Multidisciplinary meeting framework

A guide for Victorian health services providing care to children and adolescents with cancer

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Administrative Host:

The Royal Children's Hospital
1st Floor South Building
50 Flemington Rd
Parkville, Victoria 3052

Telephone +61 3 9345 4433
Email pics.admin@rch.org.au
Website www.pics.org.au

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1. Introduction

> "I like the idea that our daughter is being treated by a collection of the best brains in paediatric oncology."
>
> *David, father of a girl with childhood cancer*

1.1 Context

International evidence demonstrates multidisciplinary care is a key part of providing best-practice cancer treatment.[1] Multidisciplinary care provides an opportunity to deliver consistent, high quality, clinically safe and accountable services in the treatment and care of patients with cancer.[2]

A mechanism in the delivery of multidisciplinary care is the multidisciplinary meeting (MDM). MDMs provide an opportunity to ensure that all children with a new diagnosis of cancer, at critical stages along their cancer treatment and those who experience relapse, are discussed at an MDM comprising appropriate health experts. In addition, the MDM is a forum whereby those who experience a change in treatment, are coming off treatment, have relapsed, are transitioning to palliative care or require end-of-life management have their case reviewed at an appropriate MDM.[1]

The MDM is designed to be a central point of discussion between a range of health care professionals inclusive of those from multiple health service sites with expertise in the diagnosis and treatment of cancer. The MDMs support best practice management and consistency of care and involve the ability to review and discuss medical imaging, pathology and patient information, to support diagnosis, staging and treatment planning.[3]

An effective, efficient and timely presentation of patients to the appropriate MDM should achieve the following outcomes:

Optimal patient care and clinical effectiveness

- Treatment and care of patients is provided by health professionals with expertise in the cancer field.
- Adherence to best practice guidelines in the optimal care of cancer patients.
- Patients are assessed and offered the opportunity to be enrolled onto clinical trials.
- Patients are provided with the most relevant information and support needed along the pathway of their cancer treatment and recovery.[4]

Patient participation and coordinated care

- Shared decision making with clear integration of the patient's values, goals and concerns.
- Treating teams and supports are organised with the patient at the centre of care.
- Enhanced communication pathways across the treating team between patients, families, carers and primary, secondary and tertiary care.
- Access to patient information and treatment recommendations.[4]

Quality care and patient safety

- Equality of outcomes through better understanding and awareness of patients' characteristics and through reflective practice.
- Robust data collection to inform audits, research and best outcomes for the patient.[4]

Skilled and effective workforce

- Enhanced working relationships between team members to improve communication, education, collegiality, wellbeing and job satisfaction.
- Opportunities for education and professional development.
- Resources optimised.[3]

1.2 Framework objectives

This framework has been developed to provide operational and organisational guidance to ensure effective delivery of statewide MDMs for paediatric cancer patients living in, or undergoing treatment in Victoria. In addition, the framework articulates indicators to demonstrate effective governance in clinical decision making, responsibility and accountability of MDM decisions and outcomes.

The aim is to ensure 100 per cent of all children and adolescents suspected or newly diagnosed with cancer in Victoria have their diagnosis, staging and treatment plan discussed and agreed upon at an appropriate tumour-specific MDM with a statewide remit.[2]

Terms of reference will sit alongside this framework to inform the individual structure of the tumour-specific meetings for neuro-oncology, leukaemia and solid tumours which will specify the core membership, consent and documentation and the host site responsibilities.

2. Meeting structure

2.1 Role of health services

The role of each health service within the MDM framework is based on the hospital level described in the Service Capability Framework[5] developed by the Victorian Paediatric Integrated Cancer Service:

- the host site will be a level five or six cancer service
- all level five and six cancer services attend and contribute to tumour-specific MDMs
- level four health services sharing the care of children with cancer are invited to attend and participate for the presentation of shared care patients
- all health professionals delivering services within the community and who are involved in the care of the patient being presented are invited to attend the MDM, including general practitioners and paediatricians.

2.2 Meeting protocols

- An agreed Terms of Reference for each tumour-specific MDM is established to govern the meetings.
- An agreed reference set that includes details of the paediatric oncology care pathway[2] and the standard of care for each diagnosis will be documented.
- There is an identified host site for each tumour-specific MDM.
- Details of relevant open clinical trials are made available during meetings.

2.3 Meeting roles and responsibilities

There are five critical roles and responsibilities required to support the MDM:

1. Chair
2. Deputy Chair (delegate)
3. Clinical Lead
4. Scribe
5. Operational support

2.3.1 Chair

Each tumour-specific MDM should have a designated MDM Chair. This Chair is responsible for:

- attending each meeting until the meeting is concluded. In the event of delay in arriving or needing to leave prior to completion, a delegate (i.e. Deputy Chair) should chair the meeting
- ensuring the meeting is punctually opened and closed
- introducing members and invited guests if applicable
- ensuring the meeting reaches a quorum
- ensuring the meeting flows appropriately and facilitates discussion of all patients allowing time for any additional cases to be presented
- ensuring all members have an opportunity to contribute to the discussion of each patient inclusive of those attending via video or teleconference
- setting clear objectives for the team and establishing and maintaining the expectation of team members
- ensuring the relevant clinical leads/specialists are present to discuss the individual patients
- mediating when disagreement arises within the meeting
- maintaining meeting etiquette, especially for those participating from remote sites (See 4.5)
- accepting late cases for discussion (see tumour-specific Terms of Reference for process).

The Chair may also act as the operational lead and may be a Clinical Lead in the MDM.

2.3.2 Deputy Chair (delegate)

The Deputy Chair must be available to undertake all roles and responsibilities of the Chair in their absence.

2.3.3 Clinical Lead

The Clinical Lead(s) is appointed in line with the tumour-specific Terms of Reference and is responsible for clinical leadership of the meeting. The Clinical Lead(s) is responsible for:

- ensuring the relevant clinicians and specialists are present for the case reviews
- ensuring patients are referred to the MDM within five working days of presentation/ diagnosis
- accepting/reviewing referrals from external sites for discussion at the appropriate MDM
- ensuring the relevant general practitioner/paediatrician of the patient is invited to attend, as well as any additional 'by invitation' attendees
- ensuring patients are presented at critical time points within their treatment and recovery pathway
- ensuring discussions are clinically focused and relevant
- ensuring patient consent for MDM discussion has been obtained
- promoting evidence-based and patient-centred recommendations
- ensuring eligibility for relevant clinical trial recruitment is considered

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- ensuring there is a patient MDM summary and recommendations for treatment before the next patient discussion starts
- ensuring the MDM summary contains all relevant information, including staging, treatment plans and who will complete actions post meeting
- ensuring systems are in place to communicate the outcomes of the MDM recommendations to the patient, family, general practitioner and treating team
- nominating a member of the MDM to communicate recommendations to the patient and family
- escalating concern related to safety, outcomes or treatment recommendations
- supporting the ongoing quality audit and review of the MDMs
- promoting the role and importance of MDMs in cancer care to internal and external stakeholders.

A Clinical Lead may also act as the Chair.

2.3.4 Scribe

- The meeting scribe will accurately document the meeting outcomes in accordance with the MDM requirements in the MDM summary template (see 4.7).
- This role is ideally held by a medical fellow.

2.3.5 Operational support

Each MDM must have operational support that will be responsible for:

- ensuring the overall coordination of MDMs and provision of operational support
- assisting the Chair, Deputy Chair and Clinical Lead in conducting and coordinating the MDM
- supporting the ongoing quality audit and review of the MDM
- sending invitations to attend the meetings to clinicians and general practitioners/paediatricians (as appropriate).

2.4 Membership

The membership of a MDM will vary depending on the tumour stream. The core team will be in line with the tumour-specific Terms of Reference and comprise relevant tumour stream specialists.

Membership and attendance may include:

MDM MEMBERS/ATTENDEES	NEURO-ONCOLOGY	LEUKAEMIA	SOLID TUMOUR
Primary paediatric oncologist	C	C	C
Medical imaging consultant	C	R	C
Consultant pathologist	C	C	C
Paediatric radiation oncologist	C	R	C
General surgeon or physician	O	I	C
Specialist surgeon	C	I	C
Palliative care clinician	I	I	I
Nurse (specialist cancer nurse)	C	C	C
Clinical trials representative	C	C	C
Pharmacist	C	C	C
Paediatric infectious diseases consultant	O	R	O
Allied health practitioners	R	R	R
Psychosocial professionals	R	R	R
General practitioner/paediatrician	I	I	I

C = Core **R** = Recommended **I** = Invitation **O** = Optional

2.5 Meeting quorum

Core members are required to be present for the discussion of all cases where their clinical expertise is relevant. Recommended members are required to be present dependent on the cases presented at the meeting. The Chair is responsible for ensuring adequate representation is present at each meeting, to make safe and appropriate treatment recommendations for all patients.

2.6 Invitation to other disciplines

General practitioners and paediatricians will be invited to attend meetings where their patients are to be discussed. Other disciplines, not included in the tumour-specific Terms of Reference core membership, will be invited to attend as required. These are noted as 'invited' and 'optional' in the table on page 7.

2.7 Responsibility of MDM members and attendees

- Members and any invited participants are required to act in accordance with the health service procedures/ policies in which the MDM meeting is hosted.
- Members are required to declare any potential conflict of interest and refrain from any involvement in the decision making process thereafter.
- Members who require discussion of late inclusion patients must present all appropriate clinical information, investigations and diagnostic results at the time of the meeting.
- Members who are unable to attend the meeting, must provide the Chair with notification that they are unable to attend.
- All meeting attendees are required to sign the attendance register for each meeting.
- Members must support the ongoing quality audit and review of the MDM.
- All attendees will respect the privacy and confidentiality of all patients discussed.

3. Infrastructure for meetings

A regular meeting time is arranged in a dedicated room with appropriate infrastructure as outlined in the tumour-specific Terms of Reference.

Rooms where MDMs take place have:

- access to equipment for projecting and viewing medical imaging of diagnostic quality and access to medical imaging reports
- facilities for projecting and viewing specimen biopsies/resections and access to pathology and histology reports
- access to the medical record to enable documentation of recommendations in real time
- projection facilities so members can view and validate the recommendations as they are recorded
- conferencing equipment so clinicians can share pathology, radiology and other multimedia, and engage in effective discussions with participants from other sites
- appropriate sound system to enable fluent communication between meeting attendees on site and at remote facilities.

4. Meeting organisation, logistics and communication

The MDM team makes treatment recommendations based on the information available at the meeting. This information includes but is not limited to, the provision of diagnostic information, information as presented by the referring consultant/fellow and patient diagnosis (if available).

The final treatment decision may vary from the MDM recommendation in cases where new information is expected or becomes available after the meeting or to meet the needs of the patient and their family. In these circumstances, the clinician is required to document the change in treatment plan and notify the MDM team so that they have the opportunity to review and learn from these cases.

4.1 Criteria for MDM presentation

Patients that fulfill the following criteria are required to be presented at an initial MDM:

- new or suspected cancer diagnosis. These patients are to be presented at the next MDM meeting or within timeframes as detailed within the tumour-specific Terms of Reference.

Patients that fulfill the following criteria are recommended to be re-presented at a MDM:

- change to treatment plan due to disease response
- refractory disease
- disease progression, recurrence or relapse
- patients transitioning to palliation and/or end-of-life management
- patients that are coming off treatment (may require noting at the MDM).

4.2 Consent

Signed consent for the MDM discussion from the patient or their parent/guardian is required prior to presentation at a MDM. The following processes for consent are required:

- patients and their families must be provided with information regarding the MDMs, which will include, but is not limited to:
  - a general description of MDMs
  - the confidentiality parameters of the meeting
  - that all health professionals involved in the patients care will have access to their information
  - how to access their treatment recommendations
  - options for patients and their families if they wish to opt-out of discussion at an MDM. If the patient and/or parent/guardian refuse consent, they should be informed that their information can be discussed at the MDM using a pseudonym.
- consent will be obtained and held within the patients treating health service irrespective of the MDM host site
- where a patient is treated in a shared care model, consent is required for each health service and is required to be filed in the individual health service medical record.

4.3 Referral pathways

4.3.1 Referral from the MDM host site health service

The referring clinician is to complete a MDM referral and submit it to the designated operational support by the cut off time outlined in the tumour-specific Terms of Reference.

4.3.2 Referral from another health service

Patients under the care of another health service are referred to the tumour-specific MDM by contacting the relevant Clinical Lead. The referring clinician and/or primary oncologist is responsible for obtaining consent and ensuring the availability of pathology and radiology results prior to presentation at the meeting.

4.4 Attendance list

All attendees are required to sign an attendance list at the MDM to acknowledge their attendance and agreement to the host site confidentiality clause. These attendance lists are to be stored in the medical record system.

4.5 Videoconferencing

Video and/or tele conferencing will be available at all MDMs with a statewide remit. Clear communication is imperative to ensure effective discussion between remote and host site team members. Etiquette includes:

- the Chair greeting each remote arrival
- encouraging participation from remote sites
- all attendees introduce themselves and speak loudly and clearly
- all attendees use names when asking questions of other members
- all attendees limit side discussion and turn mobiles and pagers to silent/vibrate.

4.6 Case presentation and discussion

- The primary paediatric oncologist (or nominated delegate) is required to present the patient for discussion, ensuring that the needs and views of the patient and their family are presented as part of the discussion.
- MDM attendees confirm concordance between the clinical, imaging and pathology information for each case. Diagnosis and staging is confirmed for new diagnoses.
- Treatment planning will occur with reference to the documented standard of care, current evidence-base and/or best practice with consideration of enrolment into a clinical trial where available.
- The clinical governance and accountability for fulfilling the recommendations of the MDM rests with the primary oncologist and treating team.

4.7 Documentation of meeting outcomes

During the meeting, a scribe will document the discussion and outcomes directly into the patient's electronic medical record or designated database of the health service caring for the patient. The scribe can be a suitably experienced nurse consultant, fellow or oncologist.

The following details are to be included in the MDM summary:

- key patient details (name, UR, date of birth, consent obtained, primary oncologist, primary treating centre, general practitioner/paediatrician)
- meeting date and reason for presentation (new diagnosis, review, relapse)
- Clinical Lead and the meeting attendees
- relevant information about the patient's medical history
- pathology/radiology findings

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- diagnosis and staging (if known)
- clinical treatment recommendations
- requirement(s) for further assessment or referral
- alternative recommendations (dissenting views)
- a follow-up plan with consideration of next MDM review.

The Chair is to review the MDM summary for each patient discussed and authorise for inclusion in the patient medical record, either 'in-time' or at the conclusion of the meeting.

All authorised patient notes are to be available to the referring consultant/fellow via the electronic medical record or designated database.

4.8 Communication

4.8.1 Patient and family

The treating clinician/primary oncologist is responsible for conveying the treatment recommendations, including dissenting views where appropriate, to the patient and family. The treating clinician/primary oncologist is to provide patients and their families with access to the written treatment recommendations.

4.8.2 General practitioner and/or paediatrician

For new diagnoses, the outcomes of the MDM discussion are to be communicated in writing, to the general practitioner and/or paediatrician, within two weeks of the meeting date. The process for this is outlined in the tumour-specific Terms of Reference.

4.8.3 Communication with external sites

The MDM summary will be made available to relevant clinicians via secure electronic medical record systems.

4.9 Changes to treatment decisions

Any changes to the MDM treatment recommendation(s) are to be documented in the medical record and the MDM team informed. This is necessary for the team to learn and monitor treatment outcomes versus final treatment decisions.

5. Governance and quality auditing

5.1 Clinical governance audit

To ensure accountability in the delivery of safe and effective quality care, a strong foundation of clinical governance surrounding the operation and procedures of the MDMs has been developed within this document.

Each MDM will undertake annual evaluation of meeting processes, adherence to treatment recommendations, outputs and communication mechanisms.

5.2 Quality audit

Quality audits associated with the Department of Health and Human Services (DHHS) Cancer Services Performance Indicators, the Victorian Paediatric Oncology Care Pathway and the Victorian Integrated Cancer Services (ICS) MDM Quality Framework are undertaken to support the effectiveness and performance of MDMs within and across health services. These measures support service improvement activities, to identify variations in practice and to build consistency across sectors.

At present the key performance indicators as stipulated by the DHHS include:[6]

- evidence that newly diagnosed patients have MDM outcomes documented in the medical record
- newly diagnosed patients have disease stage, appropriate to their diagnosis, documented on the MDM summary
- newly diagnosed patients have MDM outcomes communicated to the general practitioner and/or paediatrician, within two weeks of the meeting date.
- newly diagnosed patients have completed a Psychosocial Assessment Tool (PAT2).[7]

6. References

1. Ministry of Health (2012). *Guidance for Implementing High-Quality Multidisciplinary Meetings: Achieving best practice cancer care.* Ministry of Health, Wellington, New Zealand.
2. Paediatric Integrated Cancer Service (2017). *Victorian paediatric oncology care pathway: providing optimal care for children and adolescents – Acute leukaemia.* Paediatric Integrated Cancer Service, Melbourne, Australia.
3. National Cancer Action Team (2010). *The Characteristics of an Effective Multidisciplinary Team (MDT).* National Health Service (NHS), United Kingdom.
4. Department of Human Services (2015). *Multidisciplinary meeting toolkit.* State Government of Victoria, Melbourne, Australia.
5. Paediatric Integrated Cancer Service (2014). *Service capability framework: A guide for Victorian health services providing primary treatment and shared care to children and adolescents with cancer.* Paediatric Integrated Cancer Service, Melbourne, Australia.
6. Department of Health and Human Services (2016). *Cancer Services Performance Indicators.* State Government of Victoria, Melbourne, Australia.
7. Center for Pediatric Traumatic Stress. PAT 2.0. The Children's Hospital of Philadelphia, Division of Oncology, United States of America.

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Paediatric Integrated Cancer Service

Telephone +61 3 9345 4433
Email pics.admin@rch.org.au
Website www.pics.org.au