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| Multidisciplinary team meeting quality framework implementation audit project |
| Findings from the statewide audit 2019–2020 |
| OFFICIAL |

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Contents

[Key messages 5](#_Toc155963743)

[Summary 6](#_Toc155963744)

[About this report 6](#_Toc155963745)

[Overview of method 6](#_Toc155963746)

[Overview of results and findings 7](#_Toc155963747)

[Recommendations 8](#_Toc155963748)

[Background 10](#_Toc155963749)

[About multidisciplinary meetings 10](#_Toc155963750)

[The cancer MDM quality framework 10](#_Toc155963751)

[About the audit 11](#_Toc155963752)

[Introduction 11](#_Toc155963753)

[Audit activities 11](#_Toc155963754)

[Scope of the audit 11](#_Toc155963755)

[Audit governance 12](#_Toc155963756)

[Selection of health services 12](#_Toc155963757)

[Ethics 12](#_Toc155963758)

[The audit tools 12](#_Toc155963759)

[Collation of results and findings 14](#_Toc155963760)

[Limitations of the audit 15](#_Toc155963761)

[Participating health services, MDMs and tumour streams 16](#_Toc155963762)

[Participation for Tool 1: MDM Main Audit Tool 17](#_Toc155963763)

[Participation for Tool 2: MDM TOR Audit Tool 17](#_Toc155963764)

[Participation for Tool 3: MDM Minimum Data Audit Tool 17](#_Toc155963765)

[Participation for Tool 4: MDM Survey Tool 18](#_Toc155963766)

[Results, discussions and recommendations 20](#_Toc155963767)

[Presentation of results 20](#_Toc155963768)

[Quality Area 1: Infrastructure and organisational support 21](#_Toc155963769)

[Quality Area 2: Meeting organisation 32](#_Toc155963770)

[Quality Area 3: Membership 37](#_Toc155963771)

[Quality Area 4: Leadership 40](#_Toc155963772)

[Quality Area 5: Consent 43](#_Toc155963773)

[Quality Area 6: Patient referral 45](#_Toc155963774)

[Quality Area 7: Streamlining patient discussion – for MDMs that use prioritisation 53](#_Toc155963775)

[Quality Area 8: MDM recommendations and communication 55](#_Toc155963776)

[Lessons learnt about application of the framework from this audit 60](#_Toc155963777)

[Aggregated results by tumour stream 60](#_Toc155963778)

[Impact of self-reporting 60](#_Toc155963779)

[Conclusion 62](#_Toc155963780)

[Appendix 1: Main Audit Tool (Tool 1) results by MDM location and tumour stream 63](#_Toc155963781)

[Quality Area 1: Infrastructure and organisational support 63](#_Toc155963782)

[Quality Area 2: Meeting organisation 72](#_Toc155963783)

[Quality Area 3: Membership 76](#_Toc155963784)

[Quality Area 4: Leadership 79](#_Toc155963785)

[Quality Area 5: Consent 83](#_Toc155963786)

[Quality Area 6: Patient referral 85](#_Toc155963787)

[Quality Area 7: Streamlining patient discussion – for MDMs which use prioritisation 87](#_Toc155963788)

[Quality Area 8: MDM recommendations and communication 89](#_Toc155963789)

[Appendix 2: Minimum Data Audit Tool (Tool 3) results by MDM location and selected tumour streams 94](#_Toc155963790)

[Appendix 3: Survey Audit Tool (Tool 4) results by MDM location and selected tumour streams 98](#_Toc155963791)

[Survey Audit Tool results by location 98](#_Toc155963792)

[Survey Audit Tool results by selected tumour streams 100](#_Toc155963793)

[Abbreviations and glossary 104](#_Toc155963794)

[Endnotes 105](#_Toc155963795)

# Key messages

The *Victorian cancer multidisciplinary team meeting quality framework* (the framework)[[1]](#endnote-1) was published in 2018. This report documents the findings of a comprehensive self-report audit of 85 multidisciplinary team meetings (MDMs) against the framework. The audit was conducted in 2019–2020 across 22 Victorian health services.

The framework outlines standards for MDMs and offers a method for health services to monitor the quality of MDMs and to drive improvements. In this project, the framework was also used to combine health service results into a statewide audit of MDM practice. Participating health services compared their performance against anonymised state, metropolitan and regional and tumour stream results.

The project has shown that implementation of the framework is feasible, offering a method to identify improvement activities and a robust baseline of data against which these improvements can be measured.

Health services identified 86 improvement activities as a result of the audit. The project has also generated 10 recommendations. These recommendations offer an opportunity to implement improvement initiatives statewide.

Key findings from the audit are:

* 67 per cent of audited MDMs have a standing committee with MDM governance responsibilities; however, there was limited alignment with the framework’s quality indicators related to oversight and monitoring performance of the MDMs.
* 52 per cent of MDMs have approved terms of reference (TOR). Only 3 per cent of the TOR align with the minimum TOR content as outlined in the framework.
* Almost two-thirds of MDM participants reported that the MDM chair facilitated discussion by team members, mediated disagreements, acted fairly and objectively supporting all team members to participate in the MDM.
* 51 per cent of MDM chairs across the state ensured that new research and clinical trials were considered in treatment planning.
* 62 per cent of MDMs have information leaflets informing patients about MDMs; however, there was poor alignment with the framework’s standards on providing this information and clinicians seeking consent before presentation at the MDM.
* Practical and logistical elements of the MDMs were strongly aligned to the framework’s quality standards related to meeting organisation (good alignment was shown for MDM time, location and frequency).
* Very few clinicians refer all their patients to an MDM, and most MDMs do not have agreed protocols to support decisions on which patients are referred and prioritised for discussion.
* 87 per cent of MDMs reported that the meeting is recorded in MDM software in real time.
* The results from the audit of MDM records against the minimum dataset indicates that only seven of 26 data fields were collected by 76 per cent of MDMs.
* Medico-legal risks were identified across a number of the framework’s quality areas including infrastructure and organisational support, meeting organisation, leadership and consent.

# Summary

## About this report

The *Victorian cancer multidisciplinary team meeting quality framework*, published in 2018, has an agreed set of standards, indicators and measures for all cancer multidisciplinary meetings (MDMs) in Victoria. It includes a set of tools for monitoring their quality, supporting their effectiveness and consistency.

The framework’s standards are:

* Quality Area 1: Infrastructure and organisational support
* Quality Area 2: Meeting organisation
* Quality Area 3: Membership
* Quality Area 4: Leadership
* Quality Area 5: Consent
* Quality Area 6: Patient referral
* Quality Area 7: Streamlining patient discussion – for MDMs that use prioritisation
* Quality Area 8: MDM recommendations and communication.

A statewide audit of MDMs across 22 Victorian health services was undertaken in 2019–2020 to determine the level of alignment with the framework.

This report:

* provides comprehensive results and findings from the audit
* identifies opportunities for improvement based on the audit findings.

## Overview of method

Public health services that host two or more MDMs, or the only MDM in their region, were invited to take part in the project. One private hospital was also invited as a convenience sample. The Loddon Mallee Integrated Cancer Service (LMICS) led the audit. The LMICS project team made minor adjustments to the audit tools to allow use for a multi-site project because the framework is designed for use in a single health service.

Health services assigned auditors to the project. Auditors were provided with a copy of the framework, support documentation, audit tools and training. Auditors used a range of methods to collect the required information. Auditors then returned results to the project team for collation and analysis.

The project team created a report for each participating health service, which collated their results and included the aggregated results by region and tumour stream (baseline results). Each auditor was asked to present these results back to their MDMs to facilitate discussion and to determine improvement activities based on local conditions.

## Overview of results and findings

The project has delivered an audit of 85 MDMs across 22 health services. Table 1 shows the overall results of alignment by MDMs against each quality area (standards). A colour-coded key was created to visually represent variation across the state.

Table 1: Aggregated results showing alignment against each quality area, by percentage of ‘yes’ responses.

| Framework Quality Area | All MDMs (85) | Metro MDMs (60) | Regional MDMs (25) |
| --- | --- | --- | --- |
| Quality Area 1: Infrastructure and organisational support | 62% | 63% | 64% |
| Quality Area 2: Meeting organisation | 77% | 77% | 78% |
| Quality Area 3: Membership | 46% | 41% | 58% |
| Quality Area 4: Leadership | 70% | 70% | 69% |
| Quality Area 5: Consent | 24% | 19% | 37% |
| Quality Area 6: Patient referral | 26% | 23% | 33% |
| Quality Area 7: Streamlining patient discussion – for MDMs that use prioritisation (optional) | 46% | 52% | 32% |
| Quality Area 8: MDM recommendations and communication | 64% | 63% | 67% |

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| --- |
| Legend |
| Poor alignment (less than 55%) |
| Partial alignment (56% – 75%) |
| Positive alignment (76% – 100%) |

Table 1 shows that, overall, the MDMs showed partial alignment with the framework, with better alignment in areas that cover practical and logistical elements of the meetings. Areas of poorer alignment often related to the quality assurance of MDMs – for example:

* MDM governance and resourcing
* consent and confidentiality
* prioritisation including identification of clinical questions
* explicit recording of divergent opinion and radiology/pathology amendments based on MDM discussion
* explicit inclusion of referrers from regional Victoria into MDM processes.

MDMs have evolved over the past two decades. The framework’s quality standards reflect the National Safety and Quality Health Service Standards, international literature/evidence and privacy legislation. These provide momentum for the continued evolution of MDMs to specifically address the areas of poorer alignment.

### Improvement activities identified by health services

All 22 participating health services identified at least one improvement activity as a result of the audit. Eighty-six projects have been started to improve alignment with the framework. The six most common improvement activities and the number of health services that intended implementation of the activity are:

1. Establish or improve overall MDM governance (12 health services).
2. Review and include MDM participation requirements in employment contracts relevant to the cancer workforce (eight health services).
3. Develop MDM terms of reference (TOR) in line with the framework (eight health services).
4. Update existing MDM TOR to bring them in line with the framework (seven health services).
5. Develop new or improve the existing patient information sheet (six health services).
6. Improve MDM software fields and/or data collection processes (18 health services).

## Recommendations

The following recommendations are drawn from the audit results and findings and seek to improve MDM quality. These were identified by the project team and reviewed by the Project Advisory Group.

**Recommendation 1:** There are many quality standards and indicators in the framework designed to support management of medical indemnity and associated medico-legal risks. The audit results demonstrate poor alignment with these quality standards and further work needs to be undertaken:

* to formally define medico-legal risks of MDMs associated with confidentiality, attendance records, information quality, consent, referrals and divergent treatment recommendations
* to identify optimal management of these risks
* to communicate the extent of risks and management responsibilities to clinicians and health service executives for prioritisation of improvement activities.

**Recommendation 2:** That health services initiate routine monitoring and reporting on the alignment across their MDMs against the framework’s standards. Poor results should be escalated appropriately including to the MDM governance committee and health service executives when relevant.

**Recommendation 3:** That health services develop or enhance TORs to align with the minimum TOR content in the framework. This should include governance structure and processes, continuous quality improvement processes including biennial MDM review, monitoring of attendance against core membership recommended by the tumour-specific optimal care pathways (OCPs) for cancer, risk management, review of the clinical treatment evidence base and monitoring adherence to the TORs.

**Recommendation 4:** That health services ensure the ability for all MDM participants to review all radiology and pathology data, pre-filled patient data and live data entry for participants who join an MDM remotely and/or from another health service.

**Recommendation 5:** That MDM members set protocols for review and presentation of patients in a way that optimises meeting efficiency without compromising clinical quality. This should be based on patient needs, demonstrated by the clinical question posed for every patient presented. When radiology and pathology are not relevant to the clinical question, presentation of this information should be carefully considered.

**Recommendation 6:** The OCPs define the core and non-core disciplines required at an MDM for comprehensive discussion and treatment planning by tumour type. Health services should implement initiatives to:

* align MDM membership with that defined in the OCP (for both core and non-core disciplines) and, when clinically required
* have a process for inviting additional specialists and general practitioners (GPs) for specific case discussion
* implement formal referral pathways to alternative MDMs with the specified disciplines (specialists).

**Recommendation 7**: That health services initiate training to strengthen their collective MDM leadership. This should focus on both MDM culture and practical elements of leadership (such as ensuring required information is correctly documented before, during and after the meeting) to improve meeting discussion and rigour.

**Recommendation 8:** That health services explore options for improving alignment of the data that is collected for MDMs to the framework’s data collection requirements. This could include education and workshop activities to promote the rationale for each minimum data field. The availability of QOOL-Vic software may support these initiatives.

**Recommendation 9**: That health services consider a statewide approach to support the development and formalisation of protocols to streamline and prioritise MDM discussions. This could include an audit of protocols in use and collaboration with clinicians to develop evidence-based protocols for prioritisation by tumour stream, which individual MDMs could tailor to reflect local conditions.

**Recommendation 10**: That health services:

* consider mapping the health services that could be referring to their MDMs within an ICS region
* develop partnerships with other health services to optimise referral pathways within their ICS region and beyond
* improve processes to ensure recommendations are communicated back to referrers to enable timely and appropriate treatment planning with patients.

The Victorian Integrated Cancer Services (VICS) are Victoria’s service improvement network. They are responsible for implementing the *Victorian cancer plan* including OCPs. The VICS have prioritised improvement of MDMs in their statewide strategic plan and will work collectively with health services across the state to facilitate or lead implementation of the recommendations.

# Background

## About multidisciplinary meetings

A cancer multidisciplinary team meeting (MDM) is a deliberate, regular meeting involving a range of health professionals with expertise in diagnosing and managing cancer, with the purpose of facilitating best practice management of all patients with cancer.[[2]](#endnote-2) There are about 180 MDMs operating in Victoria that review and discuss patient information and develop treatment recommendations.

## The cancer MDM quality framework

The *Victorian cancer multidisciplinary team meeting quality framework* was published in 2018. The framework was developed in collaboration with the Victorian Integrated Cancer Services (VICS) to assist the monitoring and quality improvement of MDMs in Victoria. The framework contains:

* an agreed set of 38 standards (grouped into eight quality areas) for cancer MDMs
* indicators and quality measures for each standard
* a set of tools for measuring the quality of MDMs
* a set of exemplars and supporting documents including mapping of the framework's standards to the *National Safety and Quality Health Service Standards* (2nd edition, November 2017).

# About the audit

## Introduction

A series of MDM surveys have been undertaken in Victoria since 2006 to collect information about the characteristics and functioning of cancer MDMs across the state. This statewide audit is the first following publication of the framework. The aim of the audit was to assess alignment of current MDM structures, processes and practices with the framework’s 38 standards.

The results of the audit provide a baseline for future measurement of quality and improvement activity for MDMs. The baseline supports health services to understand both the relative and relevant quality findings for their MDMs, as an aid for prioritising quality improvement.

The Loddon Mallee Integrated Cancer Service (LMICS) coordinated the audit, and 22 health services that hosted 85 cancer MDMs across the state took part in the project.

## Audit activities

Each health service nominated an auditor, who used the framework’s audit tools to:

* audit the MDMs they chose to include in the audit
* share results by providing detailed reports of the audit findings to the participants
* identify and prioritise activities to improve MDMs in collaboration with MDM leaders.

## Scope of the audit

### In-scope activities

The following activities were in scope for the audit:

* selection and participation of a sample of Victorian public and private hospital cancer MDMs
* use of the framework’s four audit tools, tailored for statewide reporting
* extensive support of auditors, including face-to-face training
* dissemination of reports to participating health services, detailing their results and a summary of baseline results (statewide, tumour-specific and location-specific)
* identification and prioritisation of activities to improve MDMs
* centralised coordination of the audit and collation and reporting of results by the LMICS.

### Out-of-scope activities

The following activities were out of scope for the audit:

* MDMs held in private hospitals that are not signatories of an ICS memorandum of understanding
* measurement of MDM quality indicators that are not explicitly part of the framework – for example, outcome measures.

## Audit governance

### Project team

A project team of clinical, policy, quality, data and project staff was established to implement, review and edit the MDM audit.

### Advisory group

An advisory group was set up to provide advice to the project team. Its membership included key stakeholder representatives with expertise and experience in MDMs and was based on a skill mix including ICS clinical directors, ICS program managers and project staff and Department of Health representatives.

### Project oversight

The department’s Cancer Support, Treatment and Research unit was the executive sponsor with responsibility for the overall governance and contracting activities with the health services.

## Selection of health services

The project team identified all health services that host cancer MDMs in Victoria, including the number and types of MDMs hosted. After consulting with the ICS, the department funded 22 health services to take part in the audit. They were:

* a representative sample of public health service MDMs across metropolitan, regional and rural Victoria
* a convenience sample of private health service MDMs in Victoria.

The health services that agreed to take part in the audit chose 85 individual MDMs across 14 tumour streams.

## Ethics

In December 2018 an application for ethics approval was submitted to the Peter McCallum Cancer Centre Human Research Ethics Committee. This committee advised in writing that review or approval of the project was not required because it is part of a continuous quality improvement initiative.

## The audit tools

The auditors used the following framework tools to conduct the self-audit of their health service:

* Tool 1: MDM Main Audit Tool
* Tool 2: MDM Terms of Reference (TOR) Audit Tool
* Tool 3: MDM Minimum Data Audit Tool
* Tool 4: MDM Survey Tool.

Details of the purpose, use and administration of each tool are provided below.

### Tool 1: MDM Main Audit Tool

#### Purpose – Tool 1

To collect information to identify the extent to which each MDM aligns to the framework's standards. Instructions, audit reporting, analysis and suggested responses are included in this one tool to simplify future quality improvement review for health services and can be used after completing quality improvement activities to assess change.

This tool helps to:

* collect information through interviews, observation and desktop reviews
* collate results of the other three tools
* present results back to the MDM for discussion
* record improvements identified.

#### Administration – Tool 1

Auditors completed this spreadsheet for the MDMs they were auditing by:

* interviewing relevant people from the MDM
* attending MDMs to observe practice
* reviewing relevant MDM records and documents.

Auditors then:

* provided initial health service audit results to the project team.

The project team then:

* prepared a baseline report aggregating results from all health services providing statewide, and location-specific (regional and metropolitan) results. The statewide baseline report was given back to auditors for comparison with their local health service results.

Auditors then:

* presented their health service audit results back to the stakeholders of each MDM to identify improvement activities
* communicated proposed health service improvement activities back to the project team for final analysis and reporting.

The ICS provided some local support to auditors on request from health services.

### Tool 2: MDM Terms of Reference Audit Tool

#### Purpose – Tool 2

To establish if the MDM has defined TOR and, if so, to audit alignment with the minimum TOR content detailed in the framework.

#### Administration – Tool 2

Auditors completed a spreadsheet that allowed minimum standards of TOR content to be audited as fields against the MDM’s TOR.

### Tool 3: MDM Minimum Data Audit Tool

#### Purpose – Tool 3

Many of the standards in the framework can only be met if certain patient data are collected. For example, a patient’s GP details are required to meet standards associated with communicating results. To facilitate this, the framework defines the minimum data to be collected for each patient who is referred to an MDM and this Excel tool determines if minimum data was recorded in a sample of patients.

#### Administration – Tool 3

Auditors completed this spreadsheet by reviewing patient data for the last 20 patients listed for each MDM (at a minimum).

### Tool 4: MDM Survey Tool (MDM participant survey)

#### Purpose – Tool 4

To collect qualitative information about each MDM from participants for standards that can only be audited by directly asking participants.

#### Administration – Tool 4

Participants were given the survey either electronically (via SurveyMonkey) or as printed copies. They were given the option to complete a survey for each MDM they attend, or to complete one survey for all MDMs they regularly attend.

## Collation of results and findings

The auditors sent their completed tools to the project team. The project team:

* cleaned the data, which included contacting auditors for clarification (for example, where responses appeared contradictory, information was missing or marked as ‘Not Audited’)
* deidentified information
* prepared baseline reports for all participating health services with statewide results for each audit tool by tumour stream and location (regional or metropolitan).

Once the auditors had returned information about project priorities the project team:

* collated all results and findings
* developed recommendations
* provided comprehensive results back to the department
* prepared this report.

## Limitations of the audit

The audit’s limitations are as follows:

* Because each audit was a self-report audit by health services, some bias may have occurred. This may have affected:
	+ the selection of MDMs to be audited
	+ the sample of patient records to be reviewed
	+ the selection of the auditor.
* Collecting evidence of the existence of a process is different from identifying whether that process was used in the conduct of the MDM. For example, while the audit asks whether there’s an ability to send treatment plans to GPs, it does not audit whether they are routinely sent.
* Clinicians who agreed to take part in surveys may have given different perspectives on the MDM(s) to clinicians who did not complete the survey.
* Allowing survey participants to complete one survey for multiple MDMs they attend has affected the specificity of survey results.
* Some MDMs used paper-based surveys rather than the online survey, introducing variation in the collection method.
* Varying interpretation of audit questions by auditors (steps taken to limit such errors included auditor support and training, and advice to the auditors to read the framework).
* Variation in how poor audit results are interpreted and acted on by the MDM teams.
* Limitations on the sample size, particularly for results presented by tumour stream.
* Each of the framework’s ­standards have associated indicators and measures. The audit checked for evidence of a standard via its measures. Indicators are not included in the framework’s audit tools because this is thought to affect the ease of usability of the tools for audit and presentation. Similarly, they are not detailed in this report. Indicators are important to understand the rationale for how a measure was determined and what solutions may be appropriate to meet framework standards. Auditors were trained on how to use and understand indicators via reference to the framework.

### A note on limitations of the framework

* The framework does not have standards for MDM outcomes for patients.
* Measurement of framework *Standard 6.1 Clinicians refer all patients with a new or suspected cancer diagnosis to an MDM* was not fully achieved. This is because there are no formal predefined MDM catchments in Victoria, meaning it is not possible to define ‘all’. In addition, it is not always possible to identify if the patient has been presented at an MDM in another health service.
* Some minimum data standards may not apply to all tumour types. For example, in tumours without known genetic factors, familial cancer clinic referrals are not required.

The department is committed to maintaining the relevance of the framework by ensuring it reflects the available best practice evidence. It may in future make minor updates to standards, tools and instructions based on the outcomes of this project.

VICS may assist health services to implement MDM improvement activities and to continue monitoring of MDMs against the framework.

# Participating health services, MDMs and tumour streams

Tables 2 and 3 provide details of the participating health services and the type and number of MDMs audited by health service sites (totalling 85).

Table 2: Site and number of audited MDMs – metropolitan

| Health service | Tumour streams | MDMs audited |
| --- | --- | --- |
| Alfred Health | Upper gastrointestinal, breast, hepatobiliary, neurological, lung | 5 |
| Austin Health | Breast, colorectal, hepatoma, head & neck, lung, myeloma | 6 |
| Cabrini Health | Upper gastrointestinal, breast, haematology | 3 |
| Eastern Health | Advanced breast, early breast, colorectal, endocrine, genitourinary, gynaecology, head & neck, hepatoma, lung, lymphoma, myeloma, upper gastrointestinal | 12 |
| Monash Health | Breast, colorectal, genitourinary gynaecology, head & neck | 5 |
| Northern Health | Breast, colorectal, hepatobiliary, genitourinary, lymphoma, myeloma, lung, upper gastrointestinal | 8 |
| Peninsula Health | Breast, lung, upper gastrointestinal | 3 |
| Peter MacCallum Cancer Centre  | Breast, colorectal, genitourinary, lung, melanoma  | 5 |
| The Royal Melbourne Hospital | Central nervous system, haematology, head & neck | 3 |
| The Royal Women’s Hospital | Gynaecology | 1 |
| St Vincent’s Hospital Melbourne | Central nervous system, colorectal, genitourinary, haematology, head & neck, upper gastrointestinal | 6 |
| Western Health | Haematology, genitourinary, lung | 3 |
| **Total metropolitan** |  | **60** |

Table 3: Site and number of audited MDMs – regional

| Health service | Tumour streams | MDMs audited |
| --- | --- | --- |
| Albury Wodonga Health | Breast, gastrointestinal, genitourinary, head & neck, lung | 5 |
| Barwon Health | Breast, colorectal, genitourinary, head & neck, lung  | 5 |
| Bendigo Health | Haematology, head & neck, thoracic | 3 |
| Ballarat Health Services | Breast, gastrointestinal, thoracic | 3 |
| Central Gippsland Health | Lung | 1 |
| Goulburn Valley Health | Breast, multi-tumour  | 2 |
| Latrobe Regional Hospital | Advanced disease, lymphoma, multi-tumour | 3 |
| Northeast Health Wangaratta  | General | 1 |
| South West Healthcare | General | 1 |
| Wimmera Health Care Group | Lung | 1 |
| **Total regional** |  | **25** |

## Participation for Tool 1: MDM Main Audit Tool

Number of Main Audit Tools completed: 63.

There were fewer Main Audit Tools completed than MDMs included in the project because health services were given the option of completing a Main Audit Tool for each MDM audited, or combining their results into one Main Audit Tool.

The following eight health services submitted one Main Audit Tool for all of their MDMs:

* The Alfred
* Austin Health
* Ballarat Health Services
* Bendigo Health
* Cabrini Hospital
* Goulburn Valley Health
* Latrobe Regional Hospital
* Monash Health.

## Participation for Tool 2: MDM TOR Audit Tool

Seventeen of the 22 participating health services submitted TOR audits. Five health services did not have TOR so did not submit data for this part of the project.

## Participation for Tool 3: MDM Minimum Data Audit Tool

All 22 health services completed the minimum data audit tool.

A total of 1,862 patient records were audited. Of these, 1,292 were from metropolitan health services and 570 were from regional health services.

## Participation for Tool 4: MDM Survey Tool

A total of 626 respondents completed the MDM participant survey:

* 526 completed the digital survey (SurveyMonkey)
* 100 completed the paper survey.

Participants were given the option to complete one survey for each MDM they attend, or one survey for all MDMs regularly attended. Of the 626 participants, 83 chose to complete a separate survey for each MDM of which they are a member. These results were then populated into the results for each MDM they attended, resulting in 1,380 counted responses.

The survey response rate cannot be calculated because auditors did not record the number of MDM members invited to take part.

### Survey participants by discipline and role

Table 4 shows the disciplines and/or role held by respondents, and the corresponding number and percentage of total respondents.

Table 4: Survey respondents by role

| Discipline/role | Number | Percentage |
| --- | --- | --- |
| Surgeon | 130 | 20.8% |
| Nurse | 115 | 18.4% |
| Medical oncologist | 82 | 13.1% |
| Radiologist | 50 | 8.0% |
| Registrar/resident | 41 | 6.5% |
| Pathologist | 31 | 5.0% |
| Radiation oncologist | 30 | 4.8% |
| Allied health staff | 25 | 4.0% |
| MDM chair | 23 | 3.7% |
| MDM administrator | 22 | 3.5% |
| Other medical practitioner | 17 | 2.7% |
| ICS program staff | 12 | 1.9% |
| Intern | 11 | 1.8% |
| Nuclear medicine physician | 10 | 1.6% |
| Haematologist | 7 | 1.1% |
| Physician | 6 | 1.0% |
| Unknown | 6 | 1.0% |
| Palliative care specialist | 4 | 0.6% |
| Clinical trials staff | 4 | 0.6% |
| **Total** | **626** | **100%** |

### Survey participants by tumour stream

Table 5 shows the number and percentage of respondents by tumour stream included in the MDMs which they attend.

Table 5: Survey responses by tumour stream

| Tumour stream | Count | Percentage |
| --- | --- | --- |
| Colorectal/gastrointestinal | 237 | 17% |
| Lung/thoracic | 173 | 13% |
| Breast | 171 | 12% |
| Genitourinary | 134 | 10% |
| Upper gastrointestinal | 125 | 9% |
| Haematology/myeloma/lymphoma | 119 | 9% |
| Head & neck | 101 | 7% |
| Hepatobiliary/hepatoma | 101 | 7% |
| Melanoma/skin | 53 | 4% |
| General/multi-tumour | 46 | 3% |
| Central nervous system | 44 | 3% |
| Gynaecology | 40 | 3% |
| Endocrine/thyroid | 26 | 2% |
| Other | 10 | 1% |
| **Total** | **1,380** | **100%** |

Note: ‘Other’ includes sarcoma, advanced disease, pituitary, paediatrics & youth and unknown.

# Results, discussions and recommendations

## Presentation of results

This section contains the results for each standard, followed by a discussion of the findings and recommendations for improvement activity.

Results are arranged by the framework’s quality areas. When a group of standards share a thematic link, results have been presented together. The section and table headings indicate this. For example:

Table 10: Main Audit Tool results for Standard 1.5: All public and private patients have access to MDMs (by percentage of ‘yes’ responses)

Additional results are also presented in the appendices, specifically:

* Appendix 1: Main Audit Tool (Tool 1) results by MDM location and tumour stream
* Appendix 2: Minimum Data Audit Tool (Tool 3) results by MDM location and tumour stream
* Appendix 3: Survey Tool (Tool 4) results by MDM location and tumour stream.

### Main Audit Tool

For each standard, the complete results from the Main Audit Tool are presented in a table that shows the percentage of MDMs (total [statewide], metropolitan and regional) that answered ‘yes’ to a question.

Each table uses the following colour-coding.

| Colour | % of MDMs answering YES to this question |
| --- | --- |
| Red  | less than 55% of audited MDMs had YES results |
| Amber | 56% to 75% of audited MDMs had YES results |
| Green | 76% to 100% of audited MDMs had YES results |

The selection of these thresholds considered factors such as (a) the framework assigns 80 per cent as a target measure for many framework standards and (b) many standards are new and/or less applicable to some tumour streams.

Where there is a variation of 20 per cent or more between metropolitan and regional results for an audit question, the **question** is highlighted in grey.

For example:

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a. | Does MDM appear as a named activity in a strategic/operational plan in the host health service? | 56% | 69% | 22% |

### MDM Minimum Data Audit Tool and MDM Survey Tool

Relevant results and comments from the MDM Minimum Data Audit Tool and MDM Survey Tool and are also provided.

## Quality Area 1: Infrastructure and organisational support

### Overview

Meetings between clinicians to plan patient treatment have evolved over time into formal MDMs. Results suggest that health service executives have not considered the infrastructure and organisational support requirements of MDMs during their evolution.

#### Standard 1.1: Health service executive support underpins MDM activities and Standard 1.2: MDMs have a clear governance structure

##### Main results – Standards 1.1 and 1.2

Table 6: Main Audit Tool results for Standard 1.1: Health service executive support underpins MDM activities (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a. | Does MDM appear as a named activity in a strategic/operational plan in the host health service? | 56% | 69% | 22% |
| b. | Is the person responsible for quality aware of MDM? | 81% | 89% | 61% |
| b. | Has there been at least one quality change related to MDM in the last two years? | 81% | 80% | 83% |
| b. | Is the person responsible for risk aware of MDM? | 65% | 69% | 56% |
| b. | Is there at least one MDM-related risk in the organisation risk log or equivalent in previous 12 months? | 19% | 27% | 0% |
| c. | Are MDM staffing needs incorporated into any budgets?  | 70% | 64% | 83% |
| c. | Do MDM referrers get paid to attend MDMs (include MBS billing)? | 25% | 24% | 28% |
| c. | Are MDM IT needs incorporated into any budgets? | 63% | 53% | 89% |
| d. | Has there been any review of the MDM in the last two years?  | 59% | 71% | 28% |

Table 7: Main Audit Tool results for Standard 1.2: MDMs have a clear governance structure (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a. | Is there a standing committee with MDM governance responsibilities? | 67% | 71% | 56% |
| a. | If yes, can you locate TOR or equivalent for this committee that includes MDMs? | 83% | 78% | 100% |
| a. | Is there evidence of a process to log quality changes and suggestions made at MDMs?  | 52% | 53% | 50% |
| b. | If yes, does membership include clinicians, radiologists, pathologists, business units, executive staff, consumers and leaders within MDM? | 95% | 97% | 90% |
| c. | If yes, does the committee receive biannual updates on changes to MDM treatment evidence base and protocols? | 10% | 6% | 20% |
| c. | If yes, does the committee monitor MDM attendance against recommended membership in optimal care pathways (OCPs)? | 17% | 9% | 40% |

|  |
| --- |
| More than 20% variation of responses between metro and regional health services |
| Poor alignment (less than 55%) |
| Partial alignment (56% – 75%) |
| Positive alignment (76% – 100%) |

##### Relevant survey comments – Standards 1.1 and 1.2

Comments from survey participants showed a desire for health services to provide more MDM resourcing, as evidenced in the following quotes:

‘Administrative tasks for operation of the meeting falls in part to staff without additional EFT. Ongoing IT issues related to MDM broadcasting have been persistent for several years. Untrained in IT, staff are expected to troubleshoot complex IT issues.’ [Nurse]

‘MDM essential in determining the best management pathway for patients. Should be given high priority for resource allocation in hospitals.’ [Radiologist]

##### Improvement activities – Standards 1.1 and 1.2

As a result of this audit:

* two health services prioritised projects to include MDMs in their operational plans
* three health services prioritised projects to establish quality and/or risk logs for their MDMs and two participating health services prioritised projects improving their quality logs for MDMs
* five health services prioritised projects to introduce billing or clarify contracts (staff or external service provider contracts)
* 11 health services prioritised projects to introduce or improve governance arrangements for MDMs
* 11 health services prioritised projects to implement TOR aligned with the framework.

##### Discussion – Standards 1.1 and 1.2

In the framework’s standard ‘1.1 Health service executive support underpins MDM activities’, the audit tools look for evidence that MDMs are considered in the health services’ quality and risk management systems. Awareness of MDMs by hospital quality units exists (81 per cent statewide); however, inclusion in risk management systems is very low. One way that health services can manage the quality and risk of MDMs is by measuring and monitoring performance and employing governance structures to address any issues identified. Appropriate risk management is supported by the Victorian Managed Insurance Authority as part of their public health service medical indemnity insurance.

Medical indemnity issues related to MDMs are relevant to Quality Area 1 as well as a number of other framework standards. If not managed appropriately, these can expose health services to greater risks. These ‘medico-legal’ issues are also referenced in:

* Quality Area 3: Membership – management of confidentiality and attendance records
* Quality Area 4: Leadership – role of chair in maintaining minimum data standards to ensure appropriate discussion and documentation. Also, leadership to escalate safety, quality and risk issues
* Quality Area 5: Consent – ensuring patients give informed consent and have the opportunity to opt out
* Quality Area 6: Patient referral – referring clinicians are responsible for information quality and presentation
* Quality Area 7: Streamlining patient discussion – formalised clinical guidelines
* Quality Area 8: MDM recommendations and communication – recording of divergent opinions on treatment recommendations and presentation of these to patients.

The results indicate variable support for cancer MDMs at the health service executive level. Metropolitan MDMs are more likely to be named as an activity in the strategic/operation plan of the host health service.

Regional health services are more actively managing MDM resources, as evidenced by the higher proportion of health services allocating budget for MDM staffing and IT. One possible reason for better alignment with this standard is that regional MDM participants are more likely to attend remotely. Therefore, regional MDMs have a higher need to ensure technical and support issues are resolved. The smaller number of MDMs held in regional health services might be another factor.

Approximately two-thirds of MDMs had an existing governance structure. Despite this, there was limited alignment with the quality indicators related to oversight, monitoring performance of the MDMs and documentation regarding quality improvement activities.

The improvement activities identified by health services following the audit show a greater awareness of the importance for robust governance structures and the linkage to existing quality and risk systems.

#### Standard 1.3: The organisation ensures MDM participation and operations are included in workforce planning

##### Main results – Standard 1.3

Table 8: Main Audit Tool results for Standard 1.3: The organisation ensures MDM participation and operations are included in workforce planning (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a. | Does the organisation use contract templates or standardised position descriptions for contracts with medical staff who provide cancer care? | 79% | 78% | 83% |
| a. | If yes, are MDM activities included in the templates or position descriptions? | 30% | 23% | 47% |
| b. | Did 90% of core membership specialties (identified in OCPs and in Standard 3.3) attend the last three MDMs? | 83% | 87% | 72% |
| b. | If no – which types of members were missing more than once (e.g. pathologist)? | See footnote | See footnote | See footnote |

|  |
| --- |
| More than 20% variation of responses between metro and regional health services |
| Poor alignment (less than 55%) |
| Partial alignment (56% – 75%) |
| Positive alignment (76% – 100%) |

Of the 11 MDMs that had members missing more than once:

seven indicated that pathologists, palliative care clinicians, radiologists, special needs dentists and speech pathologists were all absent more than once

* four did not specify which health professionals were absent.

##### Relevant survey comments – Standard 1.3

There was a high number of comments related to resourcing of MDMs. For example:

‘Working with outsourced (private public radiology and pathology services) is one of our biggest challenges. Most of these diagnosticians are really good but there is an extra level of complexity needed to negotiate with these services when there are service gaps or problems,’ [MDM chair]

‘MDMs are significantly under-resourced for the amount of work that they do. The discussions often directly translate to better patient outcomes, or intangible cost savings (for example, futile treatment not undertaken). We need significant increase in resourcing of MDMs to ensure patient access is maintained.’ [Radiologist]

‘Pathology presentations are requested in too many cases. It should be an opt-in rather than an opt-out process. The surgeons’ secretaries routinely request full path presentations on every case where they have a pathology result, rather than in cases where something will be learned from slide presentations … This is extremely irritating when the work has been done by the pathologist, but full presentation of the case usually adds nothing useful and simply wastes time.’ [Pathologist]

‘Preparation from the radiology/nuclear medicine/pathology departments can take hours and are often performed outside normal working hours. It is not possible to keep increasing the number of MDMs without proper support of these departments without compromising daily clinical work. Very often when these departments are short staffed, there may not be a representative who can attend the MDMs.’ [Nuclear medicine physician]

##### Improvement activities – Standard 1.3

As a result of this audit:

* eight health services prioritised projects to review and include MDMs in the employment contracts of clinicians involved in cancer care.

##### Discussion – Standard 1.3

Health service workforce planning ideally considers the clinical loads of all MDM team members. When attendance at MDMs is not specified in position descriptions and relevant external contracts (for example, pathology contracts), it is often up to MDM clinicians to negotiate who attends. The high number of comments on the matter of resourcing and efficient use of human resources is notable.

The framework standard specifies inclusion of MDM participation in employment and service contracts as a way to highlight the importance of health services investing in MDMs. However, clinician capacity will always be finite, and the pressure on resourcing is expected to increase as the cancer incidence increases.

The framework’s emphasis on agreed processes and quality improvement could drive greater efficiency for MDMs by ensuring there is a clinical question that guides prioritisation and what is presented during the meeting. For example, if the clinical question is whether a patient is fit for surgery (as opposed to whether surgery would be technically possible), a detailed pathological review may not be required. Close collaboration between MDM members will ensure clinical quality is not compromised when this approach is used.

For a more detailed discussion of protocolisation of meeting processes see framework standard 6.2 and Quality Area 7 below.

#### Standard 1.4 Organisational culture recognises the teaching and training role of activities within MDMs

##### Main results – Standard 1.4

Table 9: Main Audit Tool results for Standard 1.4: Organisational culture recognises the teaching and training role of activities within MDMs (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a. | Results from MDM survey shows 80% of team members responded positively to questions about broad input in decision making. | 79% | 78% | 83% |
| b. | Results from MDM survey shows 80% respondents who were interns, registrars, fellows or students responded positively to questions about MDM providing good opportunities for their own learning and professional development. | 35% | 47% | 6% |

|  |
| --- |
| More than 20% variation of responses between metro and regional health services |
| Poor alignment (less than 55%) |
| Partial alignment (56% – 75%) |
| Positive alignment (76% – 100%) |

Note that the proportion of responses that were junior members was low: 9% in metropolitan MDMs, and less than 1% in regional MDMs.

##### Improvement activities – Standard 1.4

As a result of this audit:

* three health services prioritised projects to address cultural/training aspects of their MDMs.

##### Discussion – Standard 1.4

Across all MDMs, results indicate that broad input from MDM participants is achieved in decision making at the MDM, which reflects the value of the MDMs. The results indicate poor alignment with the framework’s standard for MDMs providing teaching and training opportunities for participants; however, it’s noted that the response rate for this item was very low.

#### Standard 1.5: All public and private patients have access to MDMs

#### Standard 1.6: Health services who participate in MDMs provide an appropriate room for MDMs

#### Standard 1.7: MDM participants can view the required information in real time during MDMs

#### Standard 1.8: The infrastructure to support MDMs including software and hardware is appropriate and reliable

##### Main results – Standards 1.5, 1.6, 1.7 and 1.8

Table 10: Main Audit Tool results for Standard 1.5: All public and private patients have access to MDMs (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a. | Does the MDM accept referrals from public and private services outside of the host agency? | 100% | 100% | 100% |
| b. | Results from MDM survey shows 80% respondents agreed they referred relevant patients to external MDMs when more specialised expertise is required. | 21% | 13% | 39% |

Table 11: Main Audit Tool results for Standard 1.6: Health services who participate in MDMs provide an appropriate room for MDMs (by percentage of ‘yes’ responses)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| a. | Can all participants sit down during busy meetings?  | 97% | 98% | 94% |
| a. | Do rooms where meetings take place allow confidential discussion (including remote sites)? | 100% | 100% | 100% |

Table 12: Main Audit Tool results for Standard 1.7: MDM participants can view required information in real-time during MDMs (by percentage of ‘yes’ responses)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| a. | Do MDM facilities enable on-site participants to view radiology, pathology and prefilled patient data and live data entry?  | 94% | 98% | 83% |
| a. | Do MDM facilities enable off-site participants to view radiology, pathology and prefilled patient data and live data entry and contribute to meeting at host site?  | 73% | 71% | 78% |
| a. | If no, describe restricting factors, stratified by site. | N/A | N/A | N/A |

Table 13: Main Audit Tool results for Standard 1.8: The infrastructure to support MDMs, including software and hardware, is appropriate and reliable (by percentage of ‘yes’ responses)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| a. | Is there an identified person to provide emergency IT support during MDM meetings?  | 71% | 64% | 89% |
| b. | Are there any ongoing technical faults impacting the meeting?  | 19% | 7% | 50% |

|  |
| --- |
| More than 20% variation of responses between metro and regional health services |
| Poor alignment (less than 55%) |
| Partial alignment (56% – 75%) |
| Positive alignment (76% – 100%) |

Low numbers in ‘b’ indicate good alignment with the standard, so highlight is green.

##### Relevant survey comments – Standard 1.5, 1.6, 1.7 and 1.8

Comments from MDM participants highlighted some concern with infrastructure (physical and technical) issues.

‘Our biggest issue is the physical space we hold our MDMs. Need a dedicated space with appropriate seating, general room set-up and technology.’ [Nurse]

‘Severely limited due to slow internet/computers.’ [Radiologist]

‘My main concern about our regional MDM is the consistently poor quality of the video/sound link up as I video-conference. I really value the importance of the exercise but sometimeswonder whether the frustration is really worth it.’ [Surgeon]

##### Improvement activities – Standards 1.5, 1.6, 1.7 and 1.8

As a result of this audit:

* one health service prioritised a project to seek upgrades to teleconference equipment.

##### Discussion – Standards 1.5, 1.6, 1.7 and 1.8

While all MDMs accepted referrals from public and private health services outside their health service, six metropolitan health services and three regional services did not support off-site participation for all audited MDMs. This included neuro-oncology (*n* = 1) and haematology (*n* = 5) meetings where a high percentage of patients may be referred from other health services, and where video/telephone attendance from referring sites may be desirable.

Survey results indicate that not all clinicians refer to MDMs outside their host site. Thirty-nine per cent of clinicians from regional Victoria refer to other MDMs when specialist input is required compared with 13 per cent of metropolitan clinicians. This may be because of greater specialisation seen in metropolitan health services. Detailed service capability mapping and formalisation of referral pathways from metro to regional MDM may help to see gaps in MDM access. Health services did not identify any such improvement initiatives.

Audit results show a positive alignment with framework standards for MDM facilities including the availability of an appropriate meeting venue to support confidential treatment planning discussions. However, this was not always the case, with about 20–30 per cent of all MDMs reporting that access to information and contribution to the MDM discussion was limited for ‘off-site’ participants.

Real-time peer review of patient information and treatment planning is an important quality principle of MDMs. If IT issues compromise off-site participation, the health service risks not meeting best practice for specialist review of patients at their MDMs. Robust protocols for referral, discussion and patient record management outside of the host health service would support improvement. The availability of QOOL-Vic MDM software may support cross-MDM referrals because patients and associated data are discoverable or accessible between health services.

The audit results indicate that infrastructure to support MDMs is generally available and reliable. It appears that IT support for metropolitan MDMs was less available than for regional MDMs. Technical barriers to remote access have mostly resolved because the COVID-19 pandemic necessitated remote access for all participants.­

#### Standard 1.9: Information is captured across patients and MDMs to enable analysis and reporting and benchmarking of diagnostic, treatment and administrative trends

##### Main results – Standard 1.9

Table 14: Main Audit Tool results for Standard 1.9: Information is captured across patients and MDMs to enable analysis and reporting and benchmarking of diagnostic, treatment and administrative trends (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a. | Is the meeting being recorded in software in real time? | 87% | 84% | 94% |
| a. | Were the following fields all captured during the meeting:1. Staging (pathological, histological, clinical)2. Treatment recommendation3. Recommended referrals4. Clinical trial suitability | 49% | 51% | 44% |
| a. | If no, what fields were missed? | See footnote | See footnote | See footnote |
| b. | Meeting software can report minimum data outlined in Quality Area 6 across individual MDMs. | 76% | 89% | 44% |
| c. | Can you identify a process to place MDM recommendation in medical records for the patient at host MDM health service?  | 87% | 96% | 67% |
| c. | Can you identify a process to place MDM recommendations in medical records for the patients outside host MDM health service? | 86% | 82% | 94% |

|  |
| --- |
| More than 20% variation of responses between metro and regional health services |
| Poor alignment (less than 55%) |
| Partial alignment (56% – 75%) |
| Positive alignment (76% – 100%) |

The fields most frequently missed in the 15 health services who responded to this question were:

clinical trials [15/15]

staging [10/15]

treatment recommendations [6/15]

recommended referrals [4/15].

##### Relevant survey comments – Standard 1.9

Comments made by survey participants show that some staff appreciate the importance of minimum data requirements. For example:

‘Standardisation of a minimum standard of documentation at MDMs is critical. Too often there are robust discussions of which detail is not adequately captured (often because of the volume of patients, or the lack of knowledge of meeting scribe). When this occurs, the MDM discussion and the time of the meeting participants has been totally lost and wasted.’ [Medical oncologist]

‘Until such time as data necessary to track the patient pathway to compare to optimal care pathways is recorded, reviewed and presented back to MDM participants, the MDM will remain “all talk, no action”.’ [Surgeon]

##### Improvement activities – Standard 1.9

As a result of this audit:

* three health services prioritised projects to improve processes to place MDM recommendations in the medical records of patients who were referred to the MDM from outside the host health service
* 18 health services prioritised projects to improve the recording of minimum data in the meeting software. The availability of QOOL-Vic software may support these initiatives.

##### Discussion – Standard 1.9

Minimum data standards support best practice discussion and treatment planning by ensuring all relevant information is presented and recorded. This supports analysis and benchmarking of diagnostic, treatment and administrative trends at the MDM and continuous quality improvement within health services. The poor alignment against the minimum data recording standard led most audited health services to identify this as an area of improvement. QOOL-Vic software has built in quality assurance reporting that will facilitate auditing of this quality standard.

Processes for filing MDM recommendations within the medical record of the host MDM health service were not readily identified by a third of regional MDMs. In contrast, regional MDMs processes for filing the MDM recommendations in the medical records of the referring (external) health services was far better. This is a relevant finding for patients treated at more than one health service or for those who have been referred to the host service MDM from a sub-regional service.

### Recommendations relating to Quality Area 1 – Infrastructure and organisational support

**Recommendation 1**: There are many quality standards and indicators in the framework designed to support management of medical indemnity and associated medico-legal risks. The audit results demonstrate poor alignment with these and further work needs to be undertaken:

* to formally define medico-legal risks of MDMs associated with confidentiality, attendance records, information quality, consent, referrals and divergent treatment recommendations.
* to identify optimal management of these risks
* to communicate the extent of risks and management responsibilities to clinicians and health service executives for prioritisation of improvement activities.

**Recommendation 2:** That health services initiate routine monitoring and reporting on the alignment across their MDMs against the framework’s standards. Poor results should be escalated appropriately including to MDM governance committee and health service executives when relevant.

**Recommendation 3**: That health services develop or enhance TORs to align with the minimum TOR content in the framework. This should include governance structure and processes, continuous quality improvement processes including biennial MDM review, monitoring of attendance against core membership recommended by the tumour-specific optimal care pathways (OCPs) for cancer, risk management, review of the clinical treatment evidence base and monitoring adherence to the TORs.

**Recommendation 4:** That health services ensure the ability for all MDM participants to review all radiology and pathology data, pre-filled patient data and live data entry for participants who join an MDM remotely and/or from another health service.

**Recommendation 5:** That MDM members set protocols for review and presentation of patients in a way that optimises meeting efficiency without compromising clinical quality. This should be based on patient needs, demonstrated by the clinical question posed for every patient presented. When radiology and pathology are not relevant to the clinical question, presentation of this information should be carefully considered.

## Quality Area 2: Meeting organisation

### Overview

The framework’s minimum standards for TOR content prompts health services to consider governance, role definition, attendance/quorum, patient consent, recording of minimum data, meeting documentation, and MDM monitoring and evaluation (detailed in Appendix 3 of the framework). Many of these areas differ from the practical and logistical elements of the meetings that clinicians often focus on. Development or improvement of TOR in line with framework standards may not always change processes in meetings, but they do prompt a quality assurance approach.

Results show partial alignment with the framework relating to how meetings are run. However, variations occur in:

* the degree of formality of MDMs
* the existence of TOR for MDMs and how they align with the minimum standards for TOR as documented in the framework.

#### Standard 2.1: The MDM has terms of reference (TORs) or equivalent that meet minimum standards

##### Main results – Standard 2.1

Table 15: Main Audit Tool results for Standard 2.1: The MDM has terms of reference (TOR) or equivalent which meet minimum standards (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a. | Does MDM have approved TOR or equivalent? | 52% | 64% | 22% |
| a. | Using results from MDM TOR Audit Tool, do more than 80% of TOR standards align with Appendix 3 – the minimum TOR content in the framework? | 3% | 0% | 11% |
| a. | Please list TOR areas that do not align or are missing from heath service TOR or equivalent against Appendix 3 – the minimum TOR content in the framework. | See below | See below | See below |

|  |
| --- |
| More than 20% variation of responses between metro and regional health services |
| Poor alignment (less than 55%) |
| Partial alignment (56% – 75%) |
| Positive alignment (76% – 100%) |

##### MDM TOR Audit Tool results – Standard 2.1

The MDM TOR Audit Tool contains 25 questions to test the level of alignment with the framework standards. This MS Excel tool then calculates the number and percentage of TOR standards that have been achieved. Seventeen of the 22 participating health services submitted TOR audits. Five health services did not have TOR so did not submit data for this part of the project. Of the sites with TOR who returned this Audit Tool, the average alignment was 43 per cent. The five components of the exemplar TOR that were most likely to be present were:

1. post-MDM responsibilities for MDM recommendations outlined
2. instructions for filing MDM records in the patient’s medical record for each relevant health service outlined
3. core team members defined
4. non-core team members defined
5. criteria for patient referral to MDM defined.

The five components of the exemplar TOR that were least likely to be present were:

1. information on who to call for issues relating to the software and hardware used for the meetings
2. the type of information to be provided to patients before their case was discussed at the MDM
3. governance responsibilities for the MDM
4. process for invitation of GPs outlined
5. requirement and process for documenting divergent treatment recommendations defined, including the need to record the name of the relevant clinician(s).

##### Relevant survey comments – Standard 2.1

‘Victoria should have a standard terms of reference for oncology MDMs.’ [Surgeon]

##### Improvement activities – Standard 2.1

As a result of this audit:

* 14 health services prioritised the development of or revision of TOR to align with the framework’s minimum standards for TOR content.

##### Discussion – Standard 2.1

Many of the quality standards in the framework can be met by health services having comprehensive TOR. Results from the MDM Main Audit Tool and the MDM TOR Audit Tool indicate that alignment with the framework could be improved. The exemplar minimum content for TOR appended to the framework prompts health services to consider infrastructure and resourcing as well as processes that are crucial for risk management – for example, agreements about core membership, including monitoring of attendance and speciality coverage, appointment of a chair and evaluation of the MDM using agreed data sources.

#### Standard 2.2: The MDM has an appointed or nominated staff member to coordinate the MDM

#### Standard 2.3: A regular meeting date, time, meeting length and location are set to ensure regular attendance

#### Standard 2.4: Meetings occur at least fortnightly

##### Main results – Standards 2.2, 2.3 and 2.4

Table 16: Main Audit Tool results for Standard 2.2: The MDM has an appointed or nominated staff member to coordinate the MDM (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a.i. | Can you identify a staff member responsible for notifying and inviting members regarding MDM? | 100% | 100% | 100% |
| a.ii. | Can you identify a staff member responsible for preparing and distributing the agenda? | 98% | 98% | 100% |
| a.iii. | Can you identify a staff member responsible for supporting off-site participation? | 76% | 69% | 94% |
|  |  |  |  |  |
| a.iv. | Can you identify a staff member responsible for documenting MDM attendance? | 92% | 89% | 100% |
| a.v. | Can you identify a staff member responsible for escalating technical issues?  | 95% | 93% | 100% |

Table 17: Main Audit Tool results for Standard 2.3: A regular meeting date, time, meeting length and location are set to ensure regular attendance (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a. | Were meetings held at the same time?  | 98% | 98% | 100% |
| a. | Were meetings held at the same location?  | 98% | 98% | 100% |
| a. | Were meetings held with the same frequency?  | 98% | 98% | 100% |

Table 18: Main Audit Tool results for Standard 2.4: Meetings occur at least fortnightly (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a. | Were at least three meetings held in the last six weeks?  | 86% | 96% | 61% |

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| More than 20% variation of responses between metro and regional health services |
| Poor alignment (less than 55%) |
| Partial alignment (56% – 75%) |
| Positive alignment (76% – 100%) |

##### Improvement activities – Standards 2.2, 2.3 and 2.4

As a result of this audit:

* two health services prioritised projects to support off-site participation in MDMs.

##### Discussion – Standards 2.2, 2.3 and 2.4

Practices in MDMs across Victoria aligned well with the framework standards for MDM coordination and organisation. The exception was related to metropolitan MDMs having fewer nominated personnel to support off-site participation by other clinicians. This finding aligns with the finding under Standard 1.7 that showed that regional MDMs had a greater alignment to the quality indicator for facilities, which enabled participation by off-site participants.

Regional MDMs showed poorer alignment to the framework standard on MDM frequency, which specifies fortnightly meetings. Regional health services have lower numbers of medical specialists and/or patient numbers. Lack of available clinical staff due to rostering and staffing shortages, including availability of backfill, contributes to difficulties in scheduling and increased meeting cancellations. This can lead to delays in care and deviation from the OCPs. Linkage with other MDMs may help to resolve this issue.

#### Standard 2.5: The agenda is distributed to give participants enough time to prepare

##### Main results – Standard 2.5

Table 19: Main Audit Tool results for Standard 2.5: The agenda is distributed to give participants enough time to prepare (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a. | Were agendas for the previous 3 meetings sent more than 48 hours before the meeting? | 75% | 78% | 67% |
| b. | Does TOR or equivalent for MDM include a documented process for the late addition of patients to agenda?  | 30% | 20% | 56% |

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| More than 20% variation of responses between metro and regional health services |
| Poor alignment (less than 55%) |
| Partial alignment (56% – 75%) |
| Positive alignment (76% – 100%) |

##### Relevant survey comments – Standard 2.5

‘I don’t think that the surgeons realise that radiologists prepare for the meeting and this takes time, hence late additions need to be avoided as they don’t get the same work up. The best MDMs have a clear question/focus to guide review of radiology and pathology. Unfortunately, some patients are added with disorganised information and this reduces the benefit for the patient.’ [Radiologist]

##### Improvement activities – Standard 2.5

As a result of this audit:

* 14 health services prioritised the development of or revision of TOR to align with the framework’s minimum standards for TOR content.

##### Discussion – Standard 2.5

Up to one-quarter of MDMs didn’t circulate the agenda in a timely matter. Almost half of all MDMs don’t clarify the process for the late addition of patients to the agenda within the TOR. The late addition of patients to an MDM may facilitate urgent care and is supported when appropriate. Processes to limit late additions and to ensure all required case data is considered are necessary. Late additions have a particular impact on radiologists and pathologists, who must either review imaging/slides after hours or under time pressure.

### Recommendations relating to Quality Area 2 – Meeting organisation

Note: Refer to **Recommendation 3** as it relates toMDM TOR.

## Quality Area 3: Membership

#### Standard 3.1: Every MDM has a register of attendance

#### Standard 3.2: Patient information remains confidential and is used only for the purpose of clinical management

##### Main results – Standards 3.1 and 3.2

Table 20: Main Audit Tool results for Standard 3.1: Every MDM has a register of attendance (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a. | Is there an attendance register for MDMs?  | 90% | 87% | 100% |
| a. | Does the register include those attending remotely?  | 67% | 60% | 83% |
| a. | Is the register signed by attendees?  | 48% | 42% | 61% |

Table 21: Main Audit Tool results for Standard 3.2: Patient information remains confidential and is used only for the purpose of clinical management (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a. | Can you locate signed MDM confidentiality agreements for those attendees who are not directly employed by the host agency? | 22% | 11% | 50% |
| a. | Does MDM TOR or equivalent assign responsibility for maintaining signed confidentiality agreements covering attendees not directly employed by the host agency? | 14% | 4% | 39% |

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| --- |
| More than 20% variation of responses between metro and regional health services |
| Poor alignment (less than 55%) |
| Partial alignment (56% – 75%) |
| Positive alignment (76% – 100%) |

##### Relevant survey comments – Standards 3.1 and 3.2

None of the survey respondents made any comment relating to confidentiality and privacy issues.

##### Improvement activities – Standards 3.1 and 3.2

As a result of this audit:

* one health service prioritised a project to improve recording of MDM attendance.

##### Discussion – Standards 3.1 and 3.2

Development of the framework included consideration of literature on medico-legal aspects of MDMs.[[3]](#endnote-3),[[4]](#endnote-4),[[5]](#endnote-5)11,11 For example, decisions made in an MDM can be associated with sentinel events and be subject to legal discovery. For these reasons, it is important that names of all attendees are recorded accurately, and that confidentiality agreements are in place. Infringements could expose health services and clinicians to unnecessary risk.

The fact that multiple health services and clinicians may take part in any one MDM makes confidentiality a particularly important issue for health services because:

* participants can include people who have not signed employment or other contracts with the host health service (for example, drug representatives, private pathologists and radiologists, GPs and students)
* breaches of patient confidentiality may occur if there is improper use and/or disposal of MDM documents containing patient information.

Requests for all attendees to sign confidentiality agreements and maintenance of attendance registers acknowledges the unique medico-legal aspects of MDMs, including discussion of patient information with clinicians who may never be directly involved in the patient’s care.

#### Standard 3.3: The MDM team contains appropriate core members

#### Standard 3.4: Specialties beyond the defined core membership listed in the OCPs attend meetings when clinically required

#### Standard 3.5: There is an opportunity to involve patients’ GPs in MDMs

##### Main results – Standards 3.3, 3.4 and 3.5

Table 22: Main Audit Tool results for Standard 3.3: The MDM team contains appropriate core members (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a. | Were 90% of OCP-identified core membership specialties in attendance at previous 3 meetings?  | 81% | 84% | 72% |

Table 23: Main Audit Tool results for Standard 3.4: Specialties beyond the defined core membership listed in the OCPs attend meetings when clinically required (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a. | Does MDM TOR or equivalent include a process for invitation of non-core specialties?  | 27% | 31% | 17% |

Table 24: Main Audit Tool results for Standard 3.5: There is opportunity for the involvement of patient GPs in MDMs (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a. | Does MDM TOR or equivalent include a process for invitation of GPs? | 19% | 11% | 39% |

|  |
| --- |
| More than 20% variation of responses between metro and regional health services |
| Poor alignment (less than 55%) |
| Partial alignment (56% – 75%) |
| Positive alignment (76% – 100%) |

##### Discussion – Standards 3.3, 3.4 and 3.5

The statewide result for attendance by core members at MDMs was 81 per cent, showing positive alignment with framework standards, but noting that for regional MDMs this figure was lower. The discrepancy between regional and metropolitan MDMs might be due to workforce numbers and availability of specialists. If extra expertise is required, referral to a metropolitan MDM or other regional MDM may be indicated. Alternatively, extending invitations to clinicians/specialists from other health services to join the MDM is an option.

GPs are identified in the OCPs as a non-core specialty that may be invited when their expertise is needed for patient discussion. Evidence of a process for inviting GPs was overall low, although it was slightly higher in regional health services. The inclusion of GP contact details and date of primary care diagnosis in minimum data standards (standard 6.2) and auditing whether MDM recommendations can be sent to GPs within the OCP timeframe of one week (standard 8.4) also support the importance of communication with the patient’s GP.

### Recommendations relating to Quality Area 3 – Membership

**Recommendation 6:** The OCPs define the core and non-core disciplines required at an MDM for comprehensive discussion and treatment planning by tumour stream. Health services should implement initiatives to:

* align MDM membership with that defined in the OCP (for both core and non-core disciplines) and, when clinically required,
* have a process for inviting additional specialists and general practitioners (GPs) for specific case discussion
* implement formal referral pathways to alternative MDMs with the specified disciplines (specialists).

Note: Also refer to **Recommendation 1** as it relates to medico-legal issues with confidentiality and attendance records. A record of attendance is necessary to audit core and non-core member attendance against OCP requirements.

## Quality Area 4: Leadership

#### Standard 4.1: The MDM has a designated chairperson, with a delegate/deputy nominated to cover in their absence

#### Standard 4.2: The MDM chairperson is a specialist clinician

#### Standard 4.3: The chairperson takes a leadership role within the MDM to ensure that meeting discussion is rigorous and appropriate

#### Standard 4.4: The chairperson ensures that all clinically relevant information, including recommendations (and divergent recommendations) are clearly documented

#### Standard 4.5: There are identified leaders and/or a culture of leadership so that MDM clinical requirements for resourcing, quality and safety are represented

##### Main results – Standards 4.1, 4.2, 4.3 and 4.5

Table 25: Main Audit Tool results for Standard 4.1: The MDM has a designated chair, with a delegate/deputy nominated to cover in their absence (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a. | Were the last three MDMs chaired by the designated chair or deputy chair? | 92% | 98% | 78% |

Table 26: Main Audit Tool results for Standard 4.2: The MDM chairperson is a specialist clinician (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a. | Was the chair / deputy chair for last 3 meetings a specialist clinician (not an intern or registrar)? | 98% | 100% | 94% |

Table 27: Main Audit Tool results (from MDM Survey Tool) for Standard 4.3: The chairperson takes a leadership role within the MDM to ensure that meeting discussion is rigorous and appropriate (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a.i.–a.v. | Results from MDM survey shows 80% responded positively about whether the chair:* facilitates group discussion so a variety of team members contribute
* mediates disagreements
* acts fairly and objectively so that all members are supported to raise ideas and receive peer review
* creates a culture of support for education and professional development within the MDM.
 | 59% | 56% | 67% |
| b. | Results from MDM survey shows 80% respondents agreed that the chairperson ensured new research and clinical trials are considered for relevant patients. | 51% | 58% | 33% |

Table 28: Main Audit Tool results (from Minimum Data Audit Tool) for Standard 4.4: The chairperson ensures that all clinically relevant information, including recommendations (including divergent recommendations) are clearly documented (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a.i. | Were minimum dataset records of at least 20 patients 80% complete in patient data for each MDM you are auditing?  | 0% | 0% | 0% |
| a.i. | % of previous patients with complete minimum data, by tumour stream. | 0% | 0% | 0% |
| a.ii–iv. | Did at least 80% of reviewed (audited) patient records have treatment recommendations recorded in patient data?  | 90% | 89% | 94% |
|  a.ii–iv. | Percentage of reviewed patients with treatment recommendations recorded. | 92% | 90% | 96% |

Table 29: Main Audit Tool results for Standard 4.5: There are identified leaders and/or a culture of leadership so that MDM clinical requirements for resourcing, quality and safety are represented (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a.i. | Can you identify a leader for MDM who escalates issues of concern that may impact on safety, sustainability and minimum standards for MDM quality to appropriate decision-makers?  | 95% | 93% | 100% |
| a.ii. | Can you identify a leader for MDM who ensures the host agency understands the role and importance of MDM, and provides appropriate resources to support it? | 95% | 93% | 100% |
| a.iii. | Can you identify a leader who advocates for systems that ensure timely communication of treatment recommendations from MDM to the patient, GP and treating team? | 98% | 98% | 100% |

|  |
| --- |
| More than 20% variation of responses between metro and regional health services |
| Poor alignment (less than 55%) |
| Partial alignment (56% – 75%) |
| Positive alignment (76% – 100%) |

##### Relevant survey results – Standards 4.1, 4.2, 4.3 and 4.5

There was a high number of comments across health services on leadership and the role of the chair and the results varied between the different types of respondents. For example, 73 per cent of interns were positive about the ways the chairperson ensures new research and clinical trials were considered, while 58 per cent of medical oncologists responded positively to the same question.

Comments from the survey confirmed the importance of the chair’s role in setting the culture of MDMs. For example:

‘The chair needs to know when to soften the loudest voices. Respect for differing opinions is crucial.’ [Nurse]

‘The process is really reliant on a chair who is able to manage things appropriately – and in reality, this is variable.’ [Radiologist]

‘The MDT lead needs to be a properly trained and aware person who takes the responsibility seriously (they often do) and importantly, is unafraid to challenge the prevailing view, ask for quieter members to participate, and observe cues closely.’ [Medical oncologist]

Other comments implied that the chair does not always influence the meeting culture:

‘There is not a single visible chair member that I am aware of. All of the patient’s functional domains are not discussed including current swallowing function or loss of weight. Allied health are more flies on the wall, rather than contributing to discussion. The format of discussion does not facilitate this.’ [Allied health professional]

‘I have answered for one centre where the meeting is inclusive, multidisciplinary and well chaired. The comparable meeting at a different centre is not well chaired, is not inclusive, runs along traditional lines, and has a focus on treatment with little capacity to consider supportive or palliative care.’ [Palliative care specialist]

##### Improvement initiatives – Standards 4.1, 4.2, 4.3 and 4.5

* Eighteen health services prioritised projects to improve the recording of minimum data in the meeting software. The availability of QOOL-Vic software may support these initiatives.

##### Discussion – Standards 4.1, 4.2, 4.3 and 4.5

Because framework standards for leadership are measured by survey responses from MDM participants, these results are subjective. The chairs of MDMs have a formal leadership role and can model/demonstrate leadership qualities (respect, inclusiveness, objectivity) to create a culture that optimises positive interactions between MDM members, professional conduct and adherence to good MDM processes. Chairs can advocate for MDM resourcing and processes that show a safety and quality approach though support of this advocacy by MDM leaders and executive may be necessary for health service endorsement. These limitations and strengths were recognised in some survey comments.

The measures for framework standard 4.4 draw on the data from the MDM Minimum Data Audit Tool because chairs are acknowledged as having a role in ensuring minimum data standards are maintained. More detailed results of the minimum data tool are presented and discussed in framework standard 6.2. Improving minimum data recording requires broader engagement with the value of data by MDM participants, which is also covered in framework standard 6.2.

### Recommendations relating to Quality Area 4 – Leadership

**Recommendation 7**: That health services initiate training to strengthen their collective MDM leadership. This should focus on both MDM culture and practical elements of leadership (such as ensuring required information is correctly documented before, during and after the meeting) to improve meeting discussion and rigour.

Note: Refer to **Recommendation 1** as it relates to medico-legal issues as it pertains to the role of chair and MDM leadership.

## Quality Area 5: Consent

#### Standard 5.1: Patients are provided appropriate information to ensure informed consent to MDM participation

#### Standard 5.2: Patient consent is sought prior to presentation of their case

##### Main results – Standards 5.1 and 5.2

Table 30: Main Audit Tool results (from MDM Survey Tool) for Standard 5.1: Patients are provided appropriate information to ensure informed consent to MDM participation (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a. | Results from MDM survey shows 90% respondents agreed they provide written or verbal information to patients covering MDM and who will be able to view their information prior to presentation. | 5% | 2% | 11% |
|  a. | Is there a patient information leaflet on MDM that covers all of the following topics:1. Who will be able to view their information.

ii. How they will be informed of recommendations.iii. How they can opt-out of MDM presentation. | 62% | 56% | 78% |
|  |  |  |  |  |
|  a. | Results from MDM survey shows 90% respondents agreed they givepatients the opportunity to opt-out of presentation at MDM. | 5% | 0% | 17% |
|  a. | If record no, % of respondents who agreed they givepatients the opportunity to opt-out of presentation at MDM | 31% | 25% | 46% |

Table 31: Main Audit Tool results for Standard 5.2: Patient consent is sought prior to presentation of their case (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a. | Did 90% of reviewed patient records have patient consent recorded in patient data?  | 13% | 7% | 28% |
| a. | If no, record % of consent recorded in reviewed patient records.  | 26% | 21% | 44% |

|  |
| --- |
| More than 20% variation of responses between metro and regional health services |
| Poor alignment (less than 55%) |
| Partial alignment (56% – 75%) |
| Positive alignment (76% – 100%) |

##### Relevant survey results – Standards 5.1 and 5.2

Results for questions relating to consent were consistently low across tumour streams, with melanoma MDMs performing slightly better.

There were very few comments by survey participants about consent, which does not provide the opportunity for theming responses. The clearest comment was:

‘Obtaining patient consent for MDM is very difficult and perhaps should be captured in a generic way such as advanced care planning.’ [Surgeon]

##### Improvement activities – Standards 5.1 and 5.2

As a result of this audit:

* six health services prioritised projects to improve or develop patient information leaflets on MDMs
* four health services prioritised projects to initiate a clinician training/script/improvement project for patient consent
* one health service decided to task the MDM coordinator to record consent.

##### Discussion – Standards 5.1 and 5.2

The results show that clinicians are not routinely obtaining and recording patient consent before MDM presentation, nor providing the opportunity for patients to opt out. Comments from clinicians involved in developing the framework and audit tools revealed a wide range of views on the issue of patient consent and on the legal advice available about consent for MDMs in relation to service risks. This warrants further exploration and engagement with health services to determine an appropriate strategy for patient consent.

There was also poor alignment with the framework standards for the recording of consent, which is supported by the results from the MDM Minimum Data Tool Audit. The use of patient information leaflets and a mandatory consent field in the MDM software provides an opportunity to improve results against this standard. The availability of QOOL-Vic software may support these initiatives.

### Recommendations relating to Quality Area 5 – Consent

Refer to **Recommendation 1** as it relates to medico-legal issues on consent.

## Quality Area 6: Patient referral

#### Standard 6.1: Clinicians refer all patients with a new or suspected cancer diagnosis to an MDM for endorsement of patient-specific treatment recommendations. To assist with the burden of demand in common tumour streams, sites that have ‘agreed standardised treatment protocols’ (or like) can elect to deal with referrals by exception

##### Main results – Standard 6.1

Table 32: Main Audit Tool results for Standard 6.1: Clinicians refer all patients with a new or suspected cancer diagnosis to an MDM for endorsement of patient-specific treatment recommendations. To assist with the burden of demand in common tumour streams, sites that have ‘agreed standardised treatment protocols’ (or like) can elect to deal with referrals by exception (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a. | Whether the average number of unique patients discussed at MDM over a three-month period is 80% of the patients that can be reasonably estimated for the catchment using state-level datasets. | 46%\* | 49%\* | 39%\* |
|  b. | Results from MDM Survey showed 80% of respondents agreed they refer all public patients with a new or suspected diagnosis of cancer to MDM. | 21% | 18% | 28% |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  c. | Results for from MDM Survey showed 80% respondents agreed they refer all private patients with a new or suspected diagnosis of cancer to MDM. | 11% | 7% | 22% |

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| --- |
| More than 20% variation of responses between metro and regional health services |
| Poor alignment (less than 55%) |
| Partial alignment (56% – 75%) |
| Positive alignment (76% – 100%) |

\* There were significant limitations in establishing a denominator for this indicator because there are no formal predefined MDM catchments in Victoria. Also, the numerator cannot be established because there is no uniform statewide data reporting on MDM presentation, which means that an individual MDM often cannot see if the patient has been presented at another MDM.

##### Relevant survey comments – Standard 6.1

‘… I am unclear of the role of MDMs for private patients.’ [Radiologist]

‘It would be helpful to automate referrals as this saves time for clinicians who have already used it to input the data.’ [Registrar]

##### Discussion – Standard 6.1

The purpose of this standard is to measure whether health services are providing an opportunity for all patients with confirmed/suspected cancer to be referred to an MDM for treatment planning. This is a key principle in the OCPs.

The results show poor alignment with the framework standards for patient referral to an MDM. Most survey respondents reported that they do not refer all their patients to MDMs. The full range of therapeutic treatments, clinical trials, supportive and palliative care may not be considered for patients who are not referred to an MDM. Rather than criteria for MDM referral being individually determined by clinicians (with unknown variations), an agreed process between MDM referrers would align MDM referral practice.

Tumour streams with higher patient volumes may not be able to discuss all patients due to resource constraints. The use of MDM referral protocols and standardised agreed treatment protocols means the most complex patients can be prioritised for discussion using equitable and transparent methodology. This is further explored under Quality Area 7. The MDM referral protocol could include criteria for managing non-curative patients, which specify referral to a supportive or specialist palliative care MDM.

As there are no formal predefined MDM catchments in Victoria and no mechanisms for statewide reporting on MDM presentations, the ability of individual MDMs to measure standard 6.1 (referral of all patients to an MDM) is limited to self-reporting via survey. The indicator ’80 per cent of unique patients estimated from the health service catchment were discussed at an MDM over a three-month period’ would benefit from a review if accurate data capture is not possible in the medium term.

#### Standard 6.2: Clinicians who refer patients to MDMs provide enough information about each patient and this is considered by the MDM

##### Main results – Standard 6.2

Table 33: Main Audit Tool results for Standard 6.2: Clinicians who refer patients to MDMs provide enough information about each patient and this is considered by the MDM (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a. | Record percentage of audited patients with at least 80% of minimum data complete. | 0%\* | 0% | 0% |
| b. | Results from MDM Survey showed 80% respondents agreed that presenters are adequately prepared to answer questions about patients they are presenting at MDM. | 51% | 49% | 56% |

|  |
| --- |
| More than 20% variation of responses between metro and regional health services |
| Poor alignment (less than 55%) |
| Partial alignment (56% – 75%) |
| Positive alignment (76% – 100%) |

##### Relevant survey comments – Standard 6.2

Comments by MDM survey participants showed support for the availability of minimum data to aid discussion and treatment planning at the MDM:

‘Decisions are often made with inadequate information e.g. comorbidities, psychosocial issues. Documentation of the MDM recommendations is often very brief, sometimes inaccurate and commonly fails to convey the complexity and nuance of the discussion.’ [Medical oncologist]

‘The intern often has no idea why we are discussing this patient, and so relevant information/slides are not ready on the day. Quality of clinical information provided on the pre-meeting list is extremely poor.’ [Registrar]

##### Results of MDM minimum data audit tool – Standard 6.2

Table 34: Minimum Data Audit Tool results Standard 6.2: Clinicians who refer patients to MDMs provide enough information about each patient and this is considered by the MDM (by percentage of ‘yes’ responses)

| Minimum Data Audit question | StatewidePatients = 1,862; MDMs audited = 85 | MetroPatients = 1,292; MDMs audited = 60 | RegionalPatients = 570; MDMs audited = 25 |
| --- | --- | --- | --- |
| The surname and first given name of the lead clinician (treating doctor) are all listed | 82% | 76% | 84% |
| The surname and first given name of the patient’s GP are listed | 61% | 59% | 67% |
| An email, fax, address or other means of contacting the GP is listed | 62% | 51% | 85% |
| The DATE of original referral from GP/other notifying party is listed | 24% | 34% | 1% |
| At least THREE of the following approved patient identifiers are present: patient name (family and given names), date of birth, gender, address, UR or other medical record number | 99% | 98% | 100% |
| You can find EITHER a UR number for the patient OR clear evidence that the patient doesn't yet have a UR | 88% | 93% | 78% |
| There is a place on the record for a second UR number to be recorded and the hospital it belongs to | 54% | 65% | 29% |
| There is evidence that the patient has consented to MDM presentation | 35% | 24% | 59% |
| You can clearly see the reason why the patient was discussed. E.g. to plan further investigations, develop or change treatment recommendations, review treatment plan, other  | 93% | 92% | 97% |
| You can clearly see the clinical question the MDM will consider | 64% | 67% | 59% |
| At least TWO previous investigations relevant to the diagnosis are listed. For example, histology, cytology, surgery, endoscopy, imaging, biochemistry/immunology, clinical observation, other | 86% | 85% | 88% |
| There is a place on the record to record relevant treatment history e.g. surgery, radiotherapy, chemotherapy, other therapy | 98% | 97% | 100% |
| At least ONE comorbidity is listed  | 61% | 68% | 46% |
| At least ONE relevant medication is listed OR there is evidence that the patient was not on any medication | 22% | 27% | 9% |
| At least ONE supportive care requirement is listed e.g. physical needs, psychological needs, social needs, information needs or spiritual needs | 18% | 15% | 24% |
| At least ONE patient preference is listed e.g. wishes to stay at home, wants active treatment etc.  | 6% | 6% | 8% |
| Date of diagnosis is listed | 45% | 44% | 46% |
| ECOG Performance status is listed | 39% | 33% | 52% |
| Details of the patient’s stage of cancer are recorded e.g. TNM, Gleason, etc.  | 54% | 46% | 72% |
| At least ONE error or change associated with pathology or radiology results or other reports is recorded | 10% | 12% | 5% |
| Treatment recommendations are documented OR more investigations are requested  | 92% | 90% | 96% |
| Recommended referrals are recorded e.g. surgeon, medical oncologist, radiation oncologist, supportive care service | 65% | 60% | 76% |
| Was there a palliative care recommendation? | 5% | 4% | 8% |
| Whether or not there is a family history of cancer is listed | 14% | 14% | 15% |
| Was there a familial cancer service recommendation? | 2% | 2% | 2% |
| Was there any evidence that clinical trials were considered? | 7% | 9% | 4% |
| Mean % Total Yes – All data items | 49% | 49% | 51% |

|  |
| --- |
| More than 20% variation of responses between metro and regional health services |
| Poor alignment (less than 55%) |
| Partial alignment (56% – 75%) |
| Positive alignment (76% – 100%) |

Statewide mean against all data items is included to allow health services to compare their results against a baseline of results for all items.

##### Improvement activities – Standard 6.2

As a result of this project:

* 12 health services prioritised projects to improve their alignment with minimum data requirements.

##### Discussion – Standard 6.2

Quality Area 6 of the framework measures patient referral to the MDM by assessing the documentation of information and data available to facilitate a thorough discussion of the patient’s medical and social needs. The quality of information available at the meeting helps to achieve quality discussion at the MDM.

The results from the audit of records against the minimum dataset indicates that only seven of 26 data fields are collected by over 76 per cent of MDMs. Of the remaining data fields:

* it is sometimes appropriate for the MDM to omit information when it is not relevant to a particular tumour stream (for example, collection of familial cancer clinic referral rates for cancers with no genetic factors)
* there are some gaps in data collection that warrant investigation (for example, the recording of patient preferences).

Considerations for how the minimum data may affect the processes and outcomes of the MDM are:

1. The MDM may be the only place in the health record where the date of diagnosis and original GP referral is captured, particularly when patients are referred from private clinics. These dates are required to analyse the patient’s whole journey against optimal timeliness of care as outlined in the OCPs.
2. Recording multiple UR numbers for patients in the MDM software facilitates transfer of records/information between health services.
3. Collecting GP details facilitates communication of MDM treatment recommendations/plans to the GP.
4. The opportunity to record patient consent in the MDM software has not been widely adopted, but doing so allows health services to manage risk and accommodate referrer preferences.
5. Defining a clinical question for the MDM to address can improve the efficiency of the meeting.
6. Low recording of comorbidities, past medication, patient preferences, familial history of cancer and supportive care needs is a risk for treatment planning because their absence may mean that important patient information is not considered at the MDM. Structured collection of minimum data supports optimal treatment decisions and follow-up actions.[[6]](#endnote-6),[[7]](#endnote-7)
7. Recording ECOG and staging establishes the patient’s performance status/functioning and provides relevant information for tailoring treatment recommendations.
8. Lack of reporting pathology/radiology revisions and changes raised at the MDM means the rationale for resulting treatment planning/recommendations may not be evident at a later date.
9. Recording of actions/referrals arising from the MDM supports timeliness of patient care.
10. Low recording of palliative care, clinical trial and familial cancer service referrals may indicate poor data capture or low rates of early referral to these services (which may or may not be clinically appropriate).

These issues may become more significant if none of the MDM participants have met the patient being discussed or the clinical question has not been defined. If the clinical question is not known, there may be a negative impact on the quality and efficiency of discussion. The presentation of reports should be driven by clinical relevance for each patient. Preparation of reports not relevant to multidisciplinary care should be avoided, as should ritualised presentation of all material for each patient, because time is often limited. A focus on the population of data fields before the MDM, a clear clinical question, and the use of predetermined protocolised agreements on how to treat certain categories of patients, should streamline practice so complex patient discussions are prioritised.

This approach requires MDM participants to develop and agree on treatment protocols to optimise the efficiency of MDMs. Dynamic approaches to case presentation driven by the clinical question for each patient will ensure the time allocated for discussion of patients is optimised.

#### Standard 6.3: Clinicians who refer patients to MDMs after the agreed cut-off time for inclusion in agenda ensure patient information can be adequately reviewed

##### Main results – Standard 6.3

Table 35: Main Audit Tool results for Standard 6.3: Clinicians who refer patients to MDMs after the agreed cut-off time for inclusion in agenda ensure patient information can be adequately reviewed (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a. | Results from MDM Survey showed 80% of pathologists and radiologists agreed that the number of late presentations to MDM is acceptable | 16% | 11% | 28% |
| a. | There is a process for late inclusion in agenda in MDM TOR or equivalent? | 35% | 27% | 56% |

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| --- |
| More than 20% variation of responses between metro and regional health services |
| Poor alignment (less than 55%) |
| Partial alignment (56% – 75%) |
| Positive alignment (76% – 100%) |

The framework specifically captured responses from radiologists and pathologists because the late addition of patients to an agenda places a high burden on them to prepare reports. The statewide result for the first question (question 5.5 in the survey tool) was 59 per cent.

##### Relevant survey comments – Standard 6.3

There were many comments by radiologists and pathologists referring to the negative impact of the late addition of patients to the MDM agenda. For example:

‘As a radiologist, the thing that is most underappreciated is the time it takes to prepare an MDM. A ratio of 1 hour meeting to 4 hours prep. My team spend an extraordinary amount of time pulling together external imaging for review. The last minute add-ons are discourteous and inappropriate.’ [Radiologist]

##### Improvement activities – Standard 6.3

As a result of this audit:

* two health services prioritised projects addressing late presentation of patients.

##### Discussion – Standard 6.3

Late referral issues are perceived differently by different craft groups – there were lower ratings on the appropriateness of late presentation from those who prepare reports (pathologists and radiologists) compared with those who receive them (surgeons and other MDM participants). This could be indicative of genuine scheduling pressures such as late diagnosis of patients and urgent need for review, or alternatively behaviours that do not contribute to a respectful work culture. Refer to framework standard 1.3 for workforce planning by health services – there is a link between late presentations and the workload of some participants.

### Recommendations relating to Quality Area 6 – Patient referral

**Recommendation 8:** That health services explore options for improving alignment of the data that is collected for MDM to the framework’s data collection requirements. This could include education and workshop activities to promote the rationale for each minimum data field. The availability of QOOL-Vic software may support these initiatives.

Note: Refer to **Recommendation 1** as it relates to information quality and presentation.

Note: Refer to **Recommendation 3** as it relates to formalising processes for late presentation of patients in TOR and **Recommendation 5** about the appropriate use of pathology and radiology reports in relation to the clinical question for the patient. These support workload management for pathology and radiology providers.

## Quality Area 7: Streamlining patient discussion – for MDMs that use prioritisation

#### Standard 7.1: In MDMs that use prioritisation so that not all referred patients are routinely discussed, patient discussion is streamlined using agreed protocols

#### Standard 7.2: In MDMs where patient presentation is streamlined, processes to separate patients for noting versus discussion are formally defined

#### Standard 7.3: In MDMs where patient presentation is streamlined, when a patient is noted but not discussed, their proposed treatment recommendation is documented

##### Main results – Standards 7.1, 7.2 and 7.3

Table 36: Main Audit Tool results (from MDM Survey Tool) for Standard 7.1: In MDMs that use prioritisation so that not all referred patients are routinely discussed, patient discussion is streamlined using agreed protocols (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a. | Results from MDM Survey showed 80% respondents were satisfied with the way that routine patients are presented. | 62% | 64% | 56% |
| a. | Results from MDM Survey showed 80% respondents were satisfied with the way that complex patients are presented. | 70% | 78% | 50% |

Table 37: Main Audit Tool results for Standard 7.2: In MDMs where patient presentation is streamlined, processes to separate patients for noting versus discussion are formally defined (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a.i. | Can you identify who is responsible for allocating patients for noting versus discussion? | 71% | 87% | 33% |
| a.ii. | Can you identify which clinical guidelines underpin streamlining of patient discussion? | 32% | 40% | 11% |
| a.iii. | Can you identify how a patient could be escalated from noting to discussion? | 44% | 49% | 33% |

Table 38: Main Audit Tool results for Standard 7.3: In MDMs where patient presentation is streamlined, when a patient is noted but not discussed, their proposed treatment recommendation is documented (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a. | Is there evidence of a process to formally endorse proposed treatment plans for noted patients? | 43% | 44% | 39% |
|  | Did 80% of noted patient records have clear treatment recommendations recorded in patient data? | Excluded from analysis | Excluded from analysis | Excluded from analysis |

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| --- |
| More than 20% variation of responses between metro and regional health services |
| Poor alignment (less than 55%) |
| Partial alignment (56% – 75%) |
| Positive alignment (76% – 100%) |

Excluded from analysis = Due to a version control error, 16 health services were not sent this secondary question.

##### Relevant survey comments – Standards 7.1, 7.2 and 7.3

Comments by survey participants showed an increasing awareness of MDM prioritisation protocols, but acceptance of them as a process for achieving meeting efficiency was not universal. For example:

‘Have attempted to introduce prioritisation of patients in the UGI MDM via the development ofa Presentation Protocol but certain disciplines within the MDM disagree with the prioritisation process.’ [Cancer redesign project officer]

‘I find them extremely useful for difficult patient management but do not think every case needs presentation and these are just listed but not discussed.’ [MDM chair and surgeon]

##### Discussion – Standards 7.1, 7.2 and 7.3

The poor alignment with the framework standard for streamlining patient discussion reveals diversity in clinicians’ understanding of who should be referred and prioritised for discussion at MDMs, and what formal protocolisation means.[[8]](#endnote-8)

Development and use of formal MDM protocols for case discussion has the potential to increase the efficiency of MDMs, which is important in the context of the increasing cancer incidence. Members need to agree protocols. Protocols should be documented and context-specific so members will follow them.

### Recommendations relating to Quality Area 7 – Streamlining patient discussion – for MDMs that use prioritisation

**Recommendation 9**: That health services consider a statewide approach to support the development and formalisation of protocols to streamline and prioritise MDM discussions. This could include an audit of protocols in use and collaboration with clinicians to develop evidence-based protocols for prioritisation by tumour stream, which individual MDMs could tailor to reflect local conditions.

Note: Also refer to **Recommendation 1** as it relates to medico-legal issues with the poor ability to identify which clinical guidelines underpin streamlining of patient discussion.

## Quality Area 8: MDM recommendations and communication

#### Standard 8.1: MDMs are a mechanism for clinicians to agree on the recommended treatment

#### Standard 8.2: When there is not agreement on treatment planning, divergent views on the recommended treatment are captured

#### Standard 8.3: When developing treatment recommendations, the MDM team ensures relevant information about the patient and optimal treatment are considered

##### Main results – Standards 8.1, 8.2 and 8.3

Table 39: Main Audit Tool results (from MDM Survey Tool) for Standard 8.1: MDMs are a mechanism for clinicians to develop agreement on the recommended treatment (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a.i. | Results from MDM survey showed 80% respondents agreed that appropriate attempts are made to reach agreement about treatment recommendations. | 90% | 89% | 94% |
| a.ii. | Are response rates to the above question evenly distributed across disciplines?  | 78% | 78% | 78% |

Table 40: Main Audit Tool results (from MDM survey Tool) for Standard 8.2: When there is not agreement on treatment planning, divergent views on recommended treatment are captured (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a.  | Results from MDM survey showed 80% respondents agreed that where there is more than one treatment opinion, divergent treatment recommendations are recorded. | 29% | 22% | 44% |

Table 41: Main Audit Tool results (from MDM Survey Tool) for Standard 8.3: When developing treatment recommendations, the MDM team ensures relevant information about the patient and optimal treatment are considered (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a.i-v. | Results taken from 6.2.a. and 6.2.b.(minimum data results) | 51% | 49% | 56% |
| a.vi. | Results from MDM survey showed 80% respondents agreed that optimal care pathway timeframes are considered when making decisions about patient management. | 27% | 20% | 44% |

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| More than 20% variation of responses between metro and regional health services |
| Poor alignment (less than 55%) |
| Partial alignment (56% – 75%) |
| Positive alignment (76% – 100%) |

##### Relevant survey comments – Standards 8.1, 8.2 and 8.3

‘It is challenging to document divergent opinions, so even when there has been robust debate, the notes often don’t reflect the “meat” of the discussion.’ [Medical oncologist]

‘Most patients are discussed retrospectively of surgery, so often the option of neoadjuvant chemo is lost. No consideration for psychosocial issues. Nurses are seen as the minute-takers.’ [Nurse]

‘I am only concerned with the documentation of the discussion, which is recorded in patient files; the information is not always accurate and often does not cover the whole discussion.’ [Research nurse coordinator]

‘Occasionally the MDM recommendations are inappropriate because they have not been made in the context of the patient’s situation.’ [Medical oncologist]

##### Improvement activities – Standards 8.1, 8.2 and 8.3

As a result of this audit:

* five health services prioritised projects to ensure appropriate attempts are made to reach agreement on treatment recommendations
* three health services prioritised projects relating to the capture of divergent views on treatment recommendations
* three health services prioritised projects to ensure OCP timeframes are considered when making decisions about patient management.

##### Discussion – Standards 8.1, 8.2 and 8.3

The framework emphasises the importance of accurate recording of treatment recommendations: ‘When a consensus treatment recommendation cannot be reached, recommendations that are considered to be equivalent in benefit and intent, but differ in treatment pathway/modality, should be recorded in the treatment recommendation and communicated to the patient.’[[9]](#endnote-9)

Audit results indicate a broad acceptance of the need for consensus decision making across disciplines but a lack of understanding on the benefits of documenting divergent opinions when treatment options are equivalent.5 Such documentation is an indicator of a robust MDM dynamic that aligns with the principles of patient-centredness enabling the presentation of multiple treatment options to patients when clinically valid.[[10]](#endnote-10),[[11]](#endnote-11) It can also be a risk management strategy if medico-legal issues arise about treatment recommendations.

The following recommendations in other sections could help to address these issues:

* **Recommendation 1** – regarding medico-legal aspects of the MDM and working with health services to prioritise projects to address medico-legal gaps
* **Recommendation 7** – regarding leadership and meeting culture via initiating training to strengthen collective meeting leadership
* **Recommendation 8** – regarding education and workshop activities to promote the rationale for collecting information for each minimum data field.

#### Standard 8.4: MDM recommendations are communicated to the patient’s treatment team and GP in a timely manner

#### Standard 8.5: MDM recommendations are communicated to the patient in a timely manner

#### Standard 8.6: Clinicians who refer patients to MDMs understand how they are responsible for patient referrals after the MDM

##### Main results – Standards 8.4, 8.5 and 8.6

Table 42: Main Audit Tool results for Standard 8.4: MDM recommendations are communicated to the patient’s treatment team and GP in a timely manner (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a.i. | Can you identify how each member of the treating team, including off-site members, could gain access to MDM recommendations within 24 hours of the MDM meeting? | 92% | 91% | 94% |
| a.ii. | Can you identify how MDM recommendations are placed on the medical records in the MDM host health service? | 89% | 98% | 67% |
| Can you identify how MDM recommendations are placed on the medical records in every other referring health service? | 41% | 24% | 83% |
| a.iii. | Can you identify how MDM recommendations are sent to the patient’s GP within one week of the MDM?  | 86% | 82% | 94% |

Table 43: Main Audit Tool results (from MDM Survey Tool) for Standard 8.5: MDM recommendations are communicated to the patient in a timely manner (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a.i. | Results from MDM survey showed 80% respondents agreed that they understood their role working with the patient to develop the final treatment plan after MDMs | 65% | 71% | 50% |
| a.ii. | Results from MDM survey showed 80% respondents agreed that they understood their role in presenting the MDM recommendation to the patient, including divergent recommendations. | 70% | 71% | 67% |

Table 44: Main Audit Tool results (from MDM Survey Tool) for Standard 8.6: Clinicians who refer patients to MDMs understand how they are responsible for patient referrals after the MDM (by percentage of ‘yes’ responses)

| Framework standard | Audit question (measure) | All MDMs (85) | Metro MDMs(60) | Regional MDMs (25) |
| --- | --- | --- | --- | --- |
| a. | Results from MDM survey showed 80% respondents agreed that they understood their role in actioning patient referrals after the final treatment plan is made, post-MDM. | 63% | 62% | 67% |

|  |
| --- |
| More than 20% variation of responses between metro and regional health services |
| Poor alignment (less than 55%) |
| Partial alignment (56% – 75%) |
| Positive alignment (76% – 100%) |

##### Relevant survey comments – Standards 8.4, 8.5 and 8.6

‘Decisions made by MDM are lost in the ether – lack of responsibility for actionable events. Who is organising the scan? When is the patient being followed up? The clinician/team placing the patient up for discussion must be responsible for actioning the plan, unless stated otherwise.’ [Registrar]

##### Improvement activities – Standards 8.4, 8.5 and 8.6

As a result of this audit:

* three health services prioritised projects relating to GP communication.

There were no improvement activities around post-meeting referrals or communications to the patient as a result of this audit.

##### Discussion – Standards 8.4, 8.5 and 8.6

The varying processes for filing MDM recommendations in all relevant hospital medical records affects the accuracy of audit results. If the recommendations are not communicated to external services, this could affect a patient’s treatment and care.11 For example, it could cause delays to referrals. Formal shared care arrangements could support routine communication of MDM results to all relevant services.

The partial alignment with framework standards for recording of divergent treatment recommendations and presentation of these to patients is also associated with the lack of uniform understanding of medico-legal risks in MDMs. This is addressed in the discussion of Quality Area 1.

### Recommendations relating to Quality Area 8 – MDM recommendations and communication

**Recommendation 10**: That health services:

* consider mapping the health services that could be referring to their MDMs within an ICS region
* develop partnerships with other health services to optimise referral pathways within their ICS region and beyond
* improve processes to ensure recommendations are communicated back to referrers to enable timely and appropriate treatment planning with patients.

Also refer to **Recommendation 1** as it relates to recording of divergent treatment recommendations and presentation of these to patients.

# Lessons learnt about application of the framework from this audit

The framework was designed for use in individual MDMs within a health service. Using it to collate results at the statewide, metropolitan and regional levels introduced added complexity in interpreting and presenting the data. However, it provided a statewide baseline to enable comparison for future audits and provides some interesting insights.

## Aggregated results by tumour stream

The results from the Main Audit Tool (Appendix 1), Minimum Data Audit Tool (Appendix 2) and Survey Audit Tool (Appendix 3) were also analysed to identify the performance of MDMs by tumour stream.

High-level results and findings by tumour stream include:

* MDMs for tumour types/streams with higher volumes (for example, colorectal, melanoma, lung and breast cancers) generally had better alignment with the framework standards.
* MDMs for lower volume and more specialised tumour types/streams generally had lower alignment with the framework standards.

## Impact of self-reporting

This audit used a self-report methodology, which has both advantages and disadvantages. Use of the audit tools requires adequate resourcing, including training if multiple auditors are to be employed, to optimise the reliability and validity of measurement between MDMs.

Factors that affected the effectiveness of this audit were:

* health services not allocating appropriate auditing resources, with reports of limited access to information and/or clinicians by some auditors
* auditors not responding to questions in the audit tool because they judged that certain questions weren’t relevant to the MDMs audited or auditor responses did not accurately reflect the MDMs audited
* auditors not presenting results to clinicians/MDM leaders/chairs for confirmation before submitting data for collation by the project team
* health services not identifying improvement projects to address some areas of poor results.

Aside from a TOR review, some of the quality standards scored less than 90 per cent in the Main Audit Tool results and either did not have any projects identified by participating health services to either partially or fully address the gaps. Statewide, there were no projects identified to address the following standards (in bold) and measures:

* **Health service executive support underpins MDM activities** – people responsible for quality and risk aware of MDM, staffing and IT needs incorporated into budgets.
* **MDMs have a clear governance structure** – committee receives biannual updates on changes to MDM treatment evidence base and protocols.
* **All public and private patients have access to MDMs** – referral of relevant patients to external MDM when more specialised expertise is required.
* **MDM participants can view required information in real-time during MDMs** – MDM facilities enable off-site participants to view radiology, pathology and prefilled patient data and live data entry and contribute to meeting at host site.
* **Meetings occur at least fortnightly** – at least three meetings were held in the last six weeks and agendas for the previous three meetings were sent more than 48 hours before the meeting.
* **MDM recommendations are communicated to the patient in a timely manner** – participants understand their role working with the patient after the MDM.

The range and depth of the projects identified to improve alignment with some of the quality standards may also not be adequate, given the extent and complexity of the issues.

# Conclusion

This report details the results of a comprehensive audit of 85 MDMs across a range of cancer services in Victoria against the framework. The framework’s feasibility to measure practice against MDM quality criteria has been proven.

Audit results showed a variable level of alignment with the framework, with better alignment in areas that correlate to the practical and logistical elements of the meetings. Areas of poorer alignment related to framework standards that are newer to MDM best practice – for example, governance and risk management. These standards were drawn from the National Safety and Quality Health Service Standards, international literature and privacy legislation.

Generally, where there was poor alignment with standards, participating health services identified improvement initiatives. Some of these will require significant changes across private and public settings, and others might benefit from a state-level approach. The active support of health service executives is intrinsic to the success of these initiatives, particularly in the areas of governance, risk management and resourcing for MDMs.

A further purpose of this project was to measure the alignment of participating sites against the framework standards to create a statewide baseline. This includes results by tumour stream and location of the MDM (metropolitan or regional setting). The benefit of this baseline is that services can use it to understand their individual audit results going forward and, more broadly, for measuring MDM changes over time. This has already supported the statewide response to COVID-19, as the framework was used to compare MDM participant experience during the first wave of the pandemic in March 2020 to the 2019 baseline result.

Refinement of the framework and associated tools will continue in accord with emerging evidence and any change in policy.

# Appendix 1: Main Audit Tool (Tool 1) results by MDM location and tumour stream

Note that in the tables that follow:

* Endocrine, melanoma and advanced disease have been removed due to small numbers.
* Haematology includes myeloma and lymphoma.
* General/multi-tumour includes general (*n* = 44), molecular (*n* = 1), solid tumour (*n* = 1), sarcoma (*n* = 6) and unknown (*n* = 1).
* ^ means participant count and percentage are direct from the survey (Yes/No answers don’t always represent actual percentages due to MDMs < 5).

## Quality Area 1: Infrastructure and organisational support

Table 45: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 1.1: Health service executive support underpins MDM activities

| Measure | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a. | Does MDM appear as a named activity in a strategic/operational plan in the host health service? | 56% | 69% | 22% | 46% | 54% | 64% | 50% | 50% | 38% | 60% | 50% | 50% | 33% | 33% |
| b. | Is the person responsible for quality aware of MDM? | 81% | 89% | 61% | 85% | 77% | 82% | 80% | 88% | 75% | 100% | 75% | 100% | 100% | 67% |
| b. | Has there been at least one quality change related to MDM in the last two years? | 81% | 80% | 83% | 92% | 92% | 64% | 100% | 100% | 75% | 100% | 50% | 75% | 67% | 67% |
| b. | Is the person responsible for risk aware of MDM? | 65% | 69% | 56% | 62% | 54% | 45% | 60% | 75% | 63% | 60% | 75% | 25% | 100% | 33% |
| b. | Is there least one MDM-related risk in the organisation risk log or equivalent in previous 12 months? | 19% | 27% | 0% | 31% | 23% | 27% | 20% | 25% | 13% | 40% | 0% | 25% | 33% | 0% |
| c. | Are MDM staffing needs incorporated into any budgets?  | 70% | 64% | 83% | 69% | 69% | 64% | 90% | 75% | 88% | 40% | 50% | 50% | 100% | 33% |
| c. | Do MDM referrers get paid to attend MDMs (include MBS billing)? | 25% | 24% | 28% | 23% | 31% | 27% | 20% | 25% | 0% | 20% | 75% | 25% | 0% | 0% |
| c. | Are MDM IT needs incorporated into any budgets? | 63% | 53% | 89% | 62% | 62% | 45% | 80% | 88% | 63% | 40% | 75% | 25% | 67% | 33% |
| d. | Has there been any review of the MDM in the last two years?  | 59% | 71% | 28% | 54% | 85% | 55% | 70% | 50% | 38% | 60% | 25% | 50% | 0% | 33% |

Table 46: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 1.2: MDMs have a clear governance structure

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| a. | Is there a standing committee with MDM governance responsibilities? | 67% | 71% | 56% | 62% | 54% | 55% | 40% | 63% | 38% | 80% | 75% | 50% | 67% | 33% |
| a. | If yes, can you locate TOR or equivalent for this committee that includes MDMs? | 83% | 78% | 100% | 75% | 100% | 83% | 30% | 80% | 100% | 60% | 100% | 100% | 50% | 100% |
| a. | Is there evidence of a process to log quality changes and suggestions made at MDMs? | 52% | 53% | 50% | 46% | 38% | 45% | 30% | 50% | 25% | 60% | 75% | 50% | 33% | 33% |
| b. | If yes, does membership include clinicians, radiologists, pathologists, business units, executive staff, consumers and leaders within MDM? | 95% | 97% | 90% | 100% | 100% | 83% | 40% | 100% | 67% | 80% | 100% | 100% | 33% | 100% |
| c. | If yes, does the committee receive biannual updates on changes to MDM treatment evidence base and protocols? | 10% | 6% | 20% | 13% | 29% | 33% | 0% | 20% | 33% | 20% | 0% | 0% | 0% | 0% |
| c. | If yes, does the committee monitor MDM attendance against recommended membership in optimal care pathways (OCPs)? | 17% | 9% | 40% | 13% | 57% | 33% | 0% | 20% | 33% | 20% | 33% | 0% | 0% | 100% |

Table 47: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 1.3: The organisation ensures MDM participation and operations are included in workforce planning

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| a. | Does the organisation use contract templates or standardised position descriptions for contracts with medical staff who provide cancer care? | 79% | 78% | 83% | 92% | 77% | 73% | 70% | 88% | 63% | 100% | 100% | 100% | 100% | 33% |
| a. | If yes, are MDM activities included in the templates or position descriptions? | 30% | 23% | 47% | 23% | 20% | 9% | 30% | 57% | 40% | 0% | 50% | 0% | 67% | 0% |
| b. | Did 90% of core membership specialties (identified in OCPs and in Standard 3.3) attend the last three MDMs? | 83% | 87% | 72% | 92% | 85% | 82% | 90% | 100% | 75% | 91% | 50% | 75% | 67% | 67% |

Table 48: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 1.4: Organisational culture recognises the teaching and training role of activities within MDMs

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a. | Results for question 1.1 in MDM Survey (Patient management is decided based on broad input from a range of participants) show 80% responded positively (5 and above). | 79% | 78% | 83% | 100% | 92% | 64% | 90% | 100% | 88% | 80% | 50% | 75%^ | 66%^ | 33%^ |
| b. | Results for question 1.2 in MDM Survey (MDM provides good opportunities for my own learning and professional development) show 80% respondents who were interns, registrars, fellows or students responded positively (5 and above). | 35% | 47% | 6% | 46% | 31% | 36% | 50% | 25% | 50% | 60% | 0% | 75%^ | 67%^ | 0%^ |
| b. | % of respondents who were interns, registrars, fellows or students reporting education and professional development benefit. | 8% | 9% | <1% | 5% | 6% | 0%  | 10% | 2% | 8% | 7% | 0% | 11% | 10% | 12% |

Table 49: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 1.5: All public and private patients have access to MDMs

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a. | Does the MDM accept referrals from public and private services outside of the host agency? | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| b. | Results for question 5.3 in MDM Survey (I refer relevant patients to external MDMs when more specialised expertise is required) show 80% responded positively (5 and above). | 21% | 13% | 39% | 23% | 23% | 27% | 10% | 13% | 25% | 40% | 50% | 0%^ | 0%^ | 0%^ |

Table 50: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 1.6: Health services who participate in MDMs provide an appropriate room for MDMs

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a. | Can all participants sit down during busy meetings?  | 97% | 98% | 94% | 92% | 92% | 100% | 100% | 100% | 88% | 80% | 100% | 75% | 100% | 67% |
| a. | Do rooms where meetings take place allow confidential discussion (including remote sites)? | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

Table 51: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 1.7: MDM participants can view required information in real-time during MDMs

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a. | Do MDM facilities enable on-site participants to view radiology, pathology and prefilled patient data and live data entry?  | 94% | 98% | 83% | 85% | 100% | 91% | 100% | 100% | 100% | 100% | 50% | 100% | 100% | 100% |
| a. | Do MDM facilities enable off-site participants to view radiology, pathology and prefilled patient data and live data entry and contribute to meeting at host site?  | 73% | 71% | 78% | 54% | 77% | 73% | 70% | 88% | 75% | 60% | 50% | 50% | 100% | 33% |

Table 52: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 1.8: The infrastructure to support MDMs, including software and hardware, is appropriate and reliable

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| a. | Is there an identified person to provide emergency IT support during MDM meetings?  | 71% | 64% | 89% | 62% | 62% | 73% | 80% | 88% | 88% | 40% | 75% | 50% | 100% | 33% |
| b. | Are there any ongoing technical faults impacting the meeting?  | 19% | 7% | 50% | 38% | 23% | 36% | 40% | 25% | 50% | 20% | 50% | 25% | 33% | 0% |

Table 53: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 1.9: Information is captured across patients and MDMs to enable analysis and reporting and benchmarking of diagnostic, treatment, and administrative trends

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a. | Is the meeting being recorded in software in real time? | 87% | 84% | 94% | 100% | 85% | 82% | 100% | 88% | 88% | 100% | 100% | 100% | 100% | 67% |
| a. | Were the following fields all captured during the meeting:1. Staging (pathological, histological, clinical)2. Treatment recommendation3. Recommended referrals4. Clinical Trial suitability | 49% | 51% | 44% | 38% | 42% | 36% | 40% | 50% | 50% | 40% | 25% | 25% | 67% | 0% |
| b. | Meeting software can report minimum data outlined in Quality Area 6 across individual MDMs. | 76% | 89% | 44% | 69% | 62% | 91% | 80% | 75% | 75% | 80% | 50% | 75% | 100% | 33% |
| c. | Can you identify a process to place MDM recommendation in medical records for the patient at host MDM health service?  | 87% | 96% | 67% | 85% | 85% | 91% | 90% | 88% | 88% | 80% | 75% | 75% | 100% | 67% |
| c. | Can you identify a process to place MDM recommendations in medical records for the patients outside host MDM health service? | 86% | 82% | 94% | 85% | 92% | 82% | 80% | 75% | 100% | 80% | 75% | 75% | 100% | 67% |

## Quality Area 2: Meeting organisation

Table 54: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 2.1: The MDM has terms of reference (TOR) or equivalent which meet minimum standards

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a. | Does MDM have approved TOR or equivalent? | 52% | 64% | 22% | 46% | 54% | 45% | 40% | 38% | 13% | 80% | 50% | 75% | 33% | 67% |
| a. | Using results from MDM TOR Audit Tool, do more than 80% of TOR standards align with Appendix 3? | 3% | 0% | 11% | 0% | 8% | 9% | 0% | 0% | 13% | 0% | 25% | 0% | 0% | 0% |

Table 55: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 2.2: The MDM has an appointed or nominated staff member to coordinate the MDM

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a.i. | Can you identify a staff member responsible for notifying and inviting members regarding MDM? | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| a.ii. | Can you identify a staff member responsible for preparing and distributing the agenda? | 98% | 98% | 100% | 100% | 100% | 91% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| a.iii. | Can you identify a staff member responsible for supporting off-site participation? | 76% | 69% | 94% | 62% | 62% | 73% | 80% | 75% | 88% | 60% | 75% | 50% | 100% | 67% |
| a.iv. | Can you identify a staff member responsible for documenting MDM attendance? | 92% | 89% | 100% | 92% | 85% | 91% | 90% | 100% | 100% | 80% | 100% | 75% | 67% | 67% |
| a.v. | Can you identify a staff member responsible for escalating technical issues?  | 95% | 93% | 100% | 100% | 100% | 91% | 100% | 100% | 100% | 100% | 100% | 100% | 67% | 67% |

Table 56: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 2.3: A regular meeting date, time, meeting length and location are set to ensure regular attendance

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a. | Were meetings held at the same time?  | 98% | 98% | 100% | 100% | 100% | 91% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| a. | Were meetings held at the same location?  | 98% | 98% | 100% | 100% | 100% | 91% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| a. | Were meetings held with the same frequency?  | 98% | 98% | 100% | 100% | 100% | 91% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

Table 57: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 2.4: Meetings should occur at least fortnightly

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a. | Were at least three meetings held in the last six weeks?  | 86% | 96% | 61% | 85% | 77% | 73% | 90% | 88% | 88% | 100% | 50% | 100% | 100% | 67% |

Table 58: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 2.5: The agenda is distributed to give participants enough time to prepare

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a. | Were agendas for the previous 3 meetings sent more than 48 hours before the meeting? | 75% | 78% | 67% | 62% | 69% | 82% | 90% | 88% | 50% | 60% | 75% | 75% | 100% | 67% |
| b. | Does TOR or equivalent for MDM include a documented process for the late addition of patients to agenda?  | 30% | 20% | 56% | 31% | 46% | 36% | 40% | 25% | 38% | 20% | 75% | 25% | 0% | 33% |

##

## Quality Area 3: Membership

Table 59: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 3.1: Every MDM has a register of attendance

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a. | Is there an attendance register for MDMs?  | 90% | 87% | 100% | 92% | 85% | 91% | 90% | 100% | 100% | 80% | 100% | 75% | 67% | 33% |
| a. | Does the register include those attending remotely?  | 67% | 60% | 83% | 77% | 69% | 82% | 70% | 63% | 75% | 80% | 75% | 75% | 67% | 0% |
| a. | Is the register signed by attendees?  | 48% | 42% | 61% | 62% | 54% | 45% | 40% | 50% | 50% | 60% | 75% | 25% | 33% | 0% |

Table 60: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 3.2: Patient information remains confidential and is used only for the purpose of clinical management

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a. | Can you locate signed MDM confidentiality agreements for those attendees who are not directly employed by the host agency? | 22% | 11% | 50% | 23% | 31% | 18% | 30% | 25% | 25% | 0% | 50% | 0% | 0% | 0% |
| a. | Does MDM TOR or equivalent assign responsibility for maintaining signed confidentiality agreements covering attendees not directly employed by the host agency? | 14% | 4% | 39% | 8% | 15% | 18% | 10% | 13% | 25% | 0% | 25% | 0% | 0% | 33% |

Table 61: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 3.3: The MDM team contains appropriate core members

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a. | Were 90% of OCP-identified core membership specialties in attendance at previous 3 meetings?  | 81% | 84% | 72% | 92% | 85% | 82% | 90% | 100% | 75% | 100% | 50% | 75% | 67% | 67% |

Table 62: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 3.4: Specialties beyond the defined core membership listed in the OCPs attend meetings when clinically required

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a. | Does MDM TOR or equivalent include a process for invitation of non-core specialties?  | 27% | 31% | 17% | 23% | 15% | 27% | 20% | 25% | 0% | 0% | 75% | 0% | 33% | 33% |

Table 63: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 3.5: There is opportunity for the involvement of patient GPs in MDMs

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a. | Does MDM TOR or equivalent include a process for invitation of GPs? | 19% | 11% | 39% | 23% | 8% | 9% | 30% | 13% | 13% | 0% | 50% | 0% | 0% | 33% |

## Quality Area 4: Leadership

Table 64: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 4.1: The MDM has a designated chair, with a delegate/deputy nominated to cover in their absence

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a. | Were the last three MDMs chaired by the designated chair or deputy chair? | 92% | 98% | 78% | 92% | 85% | 82% | 100% | 100% | 88% | 100% | 50% | 100% | 100% | 100% |

Table 65: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 4.2: The MDM chairperson is a specialist clinician

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a. | Was the chair / deputy chair for last 3 meetings a specialist clinician (not an intern or registrar)? | 98% | 100% | 94% | 100% | 100% | 100% | 100% | 100% | 88% | 100% | 100% | 100% | 100% | 100% |

Table 66: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 4.3: The chairperson takes a leadership role within the MDM to ensure that meeting discussion is rigorous and appropriate

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a.i.–a.v. | Results for questions 2.1–2.4 in the MDM Survey (the chair’s role in the MDMs) show 80% responded positively (5 and above).  | 59% | 56% | 67% | 69% | 69% | 64% | 60% | 88% | 100% | 40% | 50% | 50% ^ | 33% ^ | 0% ^ |
| b. | Results for question 2.5 in the MDM Survey (The chairperson ensures new research and clinical trials are considered for relevant patients) show 80% responded positively (5 and above).  | 51% | 58% | 33% | 38% | 54% | 64% | 50% | 50% | 50% | 60% | 25% | 75% ^ | 33% ^ | 0% ^ |

Table 67: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 4.4: The chairperson ensures that all clinically relevant information, including recommendations (including divergent recommendations) are clearly documented

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a.i. | Were minimum dataset records of at least 20 patients 80% complete in patient data for each MDM you are auditing?  | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% |
| a.i. | % of previous patients with complete minimum data, by tumour stream. | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 50% | 0% | 3% | 0% | 12% | 2% |
| a.ii–iv. | Did at least 80% of reviewed patient records have treatment recommendations recorded in patient data?  | 90% | 89% | 94% | 100% | 92% | 82% | 100% | 88% | 100% | 100% | 75% | 75% | 100% | 100% |
| a.ii–iv. | % of reviewed patients with treatment recommendations recorded. | 92% | 90% | 96% | 97% | 82% | 0% | 97% | 94% | 84% | 99% | 96% | 91% | 100% | 100% |

Table 68: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 4.5: There are identified leaders and/or a culture of leadership so that MDM clinical requirements for resourcing, quality and safety are represented

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a.i. | Can you identify a leader for MDM who escalates issues of concern that may impact on safety, sustainability and minimum standards for MDM quality to appropriate decision-makers?  | 95% | 93% | 100% | 92% | 92% | 91% | 100% | 100% | 100% | 80% | 100% | 75% | 67% | 67% |
| a.ii. | Can you identify a leader for MDM who ensures the host agency understands the role and importance of MDM, and provides appropriate resources to support it? | 95% | 93% | 100% | 85% | 85% | 73% | 90% | 100% | 88% | 80% | 100% | 50% | 100% | 67% |
| a.iii. | Can you identify a leader who advocates for systems that ensure timely communication of treatment recommendations from MDM to the patient, GP and treating team? | 98% | 98% | 100% | 100% | 100% | 91% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

## Quality Area 5: Consent

Table 69: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 5.1: Patients are provided appropriate information to ensure informed consent to MDM participation

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a. | Combined results for question 4.1.i-ii in MDM Survey (I provide verbal or written information to patients on MDM: i) covering who will be able to view their information, prior to presenting them, ii) prior to presenting them) show 90% responded positively (5 and above). | 5% | 2% | 11% | 8% | 8% | 0% | 10% | 13% | 0% | 0% | 0% | 0% | 0% | 0% |
| a. | Is there a patient information leaflet on MDM that covers all of the following topics:i. Who will be able to view their information.ii. How they will be informed of recommendations. iii. How they can opt-out of MDM presentation. | 62%  | 56%  | 78%  | 77%  | 54% | 73% | 60% | 50% | 50% | 80% | 75% | 75% | 33% | 0% |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| a. | Results for question 4.2 in MDM Survey (I give my patients the opportunity to opt-out of presentation at MDM) show 90% responded positively (5 and above). | 5% | 0% | 17% | 8% | 8% | 0% | 0% | 13% | 0% | 0% | 0% | 0%^ | 0%^ | 0%^ |
| a. | If no, record % of clinicians who responded positively to question 4.2 (5 and above). | 31% | 25% | 46% | 31  | 37% | 0% | 36% | 36% | 37% | 24% | 31% | 20% | 16% | 35% |

Table 70: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 5.2: Patient consent is sought prior to presentation of their case

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a. | Did 90% of reviewed patient records have patient consent recorded in patient data?  | 13% | 7% | 28% | 15% | 23% | 0% | 20% | 25% | 0% | 0% | 0% | 0% | 33% | 0% |
| a. | If no, record % of consent recorded in reviewed patient records.  | 26% | 21% | 44% | 41% | 37% | 0% | 36% | 21% | 11% | 34% | 36% | 34% | 8% | 0% |

## Quality Area 6: Patient referral

Table 71: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 6.1: Clinicians refer all patients with a new or suspected cancer diagnosis to an MDM for endorsement of patient-specific treatment recommendations. To assist with the burden of demand in common tumour streams, sites that have ‘agreed standardised treatment protocols’ (or like) can elect to deal with referrals by exception.

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a. | Whether the average number of unique patients discussed at MDM over a three-month period is 80% of the patients that can be reasonably estimated for the catchment using state-level datasets? | 46% | 49% | 39% | 77% | 46% | 18% | 50% | 38% | 50% | 60% | 75% | 25% | 67% | 33% |
| a. | Results for question 5.1 in MDM Survey (I refer all my public patients with a new or suspected diagnosis of cancer to MDM) show 80% responded positively (5 and above). | 21% | 18% | 28% | 23% | 23% | 27% | 20% | 0% | 0% | 20% | 75% | 0%^ | 0%^ | 0%^ |
| a. | Results for question 5.2 in MDM Survey (I refer all my private patients with a new or suspected diagnosis of cancer to MDM) show 80% responded positively (5 and above). | 11% | 7% | 22% | 15% | 8% | 27% | 0% | 0% | 0% | 20% | 50% | 0% ^ | 0% ^ | 0% ^ |

Table 72: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 6.2: Clinicians who refer patients to MDMs provide enough information about each patient and this is considered by the MDM

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a. | Record percentage of audited patients with at least 80% of minimum data complete. | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 59% | 0% |
| b. | Results for question 5.4 in MDM Survey (Presenters are adequately prepared to answer questions about patients they are presenting at MDM) show 80% responded positively (5 and above). | 51% | 49% | 56% | 54% | 46% | 36% | 40% | 38% | 50% | 60% | 75% | 25% | 33%^ | 0%^ |

Table 73: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 6.3: Clinicians who refer patients to MDMs after the agreed cut-off time for inclusion in agenda ensure patient information can be adequately reviewed

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a. | Results for question 5.5 in MDM Survey (The number of late presentations to MDM is acceptable) show 80% of pathologists and radiologists responded positively (5 and above). | 16% | 11% | 28% | 15% | 31% | 9% | 10% | 13% | 13% | 0% | 25% | 0% | 33% ^ | 33% ^ |
| a. | There is a process for late inclusion in agenda in MDM TOR or equivalent? | 35% | 27% | 56% | 38% | 46% | 55% | 40% | 25% | 38% | 40% | 75% | 25% | 33% | 33% |

## Quality Area 7: Streamlining patient discussion – for MDMs which use prioritisation

Table 74: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 7.1: In MDMs that use prioritisation so that not all referred patients are routinely discussed, patient discussion is streamlined using agreed protocols

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a. | Results for question 7.1 in MDM Survey (I am satisfied with the way that routine patients are presented) show 80% responded positively (5 and above). | 62% | 64% | 56% | 62% | 77% | 64% | 80% | 88% | 75% | 100% | 25% | 75%^ | 67%^ | 33%^ |
| a. | Results for question 7.2 in MDM Survey (I am satisfied with the way that complex patients are presented) show 80% responded positively (5 and above).  | 70% | 78% | 50% | 77% | 77% | 64% | 90% | 88% | 75% | 100% | 25% | 75%^ | 33%^ | 66%^ |

Table 75: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 7.2: In MDMs where patient presentation is streamlined, processes to separate patients for noting versus discussion are formally defined

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a.i. | Can you identify who is responsible for allocating patients for noting versus discussion? | 71% | 87% | 33% | 62% | 46% | 82% | 70% | 88% | 75% | 80% | 0% | 75% | 100% | 67% |
| a.ii. | Can you identify which clinical guidelines underpin streamlining of patient discussion? | 32% | 40% | 11% | 23% | 31% | 55% | 20% | 38% | 25% | 20% | 25% | 25% | 67% | 33% |
| a.iii. | Can you identify how a patient could be escalated from noting to discussion? | 44% | 49% | 33% | 31% | 38% | 45% | 30% | 63% | 50% | 20% | 0% | 50% | 67% | 33% |

Table 76: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 7.3: In MDMs where patient presentation is streamlined, when a patient is noted but not discussed, their proposed treatment recommendation is documented

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a. | Is there evidence of a process to formally endorse proposed treatment plans for noted patients? | 43% | 44% | 39% | 38% | 38% | 55% | 30% | 38% | 50% | 40% | 25% | 50% | 67% | 33% |

## Quality Area 8: MDM recommendations and communication

Table 77: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 8.1: MDMs are a mechanism for clinicians to develop agreement on the recommended treatment

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a.i. | Results for question 3.1 in MDM Survey (Appropriate attempts are made to reach agreement about treatment recommendations) show 80% responded positively (5 and above). | 90% | ­89% | 94% | 100% | 100% | 91% | 90% | 100% | 100% | 100% | 75% | 100% | 67% | 67% |
| a.ii. | Are response rates to the above question evenly distributed across disciplines?  | 78% | 78% | 78% | 77% | 77% | 91% | 90% | 88% | 88% | 80% | 50% | 75% | 67% | 33% |

Table 78: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 8.2: When there is not agreement on treatment planning, divergent views on recommended treatment are captured

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a. | Results for question 3.2 in MDM Survey (Where there is more than one treatment opinion, divergent treatment recommendations are recorded) show 80% responded positively (5 and above). | 29% | 22% | 44% | 23% | 46% | 36% | 30% | 38% | 25% | 20% | 25% | 0% ^ | 0%^ | 0% ^ |
| a. | If no, percentage of those that responded positively to above question.  | 56% | 57% | 54% | 72% | 85% | 70%  | 76% | 49% | 64% | 72% | 74% | 0%^ | 74%^ | 63%^ |

Table 79: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 8.3: When developing treatment recommendations, the MDM team ensures relevant information about the patient and optimal treatment are considered

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a.i–v. | Results from 6.2.b. | 46% | 49% | 39% | 31% | 38% | 27% | 50% | 38% | 50% | 40% | 25% | 25% | 33% | 33% |
| a.vi. | Results for question 3.3 in MDM Survey (Optimal Care Pathway timeframes are considered when making decisions about patient management) show 80% responded positively (5 and above). | 27% | 20% | 44% | 31% | 31% | 9% | 30% | 25% | 38% | 20% | 25% | 0% ^ | 0% ^ | 0% ^ |

Table 80: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 8.4: MDM recommendations are communicated to the patient’s treatment team and GP in a timely manner

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a.i. | Can you identify how each member of the treating team, including off-site members, could gain access to MDM recommendations within 24 hours of the MDM meeting? | 92% | 91% | 94% | 92% | 92% | 91% | 100% | 100% | 88% | 100% | 75% | 100% | 100% | 100% |
| a.ii. | Can you identify how MDM recommendations are placed on the medical records in the MDM host health service? | 89% | 98% | 67% | 92% | 92% | 91% | 90% | 88% | 88% | 100% | 75% | 100% | 100% | 100% |
|   | Can you identify how MDM recommendations are placed on the medical records in every other referring health service? | 41% | 24% | 83% | 62% | 54% | 18% | 60% | 50% | 50% | 20% | 75% | 25% | 33% | 33% |
| a.iii. | Can you identify how MDM recommendations are sent to the patient’s GP within one week of the MDM?  | 86% | 82% | 94% | 77% | 77% | 73% | 90% | 100% | 88% | 60% | 100% | 75% | 100% | 33% |

Table 81: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 8.5: MDM recommendations are communicated to the patient in a timely manner

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a.i. | Results for question 6.2 in the MDM Survey (I understand my role working with the patient to develop the final treatment plan after MDMs) show 80% responded positively (5 and above). | 65% | 71% | 50% | 85% | 69% | 91% | 50% | 50% | 88% | 90% | 75% | 100% | 67%^ | 33%^ |
| a.ii. | Results for question 6.1 in MDM Survey (I understand my role in presenting the MDM recommendation to the patient, including divergent recommendations) show 80% responded positively (5 and above). | 70% | 71% | 67% | 77% | 69% | 91% | 90% | 63% | 88% | 100% | 75% | 100% | 33%^ | 33%^ |

Table 82: Main Audit Tool results by location (*n* = 85) and selected tumour streams (*n* = 82)\* (by percentage of ‘yes’ responses) – 8.6: Clinicians who refer patients to MDMs understand how they are responsible for patient referrals post-MDM

| Standard | Audit question (measure) | All MDMs (63) | Metropolitan MDMs (45) | Regional MDMs (18) | Breast (13) | Lung/thoracic (13) | Haematology (11) | Colorectal/ gastrointestinal (10) | Genitourinary (8) | Head & neck (8) | Upper gastrointestinal (5) | General/multi-tumour (4) | Hepatobiliary/ hepatoma/glioma (4) | Gynaecology (3) | Central nervous system (3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a. | Results for question 6.3 in the MDM Survey (I understand my role in actioning patient referrals after the final treatment plan is made, post-MDM) show 80% responded positively (5 and above). | 63% | 62% | 67% | 77% | 62% | 82% | 60% | 63% | 100% | 80% | 75% | 75%^ | 67%^ | 33%^ |
|   | **Mean % Yes achieved** | **59%** | **59%** | **61%** | **60%** | **60%** | **57%** | **58%** | **61%** | **60%** | **59%** | **58%** | **53%** | **58%** | **43%** |

# Appendix 2: Minimum Data Audit Tool (Tool 3) results by MDM location and selected tumour streams

Table 83: Minimum Data Audit Tool results by location and selected tumour streams (by percentage of ‘yes’ responses)

| Minimum Data Audit question | Statewide (patients = 1,862; MDMs = 85) | Metropolitan (patients = 1,292; MDMs = 60) | Regional (patients = 570; MDMs = 25) | Lung/thoracic (patients = 287; MDMs = 13)  | Breast (patients = 285; MDMs = 13) | Haematology (patients = 228 MDMs = 11)  | Colorectal/gastrointestinal (patients = 180; MDMs = 9) | Head & neck (patients = 169; MDMs = 8) | Urology/genitourinary (patients = 164; MDMs = 8) | General/multi-tumour (patients = 149; MDMs = 4) | Upper gastrointestinal (patients = 137; MDMs = 6) | Hepatobiliary/hepatoma (patients = 85; MDMs = 4) | Central nervous system (patients = 64; MDMs = 3)  | Gynaecology (patients = 60; MDMs = 3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| The surname and first given name of the lead clinician (treating doctor) are all listed | 82% | 76% | 94% | 83% | 89% | 79% | 77% | 80% | 96% | 95% | 70% | 64% | 58% | 97% |
| The surname and first given name of the patient’s GP are listed | 61% | 58% | 67% | 66% | 63% | 48% | 77% | 64% | 53% | 56% | 76% | 29% | 30% | 85% |
| An email, fax, address or other means of contacting the GP is listed | 62% | 52% | 85% | 73% | 63% | 54% | 73% | 52% | 47% | 83% | 69% | 28% | 30% | 60% |
| The DATE of original referral from GP/other notifying party is listed | 24% | 34% | 1% | 28% | 35% | 16% | 26% | 21% | 10% | 5% | 30% | 14% | 39% | 67% |
| At least THREE of the following approved patient identifiers are present: patient name (family and given names), date of birth, gender, address, UR or other medical record number | 99% | 98% | 100% | 100% | 100% | 89% | 100% | 100% | 100% | 100% | 100% | 100% | 98% | 100% |
| You can find EITHER a UR number for the patient OR clear evidence that the patient doesn't yet have a UR | 88% | 93% | 78% | 93% | 93% | 80% | 89% | 84% | 87% | 87% | 88% | 76% | 100% | 100% |
| There is a place on the record for a second UR number to be recorded and the hospital it belongs to | 55% | 66% | 29% | 42% | 58% | 54% | 67% | 48% | 44% | 40% | 49% | 76% | 63% | 100% |
| There is evidence that the patient has consented to MDM presentation | 35% | 25% | 59% | 48% | 41% | 39% | 36% | 11% | 34% | 36% | 37% | 35% | 2% | 35% |
| You can clearly see the reason why the patient was discussed e.g. to plan further investigations, develop or change treatment recommendations, review treatment plan, other | 93% | 91% | 97% | 96% | 89% | 93% | 96% | 99% | 93% | 97% | 90% | 75% | 100% | 82% |
| You can clearly see the clinical question the MDM will consider | 64% | 67% | 59% | 69% | 57% | 72% | 56% | 58% | 85% | 73% | 50% | 69% | 28% | 68% |
| At least TWO previous investigations relevant to the diagnosis are listed. For example, histology, cytology, surgery, endoscopy, imaging, biochemistry/immunology, clinical observation, other | 86% | 85% | 88% | 86% | 88% | 69% | 94% | 93% | 85% | 90% | 88% | 74% | 97% | 72% |
| There is a place on the record to record relevant treatment history e.g. surgery, radiotherapy chemotherapy other therapy | 98% | 97% | 100% | 97% | 100% | 96% | 100% | 98% | 100% | 100% | 100% | 81% | 100% | 100% |
| At least ONE comorbidity is listed | 62% | 68% | 46% | 68% | 55% | 49% | 62% | 72% | 63% | 44% | 64% | 72% | 84% | 77% |
| At least ONE relevant medication is listed OR there is evidence that the patient was not on any medication | 22% | 27% | 9% | 14% | 17% | 35% | 13% | 22% | 20% | 13% | 16% | 14% | 73% | 43% |
| At least ONE supportive care requirement is listed e.g. physical needs, psychological needs, social needs, information needs or spiritual needs | 18% | 15% | 24% | 15% | 32% | 7% | 10% | 17% | 28% | 37% | 8% | 2% | 8% | 25% |
| At least ONE patient preference is listed e.g. wishes to stay at home, wants active treatment etc. | 6% | 6% | 8% | 7% | 7% | 7% | 9% | 4% | 5% | 7% | 2% | 4% | 5% | 15% |
| Date of diagnosis is listed | 45% | 44% | 46% | 36% | 59% | 27% | 52% | 53% | 38% | 43% | 51% | 24% | 53% | 63% |
| ECOG Performance status is listed | 39% | 33% | 52% | 56% | 46% | 34% | 36% | 54% | 31% | 45% | 14% | 14% | 5% | 70% |
| Details of the patients’ stage of cancer are recorded e.g. TNM, Gleason etc. | 54% | 46% | 72% | 52% | 65% | 39% | 51% | 79% | 43% | 70% | 55% | 11% | 75% | 47% |
| At least ONE error or change associated with pathology or radiology results or other reports is recorded | 10% | 12% | 5% | 11% | 7% | 5% | 2% | 27% | 4% | 5% | 15% | 2% | 47% | 0% |
| Treatment recommendations are documented OR more investigations are requested. | 92% | 90% | 96% | 89% | 96% | 83% | 97% | 96% | 99% | 96% | 94% | 54% | 98% | 98% |
| Recommended referrals are recorded e.g. surgeon, medical oncologist, radiation oncologist, supportive care service | 65% | 60% | 76% | 75% | 78% | 30% | 74% | 65% | 82% | 71% | 49% | 46% | 73% | 73% |
| Was there a palliative care recommendation? | 5% | 4% | 8% | 5% | 1% | 1% | 9% | 7% | 10% | 13% | 3% | 4% | 8% | 3% |
| Whether or not there is a family history of cancer is listed | 15% | 15% | 15% | 2% | 48% | 1% | 14% | 6% | 5% | 27% | 10% | 0% | 0% | 45% |
| Was there a familial cancer service recommendation? | 2% | 2% | 2% | 0% | 7% | 1% | 1% | 1% | 0% | 3% | 0% | 1% | 0% | 8% |
| Was there any evidence that clinical trials were considered? | 7% | 9% | 4% | 4% | 6% | 17% | 12% | 1% | 7% | 7% | 4% | 0% | 19% | 8% |
| Mean % Total Yes – All data items | 49% | 49% | 51% | 51% | 54% | 43% | 51% | 50% | 49% | 52% | 47% | 37% | 50% | 59% |

Endocrine, melanoma and advanced disease are not reported due to small numbers.

Haematology includes myeloma and lymphoma.

General/multi-tumour includes general (*n* = 44), molecular (*n* = 1), solid tumour (*n* = 1), sarcoma (*n* = 6) and unknown (*n* = 1).

# Appendix 3: Survey Audit Tool (Tool 4) results by MDM location and selected tumour streams

## Survey Audit Tool results by location

Table 84: Survey Audit Tool results by location, weighted average [1-7 Likert scale] and percentage who agreed with statement

| Survey question | Statewide – weighted average | Statewide – percentage who agreed | Metro – weighted average | Statewide – percentage who agreed | Regional – weighted average | Statewide – percentage who agreed |
| --- | --- | --- | --- | --- | --- | --- |
| 1.1 Patient management is decided based on broad input from a range of participants. | 5.92 | 91% | 5.96 | 91% | 5.87 | 91% |
| 1.2 MDM provides good opportunities for my own learning and professional development. | 5.92 | 91% | 5.99 | 92% | 5.78 | 93% |
| 2.1 The chairperson facilitates group discussion so a variety of team members contribute. | 5.61 | 84% | 5.56 | 82% | 5.75 | 90% |
| 2.2 The chairperson mediates disagreements. | 5.35 | 78% | 5.36 | 78% | 5.40 | 83% |
| 2.3 The chairperson acts fairly and objectively so that all members are supported to raise ideas and receive peer review. | 5.63 | 83% | 5.61 | 84% | 5.75 | 90% |
| 2.4 The chairperson creates a culture of support for education and professional development within the MDM. | 5.34 | 76% | 5.34 | 75% | 5.41 | 83% |
| 2.5 The chairperson ensures new research and clinical trials are considered for relevant patients. | 5.39 | 75% | 5.41 | 78% | 5.23 | 67% |
| 3.1 Appropriate attempts are made to reach agreement about treatment recommendations. | 6.04 | 94% | 6.04 | 96% | 6.05 | 97% |
| 3.2 Where there is more than one treatment opinion, divergent treatment recommendations are recorded. | 5.27 | 73% | 5.21 | 72% | 5.39 | 77% |
| 3.3 Optimal care pathway (OCP) timeframes are considered when making decisions about patient management. | 5.01 | 63% | 4.99 | 63% | 5.17 | 71% |
| 4.1i I provide written or verbal information to patients on MDM covering who will be able to view their information, prior to presenting them. | 4.35 | 50% | 4.13 | 44% | 4.84 | 51% |
| 4.1ii I provide written or verbal information to patients on how they will be informed of MDM recommendations, prior to presenting them. | 4.72 | 59% | 4.49 | 53% | 4.96 | 58% |
| 4.2 I give my patients the opportunity to opt-out of presentation at MDM. | 3.74 | 29% | 3.57 | 25% | 4.65 | 46% |
| 5.1 I refer all my public patients with a new or suspected diagnosis of cancer to MDM. | 5.13 | 62% | 4.94 | 58% | 4.64 | 47% |
| 5.2 I refer all my private patents with a new or suspected diagnosis of cancer to MDM. | 4.64 | 44% | 4.44 | 40% | 4.60 | 37% |
| 5.3 I refer relevant patients to external MDMs when more specialised expertise is required. | 5.12 | 63% | 4.96 | 59% | 5.47 | 69% |
| 5.4 Presenters are adequately prepared to answer questions about patients they are presenting at MDM. | 5.32 | 79% | 5.17 | 74% | 5.40 | 82% |
| 5.5 The number of late presentations to MDM is acceptable. | 4.65 | 59% | 4.57 | 59% | 4.75 | 66% |
| 6.1 I understand my role in presenting MDM treatment recommendations to the patient, including divergent recommendations. | 5.89 | 86% | 5.81 | 84% | 5.84 | 82% |
| 6.2 I understand my role working with the patient to develop the final treatment plan after MDM. | 5.88 | 84% | 5.84 | 83% | 5.63 | 75% |
| 6.3 I understand my role in actioning patient referrals after the final treatment plan is made, post-MDM. | 5.85 | 83% | 5.76 | 80% | 5.73 | 82% |
| 7.1 I am satisfied with the way that routine patients are presented. | 5.66 | 88% | 5.66 | 89% | 5.44 | 84% |
| 7.2 I am satisfied with the way that complex patients are presented. | 5.72 | 90% | 5.74 | 91% | 5.55 | 87% |
| Mean % across all questions | n/a | 67% | n/a | 65% | n/a | 67% |

## Survey Audit Tool results by selected tumour streams

Table 85: Survey Audit Tool results by selected tumour streams, by the percentage of respondents who agreed with the statement

| Survey question | Colorectal/ gastrointestinal (*n* = 234) | Lung/ thoracic (*n* = 169) | Breast (*n* = 168) | Genitourinary (*n* = 131) | Upper gastrointestinal (*n* = 122) | Haematology (*n* = 115) | Hepatobiliary/ hepatoma (*n* = 100) | Head & neck (*n* = 98) | General/multi-tumour (*n* = 53) | Central nervous system (*n* = 44) | Gynaecology (*n* = 40) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  1.1 Patient management is decided based on broad input from a range of participants. | 91% | 94% | 89% | 91% | 93% | 93% | 91% | 90% | 85% | 89% | 93% |
|  1.2 MDM provides good opportunities for my own learning and professional development. | 91% | 93% | 89% | 95% | 92% | 94% | 93% | 91% | 91% | 93% | 88% |
| 2.1 The chairperson facilitates group discussion so a variety of team members contribute.  | 84% | 87% | 87% | 89% | 84% | 84% | 76% | 81% | 81% | 72% | 95% |
| 2.2 The chairperson mediates agreements.  | 78% | 82% | 79% | 85% | 78% | 83% | 72% | 74% | 79% | 71% | 84% |
|  2.3 The chairperson acts fairly and objectively so that all members are supported to raise ideas and receive peer review. | 85% | 88% | 85% | 89% | 83% | 87% | 80% | 82% | 78% | 74% | 86% |
|  2.4 The chairperson creates a culture of support for education and professional development within MDMs. | 73% | 83% | 78% | 85% | 76% | 79% | 69% | 74% | 69% | 62% | 84% |
|  2.5 The chairperson ensures new research and clinical trials are considered for relevant patients. | 72% | 77% | 73% | 80% | 75% | 83% | 71% | 70% | 65% | 64% | 86% |
|  3.1 Appropriate attempts are made to reach agreement about treatment recommendations. | 94% | 98% | 94% | 96% | 100% | 98% | 97% | 93% | 92% | 95% | 97% |
|  3.2 Where there is more than one treatment opinion, divergent treatment recommendations are recorded. | 73% | 80% | 72% | 74% | 72% | 70% | 77% | 68% | 69% | 63% | 72% |
| 3.3 Optimal care pathway (OCP) timeframes are considered when making decisions about patient management. | 70% | 68% | 64% | 70% | 62% | 52% | 60% | 70% | 57% | 60% | 70% |

Notes:

Not everyone responded to all questions.

Haematology includes lymphoma and myeloma.

General/multi-tumour includes general (*n* = 44), molecular (*n* = 1), solid tumour (*n* = 1), sarcoma (*n* = 6) and unknown (*n* = 1).

Table 86: Survey Audit Tool results by selected tumour streams, by the percentage of respondents who agreed with the statement – questions for radiologists, pathologists and clinicians who refer patients to MDM

| Survey question | Colorectal/ gastrointestinal (*n* = 234) | Lung/thoracic (*n* = 169) | Breast (*n* = 168) | Genitourinary (*n* = 131) | Upper gastrointestinal (*n* = 122) | Haematology (*n* = 115) | Hepatobiliary/hepatoma (*n* = 100) | Head & neck (*n* = 98) | General/multi-tumour (*n* = 53) | Central nervous system (*n* = 44) | Gynaecology (*n* = 40) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  4.1i I provide written or verbal information to patients on MDM covering who will be able to view their information, prior to presenting them. | 48% | 52% | 46% | 50% | 43% | 48% | 31% | 47% | 44% | 33% | 36% |
|  4.1ii I provide written or verbal information to patients on how they will be informed of MDM recommendations, prior to presenting them. | 54% | 57% | 52% | 55% | 54% | 51% | 54% | 58% | 50% | 53% | 52% |
|  4.2 I give my patients the opportunity to opt-out of presentation at MDM. | 36% | 37% | 31% | 36% | 24% | 30% | 20% | 27% | 25% | 31% | 16% |
|  5.1 I refer all my public patients with a new or suspected diagnosis of cancer to MDM. | 55% | 60% | 64% | 38% | 65% | 53% | 64% | 52% | 52% | 46% | 61% |
|  5.2 I refer all my private patents with a new or suspected diagnosis of cancer to MDM. | 38% | 38% | 44% | 15% | 49% | 48% | 46% | 43% | 48% | 24% | 39% |
|  5.3 I refer relevant patients to external MDMs when more specialised expertise is required. | 62% | 63% | 67% | 54% | 67% | 60% | 55% | 70% | 48% | 60% | 61% |
|  5.4 Presenters are adequately prepared to answer questions about patients they are presenting at MDM. | 73% | 80% | 80% | 74% | 79% | 71% | 66% | 89% | 80% | 77% | 72% |
|  5.5 The number of late presentations to MDM is acceptable. | 59% | 61% | 59% | 55% | 66% | 66% | 59% | 61% | 63% | 63% | 68% |
|  6.1 I understand my role in presenting MDM treatment recommendations to the patient, including divergent recommendations. | 82% | 84% | 87% | 76% | 90% | 85% | 83% | 87% | 85% | 71% | 92% |
|  6.2 I understand my role working with the patient to develop the final treatment plan after MDM. | 80% | 85% | 85% | 74% | 87% | 85% | 80% | 81% | 69% | 74% | 79% |
|  6.3 I understand my role in actioning patient referrals after the final treatment plan is made, post-MDM. | 79% | 82% | 83% | 77% | 87% | 81% | 79% | 77% | 81% | 78% | 78% |
|  7.1 I am satisfied with the way that routine patients are presented. | 89% | 86% | 87% | 89% | 93% | 88% | 85% | 91% | 87% | 71% | 76% |
| 7.2 I am satisfied with the way that complex patients are presented. | 92% | 88% | 89% | 92% | 93% | 91% | 91% | 89% | 93% | 81% | 71% |
| **Average percentage** | **72%** | **75%** | **73%** | **71%** | **74%** | **73%** | **69%** | **73%** | **69%** | **65%** | **72%** |

Notes:

Not everyone responded to all questions.

Haematology includes lymphoma and myeloma.

General/multi-tumour includes general (*n* = 44), molecular (*n* = 1), solid tumour (*n* = 1), sarcoma (*n* = 6) and unknown (*n* = 1).

# Abbreviations and glossary

| ECOG status | Eastern Cooperative Oncology Group Performance Status. An internationally agreed measure of the patients’ level of functioning. |
| --- | --- |
| ICS | Integrated Cancer Service |
| LMICS | Loddon Mallee ICS |
| MDM | Multidisciplinary meeting. Also known as:* MDT (in NSW)
* MDTM (in Qld, UK)
* Tumor Boards (in USA).
 |
| Metro | Metropolitan |
| Off-site attendance | Off-site attendance at MDM means attendance by those not employed directly by the MDM host health service. These might be referring clinicians attending from private rooms or contracted services.  |
| QOOL-Vic | MDM management software developed by the department for Victorian health services. Use of this software is mandated in the *Victorian cancer plan*.  |
| Remote attendance | Attending MDMs remotely means attendees are not physically in a room where the meeting is being hosted. They may be located outside the health service (for example, working from home) but could also be within the health service using technology to attend from a different room. A meeting can be entirely remote if all attendees are linked only by a digital platform, or a mix of a physical meeting location and some remote attendance. It only refers to the physical location of attendance, not the medico-legal status of attendees (for example, employment arrangements, credentialing, contracting, MOUs). |
| TOR | Terms of reference |
| VICS | Victoria is divided into eight integrated cancer service regions that cover geographical catchments – Grampians (GICS), Barwon (BSWICS), Western (WCMICS), Southern (SMICS), North Eastern (NEMICS), Hume (HRICS), Loddon Mallee (LMICS) and Gippsland (GRICS). There is one integrated cancer service by patient population, the paediatric ICS (PICS).  |

# Endnotes

1. Department of Health and Human Services 2018, *Victorian cancer multidisciplinary team meeting quality framework*, State Government of Victoria, Melbourne. [↑](#endnote-ref-1)
2. Department of Health and Human Services 2018, *Victorian cancer multidisciplinary team meeting quality framework*, State Government of Victoria, Melbourne. [↑](#endnote-ref-2)
3. Sidhom MA, Poulsen MG 2008, Group decisions in oncology: Doctors’ perceptions of the legal responsibilities arising from multidisciplinary meetings. *Journal of Medical Imaging and Radiation Oncology*; 52: 287–292. [↑](#endnote-ref-3)
4. Evans AC, Zorbas HM, Keaney MA, Sidhom MA, Goodwin HE, Peterson JC 2008, Medicolegal implications of a multidisciplinary approach to cancer care: consensus recommendations from a national workshop. *Medical Journal of Australia*; 188: 401–404. [↑](#endnote-ref-4)
5. Sidhom MA, Poulsen MG 2006, Multidisciplinary care in oncology: medicolegal implications of group decisions. *Lancet Oncology*; 7: 951–54. [↑](#endnote-ref-5)
6. Lamb BW, Brown KF, Nagpal K, Vincent C, Green JSA, Sevdalis N 2011, Quality of care management decisions by multidisciplinary cancer teams: a systematic review. *Annals of Surgical Oncology*; 18: 2116–2125. [↑](#endnote-ref-6)
7. Tayana Soukup T, Lamb BW, Arora S, Darzi A, Sevdalis N, Green JSA 2018, Successful strategies in implementing a multidisciplinary team working in the care of patients with cancer: an overview and synthesis of the available literature. *Journal of Multidisciplinary Healthcare*; 11: 49–61. [↑](#endnote-ref-7)
8. Lamb BW, Brown KF, Nagpal K, Vincent C, Green JSA, Sevdalis N. Quality of care management decisions by multidisciplinary cancer teams: a systematic review. *Ann Surg Onc* 2011, 18:2116-2125. [↑](#endnote-ref-8)
9. Department of Health and Human Services 2018, *Victorian cancer multidisciplinary team meeting quality framework*, State Government of Victoria, Melbourne, p. 39. [↑](#endnote-ref-9)
10. Lamb BW, Taylor C, Lamb JN, Strickland SL, Vincent C, Green JSA, Sevdalis N 2013, Facilitators and barriers to teamworking and patient centeredness in multidisciplinary cancer teams: findings from a national study. *Annals of Surgical Oncology*; 20:1408–1416. [↑](#endnote-ref-10)
11. Cockburn T, Madden B 2015, Questions about multidisciplinary teams. *Precedent*; 127:12–17. [↑](#endnote-ref-11)