not to be regarded as mandatory, they have been peer reviewed and would be regarded by us as "best practice". As we all have learned how to embrace off-site working in our everyday lives the MDT should be better attended and more effective, providing appropriate and adequate support is available.

We feel that the MDT is more than an arthroplasty governance/case discussion meeting. More it is fundamental to the planning of patient care, involving clinicians from multiple sub-specialties.

Who attends?

All surgeons who practice revision and other forms of low volume high complexity surgery. Whenever possible, attendance is mandatory and a record of attendance should be kept. Whilst there are no minimum standards for attendance, the Network Lead will discuss with any individuals who repeatedly do not attend how their engagement can be improved. Surgeons do not necessarily need to attend the whole meeting every time, it is respected that people have other commitments which may require late joining/early departure. We would expect the hub surgeons to be frequent attenders, joined by one of their radiology colleagues and ID support when needed as a minimum requirement. The agenda should be flexible so that surgeons can present their cases and hear the discussion whilst present if on a tight schedule. The norm should be as many people as possible present for the duration of the meeting.

To be "multi-disciplinary" we need colleagues from other specialities to join. We do not have an effective MDT unless at least one MSK-specialist radiologist is present.

When prosthetic infection is discussed, it is mandatory to have colleagues from microbiology/Infectious Disease present. Prior knowledge of the patients to be presented is vital so as to allow our ID colleagues to prepare results and treatment plans.

At least one member of the admin support team should be present to take the minutes and work with the meeting Chair-person to produce suitable meeting outputs.

A theatre department representative from all hospitals in the network where LVHC work is carried out should attend. This helps to inform surgeons what kit is "on the shelf" and what might incur a loan fee. This also facilitates early ordering of kit and avoidance of "kit clashes" across multiple theatres in the same Department.

If employed in the network, the arthroplasty clinical nurse specialist should be made welcome and to be made to feel an integral part of the MDT process.

The meeting should be open to all trainees, Fellows and Surgical Care Practitioners. The time, date and venue/joining instructions should be made freely available to everyone working in the network at all levels – everyone is welcome to attend for education as well as service.

In academic units, a representative interested in process and outcome should attend. Other colleagues who may be encouraged to attend on a case-by-case basis would include:

- Vascular surgeon
- Plastic Surgeon
- Anaesthetist
- Peri-operative physician

When?

The MDT should happen weekly. More than once a week is too onerous on time, less than once a week and the agenda gets overburdened. The timing should be locally negotiated. The BHS strongly supports job-planned, normal working hours' sessions as DCC activity. How much time is allocated will depend on the size of the network and the usual case load. A regular meeting on a set day is easier to job plan than a rolling day, but local variation may require this.

We should also provide an MDT "hit squad" which is a smaller group of committed members who will provide as required support for surgeons with acute problems such as infection and fractures.

Where?

The chairperson will dictate the venue of the meeting. Colleagues will not be required to attend in person. Instead the Chair will provide:

- A suitable room for those who want to attend in person
- A web-based solution for those not attending in person. This requires capital support for the purchase of screens, microphones, speakers and a hardware system capable of running the meeting as well as sharing high resolution PACS and non-PACS screens. It does not matter what hosting system is used, as long as colleagues can mute, be seen on screen and "put their hand up" in order to demonstrate a desire to comment. The meeting package should clearly reveal who is logged in to enable the Chair to make everyone feel engaged and to facilitate accurate attendance recording.

What is provided?

The surgeon in charge of the patient's care should provide to the admin team details of:

- Demographics
- History
- Investigations – bloods and imaging, possible aspiration Provisional surgical plan.

All of the above will hopefully be presented by the surgeon in charge at the MDT, but the case precis allows others to prep ahead of the meeting if they so wish. It allows the Chair to present the patient if necessary if the surgeon in charge be delayed, waylayed or for other reasons not be present.

The Chairperson

Working closely with their admin support help, the Chair is responsible for putting together the agenda, making sure relevant patient information is available to all (securely), running the meeting to time and producing output. Local variation will exist in how the meeting is exactly run, but it is essential that all attendees feel engaged, have an opportunity to contribute and be able to ask questions. Providing case precis prior to the meeting allows individuals the chance to prepare for the meeting ahead of time and to avoid the laborious reading out of case notes by the chair at the start of each discussion.

The network lead may want to chair the meeting themselves or delegate to someone who may have better hosting skills. Some may prefer to rotate the chairing of the meeting. The key principle is that all attendees feel it is a good use of their time. The network lead should at least have a small team of potential chairpersons in order to cover leave/absence etc.

Administrative Support

The BHS believe that good admin support is essential for excellent patient care in a network delivered high complexity low volume surgical system. All members of the MDT should receive an agenda with patient details attached at least 24 hours prior to the meeting. Surgeons will need to be made aware of any last minute changes to timings, venue or dial in details. Patients should be placed on the agenda a minimum of two weeks prior to surgery to allow for any adjustments in plans/kit requirements etc.

Minutes should not need to be taken by clinical staff. We are there for patient care reasons and if not directly involved in any specific decision making moment, we still need to feel free to comment if appropriate and at the very least are there for education. Minute taking and a record of attendance should be done by a member of the clerical staff – this is their specialty.

Immediately after the meeting, the chair person or network lead should dictate a letter on all patients discussed. Best practice guidelines for MDT outputs includes a communication with the patient discussed. It can be decided locally whether this is done by the MDT chair or the lead consultant for that patient.

No more than 48 hours after the meeting, all members of the group should receive a secure email containing the meeting minutes and a separate letter regarding any patient discussed under their individual care.

The admin support member will enter the MDT output for each patient in their electronic record. All MDT minutes will then be stored in a secure manner either locally or on a secure cloud based database where one is available e.g. BAJIR.

Model Agenda

In networks where a very large number of revisions are performed, colleagues may decide to discuss only very complex cases. The BHS strives to support this with a complexity grading system. All cases discussed should have a complexity rating decided upon at the end of deliberations.
In large regions, there will be a role for local as well as regional MDT meetings in order to co- ordinate/support care at different levels of organisation within a network.

Regardless of complexity, all post-operative revision images should be looked at in order to provide a degree of quality control. This provides an opportunity for surgeons to reflect on how they did, report back any deviations from the MDT output and for decisions to be made regarding post-op management. The admin support staff will identify all revisions performed in the network in the previous week. If post-op x-rays are not available, they will be added to the following week agenda.

The agenda should have an "any other business" section at the end where colleagues can present urgent cases or ask for advice regarding problems which can not be left until the next meeting.

Terms of reference

Each network should approve a local Terms of Reference document based upon these guidelines.

This should be ratified by all members of the network and a record should be kept by the network lead of signed copies from all MDT regular attendees.

Once or twice a year the Terms should be reviewed to allow alterations/evolution.

Network Lead responsibilities

The network lead should be the most regular attender and set the example for professionalism and meeting etiquette. The lead will need to ensure that all meetings are fair, non-discriminatory and supportive of colleagues, not critical. Regular attendance and colleague engagement depend

significantly on this. A 3 year term gives everyone the opportunity to apply for the position and specific job-planned time should be made available. We would suggest 1 PA would be appropriate to facilitate very high quality meetings and network functionality. This role may be shared between colleagues if an amicable solution can be devised.

The BHS feel that the Network Lead does have a duty of care towards patients in terms of quality of decision making and surgery performed. Where there is repeated non-engagement from a surgeon, repeated deviation from the discussed plan for no obvious reason or repeated cause for concern in terms of how procedures have been executed – the network lead should have a one to one discussion with the relevant surgeon and if a satisfactory resolution can not be achieved, then this will need to be escalated to the local Head of Service or Medical Director. In this rare occasion, it will be the duty of the network lead to ensure Duty of Candour is delivered and that appropriate incidents are discussed and reflected upon in appraisal. Locally it might be felt appropriate for HCLV surgeons to provide a network lead report for their appraisal around attendance, engagement and quality.

The network lead will work with the admin support team to prepare annual reports to be presented locally and at any national meetings as required.