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Summary

The ‘Cancer care statewide health care strategy 2014’ articulates a vision for quality public sector cancer care services across Queensland. Service directions broadly indicate how services will need to develop over the next decade to meet the health needs of cancer patients. The strategy promotes consistency of care through multidisciplinary teams using evidence based treatment protocols, guidelines and standards and the provision of information to patients throughout their cancer journey.

Multidisciplinary team meetings provide a forum for clinicians from different disciplines to provide individualised treatment planning to people with cancer. It is therefore essential that multidisciplinary team meetings operate in a manner to ensure effective, quality patient care.

Central Integrated Regional Cancer Service (CIRCS) has written the “Multidisciplinary Team Meeting Guide” which has been endorsed by the Statewide Clinical Cancer Network. The guide draws on the evidence collected by Ontario Cancer Care in Canada and used in the development of standards for multidisciplinary case conferences within their jurisdiction.
Introduction

Cancer multidisciplinary team (MDT) meetings provide a forum for clinicians working within cancer care to refer their patients for discussion and treatment planning. The primary intent of the MDT meeting is to prospectively review individual cancer patients considering the diagnostic and treatment aspects of the patient’s care and make recommendations on best management based on evidence. The MDT recognises that individual physicians are responsible for the final treatment decision in consultation with the patient.

MDT meetings are able to ensure appropriate and timely investigations and can facilitate patient treatment closer to home where appropriate. Referrals to the patient’s treating team can be streamlined. The MDT can also ensure early referral and timely access to palliative care, supportive care and on referral to other MDTs as necessary. Factors which have been identified as enhancing the effectiveness of MDT meetings include, but are not limited to, a positive team environment, clear meeting goals and strong leadership.

Having regular MDT meetings helps to improve discussion between members and enhances communication flow across treating teams and facilities. Team members are better able to monitor treatment variations and advise others regarding evidence based guidelines. MDT meetings provide education opportunities and MDT collegiality can add to the wellbeing of individual team members. Patients are more easily identified for the eligibility for clinical trials. The regularity of the MDT meeting helps treating teams better manage waiting lists, lower waiting times and makes best use of resources.

To ensure quality of patient care and improvement of outcomes, the efficient function of the team, a high standard of communication and decision making processes need to be a well-established by MDTs.

The UK’s NHS National Cancer Action Team conducted a survey in 2009 involving over 2000 MDT members to discover what makes an effective MDT meeting. Analysis of the survey findings resulted in the following MDT characteristics that result in effective MDT meetings.

- Treatment decisions and care is delivered by specialists with knowledge and skills in the relevant aspects of the particular cancer type
- Patients have the opportunity to access high quality and relevant clinical trials
- Patients are offered information and support to cope with their cancer
- There is continuity of care regardless of who provides or where care is provided
• There is good communication between primary, secondary and tertiary care
• Quality data collection is undertaken for research and audit purposes
• There is improved equality of outcomes – an example of this would be the patients views, preferences and needs informing the decision making process where relevant or possible.
• The MDT has collegial working relationships for example: having agreed team governance and processes
• The MDT has an educational component
• There is economic use of resources (e.g. telehealth).  
• There is a process in place to alert MDTs to significant changes to the recommended treatment plan so the team has the opportunity to review and record variances and learn from these cases.  
• There is a process for the auditing and monitoring of MDT processes to drive service improvement and assist service planning including sustainability of the MDT.

The characteristics of an effective MDT complement the standards. Multidisciplinary teams who collegially work together to improve the care of patients with cancer can use this guide to inform their meeting effectiveness.
A Guide for Multidisciplinary Team Meetings

Multidisciplinary team meetings should have the following elements to ensure effective meetings.


It is advised that the MDT develop Terms of Reference or similar document to provide a concise summary of their meeting standards and processes. The following points should be included as a minimum.

1. Statement of purpose.
2. List of health care professional membership including core members, disciplines and their roles and responsibilities.
3. Procedure to maintain attendance records.
4. Meeting venue, format, frequency and duration.
5. Communication flow including referral to MDT process, discussion criteria and documentation.
6. How patient consent and confidentiality will be maintained in selection and review of cases and who is responsible.
7. Data management, auditing and reporting on MDT meeting activity.
8. Clinical trials, process for identifying eligible patients and recording participation.
9. Education and training.
10. Videoconferencing etiquette.
2. Statement of Purpose

Primary function:

1. Improve cancer care delivery to patients, with each new case having their co-morbidities, Eastern Cooperative Oncology Group (ECOG) score, stage of cancer accurately assessed and recorded, and documented evidence – based treatment plan developed, reviewed and implemented by multidisciplinary team members.\(^5\)

2. Ensure that all appropriate diagnostic tests, all evidence based treatment options and the most appropriate treatment recommendation is generated for each cancer patient discussed prospectively in a multidisciplinary team meeting.\(^3\)

Secondary functions\(^3\)

1. Provide an educational opportunity for medical, nursing and other health professionals.

2. Contribute to patient care quality improvement activities and practice audit.

3. Contribute to the development of standardised patient management protocols.

4. Establish networks with regional hospitals and clinicians to ensure appropriate referrals, timely consultation and ongoing management of cancer patients.

5. Encourage innovation, research and participation in clinical trials.
3. Criteria and protocols for case discussion

1. New cancer cases, inpatient and ambulatory, and the question for the MDT or proposed treatment plan should be referred to the MDT through the mechanism most appropriate to the team i.e. letter, information system such as MOSAIQ®, Queensland Oncology Online (QOOL) or other agreed method.³
2. The individual physician and the chairperson can determine which cases are discussed in detail at the MDT meeting.³
3. Other cases (e.g. recurrent or metastatic cancer) can be referred to the MDT meeting as per the agreed method at the discretion of the individual physician.³
4. Agreed Meeting Format

1. MDT meetings should be held at regular intervals for a minimum duration of one hour and at a frequency of at least fortnightly to ensure timely prospective case review.³
2. Discussion should be encouraged from all members of the multidisciplinary team.³
3. Attendance should be recorded at each meeting and used for continuing professional development.
4. All information disclosed at the meeting will be deemed as confidential and as such the Queensland Department of Health privacy policy will be adhered to by attendees of the meeting.
5. Team Members

1. To ensure quality management and meeting processes each MDT meeting should have a designated Chair and MDT Coordinator with designated back fill.

2. Core team members should be representative of the disciplines required to diagnose, treat and support the particular tumour group and also have the required expertise in the tumour type i.e. diagnostic radiology, nuclear medicine, pathology, surgery/surgical oncology, specialist physicians, cancer care coordinator, specialist nurses and allied health.

3. A representative from each health professional discipline must be in attendance to provide the range of expert opinion appropriate for the tumour group and the hospital.

A minimum of 2 representatives from surgery, radiation oncology and medical oncology would be optimal. Where representation of the required disciplines is not available at the hospital, a virtual MDT meeting should be established using videoconferencing and other technologies.

4. Other health disciplines necessary to the management of the patient can contribute to the case discussion. This may include but not limited to allied health, dentistry, genetics, welfare, palliative care, nurses, medical students and junior doctors.

5. Health professionals may attend for educational purposes. This may include but not limited to medical students, nurses, allied health professionals, other specialist doctors or junior house doctors.

6. Industry representatives or members of the general public should not attend the MDT meeting, so as not to jeopardise confidentiality and introduce bias in the case review.

7. Patients or their representatives should not attend the MDT meeting to ensure bias is not introduced in discussion.

8. Industry representatives may be invited to give an education session prior to or after the MDT meeting.
6. Roles and Responsibilities

**Chairperson**

1. Senior core member of the MDT.
2. Accountable to the MDT.
3. Must have strong leadership abilities.
4. Delegation authority in the running of the MDT meeting and other responsibilities such as documentation or changes in processes.
5. Implement and monitor compliance of the MDT meeting standards.
6. Responsible for:
   a. the overall running of the meeting
   b. ensuring the meeting keeps to time and discussion is kept on topic
   c. encouraging the participation of all MDT members
   d. ensuring confidentiality is maintained and attendance appropriate
   e. recording dissenting opinions
   f. Provide a verbal summary/overview at the end of each case discussion or at end of meeting to confirm consensus and provide an opportunity for further questions to be raised.

7. A deputy chairperson should be assigned for when the Chair is absent.

**MDT Coordinator**

1. Administration Officer.
2. Responsible for administrative management and individual meeting functioning.
3. Preliminary preparation includes:
   a. Manage referrals to the meeting
   b. Booking meeting rooms, setting up, checking equipment is available and functioning
   c. Distribute agenda
   d. Ensure all necessary investigation results, pathology slides and radiology, patient records are available for the meeting, scanned and uploaded to computer

4. Data management by ensuring minimum data sets are recorded including diagnosis, diagnosis date, staging, ECOG and co-morbidities.
5. Maintain attendance lists.
6. Contribute to quality improvement activities through audit and evaluation of meeting.
7. Ensure documentation is completed by relevant clinician.
8. Communicate meeting changes to team and keep Chairperson informed.
9. Operationally accountable to the Chairperson and the MDT members. Produce and distribute reports on MDT activity as per MDT meeting protocol.
10. A designate should be trained in this role to provide backfill in the MDT Coordinators absence.

**Cancer care coordinator**

1. Ensures a streamlined journey for the patient, the cancer care coordinator is pivotal to the MDT meeting as patients requiring cancer care coordination are identified.
2. Provides a central contact for the patient.
3. Provides a point of contact and link between treating teams and other facilities.
4. Must work closely with the MDT Coordinator and treating team to ensure treatment recommendations and minimum data set is recorded.
5. Designated backfill should be available for this role.

**Referring doctor**

1. Presenting the case at the MDT meeting (may send a delegate)
2. Maintaining confidentiality
3. Informing patient of case discussion
4. Forwarding referral with relevant information to the MDT Coordinator
5. Informing the MDT Coordinator what investigation results are required for the meeting and where the investigations were performed
6. Informing the MDT Coordinator the question for the MDT
7. Documentation of the discussion and recommendations in the patient record
8. Informing the patient and other relevant health providers e.g. GP of proposed treatment plan
9. Reporting to the MDT any significant changes in final treatment decision for documentation

**Members of the MDT**

1. Schedule time into work plan to attend MDT meeting regularly and where not possible send a delegate.
2. Refer all new cancer cases to the MDT meeting and other cancer cases such as recurrent or metastatic which would benefit from MDT discussion.
3. Participate in discussions to provide expert opinion in area of expertise whilst giving others the opportunity to participate.

4. If referring a patient or sent as delegate to present the patient then the member and delegate are conjointly responsible for the documentation of the MDT recommendations, doctor-patient discussion and final treatment decision into patient record.
7. Essential resources required for MDT meetings

1. MDT Coordinator to provide referral management, data management, maintain communication and ensure the meeting is organised and functions efficiently. Essential to the continuity of the MDT meeting.\textsuperscript{3}
2. Dedicated meeting room.
3. Projection equipment for displaying radiology images and pathology slides.
4. Videoconferencing or teleconferencing facilities.
5. Adequate IT support especially after hours.
6. Computer and network for accessing and recording of guidelines such as Adjuvant online or eviQ in order to reach consensus on treatment recommendations.
7. Data manager to record data in suitable information system (e.g. QOOL) and to manage audit and review of data. Data manager can be MDT coordinator or nurse.
8. Microscope for pathologist
9. Cupboard or trolley for MDT Coordinator use.
8. Patient information – consent

Written consent from the patient for MDT discussion is not necessary. However, it is recommended that patients be informed of their case presentation at a multidisciplinary team meeting in order to avoid any potential breaches of confidentiality and to adhere to the Information Privacy Act 2009 (QLD) and Health Services Act 1991 (QLD).

It is the referring doctor’s responsibility to inform the patient of the referral to the MDT meeting (MDTM) and note it in the medical record. The patient should be informed of the purpose of the MDTM, who may be present at the meeting and what information will be shared. The patient has the right to refuse care provided in this way or limit what information is shared, e.g. psychiatric history or something they feel is sensitive and not relevant. 6, 7

Written consent is required if the MDT or individual clinicians bill patients for presentation at the MDT meeting through Medicare item numbers 870 and 872. The referring doctor is responsible for obtaining patient consent.
9. Documentation

Documentation of the patient discussion including dissenting views of the team ensures there is a detailed record which can be referred to in the future if questions are raised, the patient has an adverse outcome and where there are legal proceedings.

Any changes to the final treatment decision should also be documented and the MDT meeting members informed. This is not only necessary for medico-legal reasons but also for the team to learn or monitor treatment recommendations versus final treatment decisions.

Documentation processes should also include communication of treatment plans to GPs and other health professionals who will be involved in the patients care. Patients may also benefit from receiving written treatment plan from their treating teams.6, 8

Attendance list

Maintaining a MDT meeting attendance list is an important process, not only for recording professional development points, but also to monitor the attendance of required disciplines.

An attendance list may also be considered wise for medico legal reasons. There have been occurrences of patients or their families holding MDTs accountable for adverse outcomes and members could be called on in legal proceedings.6
10. **Videoconferencing**

Videoconferencing facilities, while not essential to a MDT meeting, are desirable to allow regional sites or primary care providers the opportunity to participate in their patient’s discussion at the MDT. Videoconferencing is beneficial for care coordination, identifying supportive care needs of the patient and communicating new information to the MDT.
Conclusion

Multidisciplinary care is accepted as best practise in the delivery of high quality cancer management in Australia and internationally. The portal through which multidisciplinary care can be effectively provided is the multidisciplinary team meeting. Care delivered to patients through a multidisciplinary approach results in positive outcomes especially in terms of diagnosis and treatment planning, patient satisfaction and survival.³ Participating in multidisciplinary team meetings also has positive outcomes for clinicians around the opportunity for education, improved communication and more collegial working relationships.³, ⁴

It is therefore crucial that in Queensland we follow the lead of our international and national colleagues in developing and endorsing standards for multidisciplinary meetings to address effectiveness and sustainability. This will undoubtedly benefit all people with cancer through the opportunity to have their case discussed by a team of experts in the field.
Recommendations

1. Stakeholder consultation involving members of MDTs throughout the State must be undertaken to gain acceptance of MDT meeting standards.
2. The Statewide Cancer Clinical Network endorses the MDT meeting guide for implementation by the MDT Chair.
3. Agreement to adopt Ontario Cancer Care process to enable management of uncomplicated cases where treatments are standard and give more attention to complicated cases.9
4. An information strategy is developed to disseminate the MDT meeting guide to MDT Chairs across Queensland.
References


