Multidisciplinary team meetings in Victoria

Monitoring progress towards achieving best practice cancer care

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Acknowledgements

We would like to thank the Victorian Integrated Cancer Services and their secretariats for completing the multidisciplinary team (MDT) surveys, and the MDT meeting chairs for providing details of MDTs in Victoria.
Message from the Chief Cancer Advisor

This report, *Multidisciplinary teams in Victoria: Monitoring progress towards achieving best practice cancer care 2010–11* describes statewide, self-reported information on the status of multidisciplinary team meetings in Victoria as we continue to work towards achieving best practice cancer care for Victorian cancer patients.

It is pleasing to note that we are making good progress in our efforts in linking cancer services and promoting effective collaboration across and between Integrated Cancer Services, health services and tumour stream groups. More patients with a new cancer diagnosis are being referred appropriately for prospective, evidence-based multidisciplinary discussion. More meetings have tools and templates available to support their function. I am pleased to see that most of our multidisciplinary team meetings now communicate treatment recommendations to general practitioners, who are an essential member of the patient’s multidisciplinary team.

While we recognise that certain barriers exist in implementing service improvement and reducing variation across the state, the report does identify important areas for ongoing review and development including the availability of cancer staging information, multidisciplinary team software requirements and effective data collection.

Overall, there is good evidence to suggest improved progress in comparison with previous survey evaluations, and Victoria continues to lead the way in the establishment of strategies to drive policy implementation through well-established and supported clinical cancer networks. Evaluations such as this play an important role in how we focus on those areas requiring further improvement while celebrating the success of our integrated efforts.

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Executive summary

Introduction

The Victorian Government is committed to improving multidisciplinary care for all Victorian cancer patients. Efforts focus on improving the effectiveness of teams, establishing and strengthening multidisciplinary team (MDT) meetings and building effective linkages across and between Integrated Cancer Services (ICS). The ICS and collaborating tumour groups provide the structure to drive change and deliver coordinated patient care across all geographical regions in Victoria.

Victoria’s Cancer Action Plan 2008–2011 (VCAP) includes an action to increase the number of patients assessed and treated by specialist MDTs across metropolitan and regional services.

Multidisciplinary care is considered a key component of best practice cancer care, and is essentially a team approach where health professionals work together to plan treatment and care for individual patients. Strategic directions for multidisciplinary care in Victoria are defined within the relevant policies such as Achieving best practice cancer care: a guide for implementing multidisciplinary care (Department of Human Services 2007).

The evaluation and measurement of progress in multidisciplinary cancer care assists in ensuring that improvement activities address strategic directions and supports progress towards achieving specific targets by identifying opportunities to improve and strengthen the future of multidisciplinary care in Victoria. A survey evaluation conducted in 2006 provided baseline information regarding MDT meetings and their processes in Victoria. Variations of this survey were then administered in 2008 and 2010–11 to monitor progress towards achieving best practice cancer care.

Methodology

The 2010–11 survey (see Appendix 2) was undertaken from August 2010 to April 2011 and involved:

- survey tool development incorporating a literature review and consultation with all ICS
- testing of the survey design and data collection method
- distribution of the survey tool and a covering email to each of the ICS requesting details regarding identified MDT meetings in their region
- ICS secretariats assisting in completing the surveys in consultation with MDT chairs
- submission of survey responses by ICS secretariats via Survey Monkey (an online survey tool)
- data cleaning and follow-up by phone and email where required
- analysis of survey data using Microsoft Excel
- circulation of the draft survey for review by ICS secretariats.

As the survey was administered by the ICS secretariats in their member health services, there is a significantly high proportion of public sector responses.

Overview of MDTs in Victoria

This report presents data (self-reported) regarding MDTs in Victoria. In 2010–11 there were 117 MDTs in Victoria, of which 100 (85 per cent) participated in the survey. There has been little change in the number of MDT meetings since the 2006 survey (116 MDT meetings) and the 2008 survey (119 MDT meetings); however, the number of tumour streams covered has increased.

The tumour streams with the largest increase in the number of MDT meetings since 2008 were upper gastrointestinal (with five new MDT meetings) and urology (with three new MDT meetings). The breast, colorectal, lung, upper gastrointestinal, and urology tumour streams had the highest number of MDT meetings, while new MDT meetings were established for endocrine and sarcoma tumour streams.

The largest number of MDT meetings occurred within Western and Central Melbourne ICS (39 meetings or 33 per cent of the total number of meetings in the state) and North Eastern Metropolitan ICS (27 meetings or 23 per cent). The majority of MDT meetings were held in metropolitan areas (84 meetings or 72 per cent).
and 15 new MDT meetings have been formed in these ICS since 2006.

The key areas reviewed and the findings of the survey are summarised below.

**Patient-centred clinical decision making**

**Patients discussed**

In 2010–11 aggregate survey results demonstrate that:

- 70 per cent of MDT meetings had developed documented criteria describing which patients should/can be presented for discussion.
- On average 62 per cent of patients were discussed prospectively at the time of MDT presentation.
- 64 per cent of patients discussed were newly diagnosed.
- 66 per cent of patients were presented once; 26 per cent of patients were presented two or more times.

**Referral processes**

In 2010–11 respondents reported that:

- 81 per cent of MDT meetings had documented processes and protocols in place for referring patients to MDT meetings.
- 41 per cent of patients referred from other health services had their treatment recommendations communicated back to the referring organisation.
- 50 per cent of the MDT meetings sampled had a procedure for identifying patients who required a referral to local support services outside of the geographical location of the treating organisation.

**Consent**

In 2010–11 respondents reported that:

- 53 per cent of MDT meetings had consent and/or privacy policies in place specifically for the purpose of presenting the patient for discussion at the meeting.
- 29 per cent of MDT meetings documented consent in the patient’s medical record.
- 82 per cent of MDT meetings provided verbal information to patients, compared with 42 per cent in 2006 and 45 per cent in 2008.

- 33 per cent of MDT meetings provided written MDT meeting information, compared with 16 per cent in 2008.
- 29 per cent of MDT meetings sought patient consent prior to their case being discussed compared with 24 per cent in 2006 and 2008.
- 36 per cent of MDT meetings recorded patient consent as part of MDT documentation.

**Clinical decision-making processes**

In 2010–11 respondents reported that:

- 48 per cent of MDT meetings had in place and applied clinical practice guidelines and/or evidence-based treatment protocols relevant to the diagnosis, treatment and supportive care of cancer patients.
- 52 per cent of MDT meetings had patient staging information routinely available and documented during the MDT meeting.
- A TNM staging system was used in 70 per cent of MDT meetings.
- Patients with psycho-oncology needs were routinely identified and referred for assessment in 30 per cent of MDT meetings.
- Patients with physical, social, spiritual and information needs were routinely identified and referred for supportive care assessment in 32 per cent of MDT meetings.
- 67 per cent of eligible patients were considered for current clinical trials as part of the meeting discussion.
- 89 per cent of MDTs in Victoria documented patient treatment recommendations in the patient’s medical record. In 77 per cent of responses, the presenting lead clinician was responsible for communicating recommendations from the MDT meeting to the patient.
- 93 per cent of MDT meetings communicated treatment recommendations to the patient’s general practitioner (GP), compared with 85 per cent in 2008 and 62 per cent in 2006. It was seen to be the responsibility of the lead clinician to communicate recommendations to the GP, with letter identified as the preferred method of communication.
The multidisciplinary team

The actual member composition of MDT meetings varies for each tumour stream (Department of Human Services 2006b). In 2010–11 team membership data was collected to identify the defined core members (from a list of disciplines) who attended the MDT meeting at least 75 per cent of the time.

Four disciplines (excluding GPs) are considered as core multidisciplinary members in all tumour streams. The survey findings demonstrated the following attendance rates for these four disciplines: medical oncologists, 92 per cent; radiation oncologists, 89 per cent; nurse coordinators, 63 per cent; and social workers, 29 per cent. For other disciplines listed as core members in a number of tumour streams, the follow attendance rates applied for these disciplines: surgeons, 95 per cent; pathologists, 94 per cent; radiologists, 90 per cent; respiratory physicians, 85 per cent; pharmacists, 36 per cent; and non-nursing palliative care, 27 per cent. For the two allied health disciplines listed as core members in a limited number of tumour streams, the attendance rates for these disciplines were: speech pathologists, 100 per cent; and dietitians, 32 per cent.

Fifty-three per cent of MDT meetings were cancelled between one and three times per year, with a lack of core members cited as the major reason for meeting cancellations.

Meeting organisation and logistics

Templates and tools

In 2010–11, the use of templates or tools, such as an agenda and treatment plan, to support MDT meetings increased to 91 per cent from 36 per cent in 2006. Half of the MDT meetings sampled have their terms of reference, templates or tools reviewed and updated on an annual basis.

Frequency and duration

In 2010–11, 45 per cent of MDT meetings sampled conducted meetings at least once a week, while 36 per cent conducted meetings once a fortnight. The average duration of MDT meetings was 67 minutes and members were likely to spend an average of eight minutes discussing each patient. Of the MDT meetings sampled, 61 per cent reported linkages within and/or across ICS. Of these, 11 per cent of linkages were external to ICS while 50 per cent of linkages occurred within ICS. Links/referral pathways across MDT meetings, ICS and/or cancer services were established via an informal agreement (60 per cent) or based on a previous working relationship with service/staff (65 per cent).

MDT support

In 2010–11, ICS-funded staff attended 48 per cent of MDT meetings in Victoria at least 75 per cent of the time, though their role in the MDT meetings varied. Health service administration staff were reported to attend 30 per cent of MDT meetings. Organisational arrangements to facilitate Medicare Benefit Scheme (MBS) billing were in place in only one MDT meeting.

Meeting infrastructure

Equipment and facilities

Almost all meetings in 2010–11 were conducted face to face (99 per cent), which has increased from 88 per cent in 2008. There was also an increase in the proportion of MDT meetings having a combination of teleconferencing and videoconferencing facilities available; however, these were only in use in 11 per cent and 13 per cent of MDT meetings respectively. Regional MDT meetings are likely to conduct meetings using this technology (97 per cent versus 69 per cent). Of the MDT meetings sampled in 2010–11:

- 91 per cent had a computer linked to the organisation’s network
- 75 per cent had a dedicated room/venue to conduct the MDT meeting
- 56 per cent were using meeting management software
- Only 10 meetings indicated that software was linked to the organisation’s patient information management system
- Word processing and spreadsheet applications were commonly used tools in MDT meetings, though were not considered to be ‘meeting management’ software.

Data collection

In 2010–11, the data and statistics most commonly recorded by MDT meetings were cancer diagnosis, the lead clinician, clinical and
histological cancer staging, and the team members present at each meeting.

**Recommendations**

The following recommendations are made to help drive improvements in the delivery of multidisciplinary care and apply across the state and to all ICS.

**Characteristics of cancer service MDTs in Victoria**

- Further development of MDT meetings may be required for particular tumour streams and regions with a low number of meetings and/or limited capacity compared with Victorian cancer incidence.

**Patient-centred clinical decision making**

- An increase in proportion of cancer patients presented prospectively for MDT meeting discussion and treatment recommendations is required. This may require criteria for prioritising patient presentation at an MDT meeting, and changes in the frequency and/or length of the meeting to promote prospective discussion.
- Further development of clinical handover processes are required to ensure MDT meeting treatment recommendations are communicated to the patient’s GP and/or referring health service. This may promote enhanced care coordination and patient safety.
- Further improvement is required to increase the documentation of patient consent across the state and address legal best practice requirements.
- Further development of processes to support the use of clinical practice guidelines and/or evidence-based treatment protocols is required to ensure appropriate decision making. One example supported by the Cancer Clinical Network is the use of eviQ Cancer Treatments Online, which is available at <www.eviq.org.au>.
- An increase in the availability of staging information is required to support appropriate multidisciplinary treatment decision-making. Staging is the cornerstone of treatment planning.
- Supportive care needs impact on the compliance with and outcomes of cancer treatment. Further improvement is required to increase relevant supportive care professional attendance and contribution to MDT meeting discussion.

**The multidisciplinary team**

- An increase in the attendance of core members relevant to each tumour stream may be required. Improvement in membership participation is required across all disciplines including diagnostic services, nursing and allied health.

**Meeting organisation and logistics**

- Further development of effective linkages among health service MDT meetings and ICS should promote specialist multidisciplinary treatment planning for regional patients, offer valuable peer support, promote efficiency, and build capacity among the MDT.
- A review of the Victorian *Multidisciplinary meeting toolkit* resource should be undertaken to enhance MDT meeting resources, templates and tools.
- Health services should give more consideration to available MBS funding for MDT meetings.

**Meeting infrastructure**

- Further consideration should be given to the implementation of ‘meeting management’ software across MDT meetings. In particular metropolitan ICS should promote the implementation of meeting management software in member organisations. The use of software can promote efficiencies such as rapid documentation of a treatment recommendation plan and/or integration in the patient’s medical record. Software also promotes the collection of a standardised high-quality clinical dataset.
- A multidisciplinary dataset should be established to promote consistent data collection for use in monitoring and benchmarking cancer service performance. Collecting cancer patient data could align with existing cancer registries and reporting of cancer clinical indicators.

It is also recommended that future evaluation of MDT practice include the private sector.
Conclusion

The 2010–11 Victorian MDT meeting evaluation was based on 100 survey questionnaires completed by the ICS secretariats in consultation with the chair of the MDT meeting. The evaluation provides evidence to suggest improved progress in comparison to previous survey evaluations and in achieving the strategic directions outlined in policies and VCAP. It is recognised that the ICS secretariats, member health services and tumour groups have implemented strategies to drive improvements in multidisciplinary cancer care across all geographical regions in Victoria. The most significant achievements have been:

• the increase in availability of tools and templates that assist meeting functioning
• the increase of newly diagnosed cancer patients being appropriately referred for prospective MDT discussion
• the increase in establishing effective links across and between ICS
• the increase in the proportion of MDT meetings that communicate treatment recommendations to the patient’s GP.

The ongoing evaluation and monitoring of multidisciplinary care in Victoria helps identify achievements against the policy framework, strategic directions, peer guidelines, and the VCAP multidisciplinary care action and target. The 2010–11 survey has also provided an opportunity to investigate characteristics of multidisciplinary care that have not previously been considered.

Statewide evaluation assists to identify achievements across the cancer service system, ICS and health services. The survey also identifies barriers to service improvement implementation and highlights variation across the state. The 2010–11 survey findings help inform local and statewide improvement activities. Regular local review of MDT meetings, processes and their impact will further strengthen the quality of multidisciplinary care in Victoria.
1. Introduction

1.1 Purpose

The purpose of this report is to provide statewide (self-reported) information on the status of multidisciplinary team (MDT) meetings in Victoria during 2010–11, to evaluate meetings against a range of policy criteria, and to provide direction for areas that may require further improvement.

Cancer care is complex and requires the involvement and careful coordination of multiple disciplines and treatment modalities. Multidisciplinary care is a key component of best practice cancer care, encompassing a collaborative, group decision-making approach that focuses on continuity of care through developing pathways and protocols for the treatment and care for each patient. This may also involve establishing appropriate referral networks, including appropriate referral pathways to meet psychosocial needs, and developing team protocols and guidance, including MDT meeting audit mechanisms (Department of Human Services 2006a). The patient management frameworks (PMFs) describe the ‘gold standard’ for multidisciplinary care as a team that meets regularly (whether in person or via teleconferencing) to prospectively plan care and treatment for all patients within a tumour stream (Department of Human Services 2006b).

The Victorian Government has set a target that states we will work to increase the number of newly diagnosed cancer patients that have a documented multidisciplinary care treatment plan by 20 per cent each year from 2009, with the aim of achieving 80 per cent documentation by 2012 (Department of Human Services 2008). In addition, the policy document Achieving best practice cancer care: a guide for implementing multidisciplinary care (Department of Human Services 2007) describes three strategic directions for multidisciplinary care care:

- creating and supporting effective MDTs
- establishing and strengthening multidisciplinary meetings
- building effective links across and between integrated cancer services (ICS) MDTs, that is, integrated multidisciplinary care.

1.2 Background

1.2.1 Cancer in Victoria

Cancer is a major burden of disease for the Victorian community. Each year in Victoria almost 28,000 people will develop cancer and more than 10,000 deaths per year are caused by it. Due to the age-dependent nature of cancer, 57 per cent of tumours occur in those aged over 65 years. In 2009 more men than women developed cancer (134 males for every 100 females).

Cancers of the prostate (35 per cent), bowel, (12 per cent), lung (nine per cent) and melanoma (eight per cent) accounted for the majority of new cancers in males. In females, the most common sites were breast (27 per cent), bowel (13 per cent), melanoma (nine per cent) and lung (eight per cent).

In 2009, 10,397 people died from cancer (5,850 males and 4,547 females). The most common cause of cancer deaths were lung cancer (19 per cent), bowel cancer (13 per cent), prostate cancer (eight per cent) and breast cancer (seven per cent) (Cancer Council Victoria 2011).

1.2.2 Integrated Cancer Services

The provision of cancer services in Victoria has undergone major reform in accordance with A cancer services framework for Victoria (Department of Human Services 2003), which recommended that tumour streams be developed to provide collaborative approaches to care and service improvement between consumers and health professionals and to reduce unwanted variations in practice. An integrated service model for metropolitan and rural cancer services through the formation of ICS provides established
formal partnerships between health services for the purpose of planning and service improvement across a specific geographic area to ensure consumer access to high-quality integrated care.

There are eight ICS in Victoria based on geographic regions: Barwon South Western (BSWRICS), Grampians (GICS), Gippsland (GRICS), Hume (HRICS), Loddon Mallee (LMICS), North Eastern Metropolitan (NEMICS), Southern Melbourne (SMICS), and Western and Central Melbourne (WCMICS). The Paediatric Integrated Cancer Service (PICS) constitutes a separate statewide ICS, bringing the total number of ICS in Victoria to nine. A listing of each of the health services per ICS is provided as Appendix 1.

1.2.3 Multidisciplinary care

The research literature suggests that cancer patients who are managed by multidisciplinary care teams may receive better treatment planning, live longer, enjoy better quality of life during treatment, receive services more efficiently (Studdert 2008) and have increased opportunities to participate in clinical trials (Grusenmeyer et al. 2006). Consumers/patients who experience multidisciplinary care should be aware that care is managed in this manner and provide consent for their case to be discussed. They should also understand the process, know they will be informed about the treatment and care recommendations and be involved in decision making (Department of Human Services 2007). It is also recognised that rural and private hospitals may face barriers to multidisciplinary care that urban and public settings do not.

1.2.4 Multidisciplinary team meetings

The Multidisciplinary meeting toolkit (Department of Human Services 2006a) defines MDT meetings as a regularly scheduled meeting of core and invited team members for the purpose of prospective treatment and care planning of newly diagnosed cancer patients, as well as those requiring review of treatment plans or palliative care. It is also recognised that retrospective case review is a valuable approach to multidisciplinary learning. Review and audit of outcomes of prospectively planned treatment and care is valuable.

The objectives of MDT meetings are:

• to provide an opportunity for MDT discussion of all newly diagnosed and review cases of cancer within an appropriate timeframe to facilitate effective treatment planning
• to determine, in light of all available information and with reference to the evidence base, the most appropriate treatment plan for each individual patient
• to provide educational opportunities for team members and trainees
• to provide peer support to team members.
1.3 Monitoring progress towards achieving best practice cancer care

1.3.1 Baseline

Strategic directions for multidisciplinary cancer care in Victoria are defined within the relevant policies. In 2006 an MDT meeting survey was completed by each ICS secretariat to provide baseline information about the number of MDTs, their composition, meeting frequency, processes and protocols. This work was partly driven by Victoria’s participation in a national multidisciplinary care study conducted by the National Breast and Ovarian Cancer Centre (NBOCC). In 2007 the ICS also began to provide information about MDT processes through local medical record audit.

1.3.2 Evaluations

The second multidisciplinary survey completed by each ICS in 2008 aimed to collect data about MDT meetings in Victoria two years after the initial survey and 18 months after the introduction of the multidisciplinary policy. The survey repeated the questions asked in the 2006 multidisciplinary survey and additional questions sought information about communication, referral and treatment protocols.

The information provided by the ICS has enabled measurement of the change in the number of MDTs across tumour streams, MDT membership, team linkages and team processes against the relevant policies. The recommendations from the 2008 evaluation were to action the following.

1. Improve documentation in the shared patient medical record to:
   - document patient consent for an MDT to discuss their case
   - ensure appropriate communication of multidisciplinary recommendations between team members.

2. Improve access to multidisciplinary care and the appropriate team by:
   - increasing access (number of meetings, length of meetings) for cancer patients to MDT meetings and, where possible, adjust the frequency of meetings to enable prospective treatment and care planning
   - increasing links between MDTs, especially between regional/rural and metropolitan health services and ICS
   - increasing representation by general practitioners (GPs) at MDT meetings, either in person or via information and communication technology

- Release of Victoria’s Cancer Action Plan (VCAP) – the first state in Australia to set measurable targets and milestones across the cancer control spectrum
- Release of policy documents Achieving best practice cancer care: A guide for implementing multidisciplinary care and Clinical Excellence in Cancer Care
- Release of Patient Management Frameworks and the Multidisciplinary Meeting Toolkit
- Baseline evaluation regarding the number of multidisciplinary team meetings in Victoria, their processes, composition of each team, meeting frequency, prospective multidisciplinary discussion and development of team protocols
- Collaboration with NBOCC as part of a national approach in developing a multidisciplinary toolkit
- Implementation of the Cancer Services Framework and establishment of nine Integrated Cancer Services to lead cancer reform
- Victoria’s cancer reform program established following release of a Cancer Services Framework for Victoria. Establishment of a Ministerial Taskforce for Cancer to develop priorities for implementation
• ensuring representation by appropriate supportive care health practitioners at multidisciplinary meetings.

3. Improve MDT processes by:
   • developing MDT meeting protocols to support team processes and functioning.

In 2010–11 a third survey (see Appendix 2) was distributed to continue to evaluate and measure progress in MDT meetings within the ICS and across the state. The MDT meeting survey aimed to collect responses from all MDT meetings that occurred across Victoria to:
   • assess Victorian cancer MDT meeting processes against the strategic directions set out in the relevant policy documents
   • provide process information to inform enablers for achieving progress against the VCAP target
   • identify opportunities to improve and strengthen MDT meetings in the future.

1.4 Context

Victoria’s model for multidisciplinary care incorporates the structures established to drive change (the ICS and tumour groups) and the models that describe the requirements for optimal delivery of care that is safe, of high quality and consistent with best practice (Department of Human Services 2006a). The following list outlines a number of policies, reviews and evaluations that apply to enhance the strategic directions for multidisciplinary cancer care in Victoria:
   • previous evaluations in 2006 and 2008 regarding MDT meetings in Victoria
   • Cancer Australia’s 2011 MDT project, which included a literature review and national survey evaluation
   • a 2010 cancer service performance indicators report
   • the Victorian multidisciplinary care policy and toolkit update.

1.5 Methodology

Data collection

Information on MDT meetings occurring in Victoria was captured in a cross-sectional, self-report survey consisting of 44 items (42 questions). These items were based on the multidisciplinary care policy, the 2006 and 2008 surveys, a review of available literature including the UK’s National Health Service guidelines, consultation with the ICS, and consultation with the Cancer Institute of NSW. The survey and data collection method were tested with one ICS. The survey and a covering email were then distributed in August 2010 to the ICS to complete for each of the identified meetings in their region. ICS secretariats assisted in completing the surveys in consultation with the chairs of MDT meetings. The chairs were required to approve and sign off on the completed surveys. Surveys were then submitted to the department by the ICS secretariats via Survey Monkey. The data was summarised and analysed with Microsoft Excel. The ICS were given nine months to complete the survey.

MDT definition and response rate

Respondents were asked to include MDT treatment decision meetings. These are defined by the Multidisciplinary meeting toolkit as a deliberate, regular, face-to-face (or videoconference) meeting involving a range of health professionals with expertise in the diagnosis and management of cancer with the purpose of facilitating best practice management of all patients with cancer (Department of Human Services 2006a). ICS secretariats submitted data for 100 MDT meetings. The ICS identified 117 known MDT meetings in existence in Victoria (a response rate of 85 per cent).

Tumour stream definition

As some MDT meetings may focus on more than one tumour stream, where two tumour streams were discussed in one meeting these have been represented as two separate tumour streams in the analysis (for example, an MDT meeting that includes both upper gastrointestinal and colorectal patients was split). The exception to this is hepatobiliary and upper gastrointestinal, which are included in the upper gastrointestinal tumour stream. It should also be noted that early breast cancer and advanced breast
cancer MDT meetings have been included under the breast tumour stream, and lymphoma has been included under haematology. In situations where three or more tumour streams were discussed in one MDT meeting, these have been represented as a general cancer tumour stream MDT meeting.

Using this methodology the 2010–11 survey sample therefore included 104 MDT tumour stream responses from the ICS identified population of 121 MDT tumour streams. The same methodology applied to the 2006 and 2008 data to further facilitate an accurate comparison of tumour stream meetings. Adolescent and young adult, as well as long-term follow-up MDT meetings are classified under the general tumour stream as they may cover a range of tumour types.

1.6 Data cleaning

Data cleaning for respondent errors and omissions was conducted prior to analysis. A noticeable limitation to the data collection method was the ability for entries to be submitted without being completed. As such, there were several instances where duplicate data was submitted for the same MDT meeting. The ICS secretariats or meeting chair were contacted to clarify any duplicate data issues or other instances where clarification was required to ensure that only one response was collected per MDT. A limitation of the survey tool design was that the option of choosing ‘not applicable’ was not available in instances where a negative response was stated in a previous and related question. The data screening process was used to overcome any discrepancies and values were altered where necessary.

Questions 24–27 asked respondents to comment on the number of patients who were discussed on the MDT meeting agenda for the last five MDT meetings. Analyses of these data revealed that missing or inconsistent data ranged from 12 per cent to 20 per cent; however, this has not affected the overall analyses because responses were omitted where values were missing.

1.7 Report Outline

This report will first review the characteristics of cancer service MDT meetings in Victoria, followed by a review of patient-centred clinical decision-making processes, the composition of the MDT, and meeting organisation and logistics. The report will conclude with a summary of the main findings, and provide key recommendations for consideration.
2. Characteristics of cancer service MDTs in Victoria

2.1 Overview of MDT meetings in Victoria

Figure 1 provides an overview of the changes in MDT meetings from 2006 to 2010–11. The total number of MDT meetings in Victoria increased from 116 in 2006 (of which 99 participated in the survey) to 119 in 2008 (of which 102 participated in the survey), and then decreased to 117 in 2010–11 (of which 100 participated in the survey). The response rate for all three surveys was consistently high at approximately 85 per cent across all surveys. It should be noted that the majority of analyses conducted throughout this report are based on the results of the submitted survey responses in 2010–11 unless otherwise stated.

Figure 1: Number of MDT meetings in Victoria, 2006, 2008 and 2010–11

2.2 Number of MDT meetings in Victoria by tumour stream

Between 2008 and 2010–11 the ICS introduced new MDT meetings for additional tumour streams. In particular, new MDT meetings were established for the endocrine and sarcoma tumour streams. There was a small decline in tumour stream MDT meetings within some ICS. This may be attributed to previous surveys including data on MDT meetings that did not meet the MDT meeting definition in the policy. Caution is recommended when comparing the number of MDT meetings with previous years.

The breast and upper gastrointestinal tumour streams had the largest number of identified MDT meetings in 2010–11 (n = 17). This was followed by genitourinary, lung and colorectal tumour streams, with 14 MDT meetings each. The tumour streams with the smallest number of MDT meetings were skin/melanoma (n = 3) and sarcoma (n = 1).

The most significant increase in the number of MDT meetings since 2008 has occurred in the upper gastrointestinal tumour stream, which includes five hepatobiliary-specific MDT meetings. The only other tumour stream meetings to increase over this time have been the genitourinary tumour stream (from 11 in 2008 to 14 in 2010–11), gynaecology tumour stream (from 5 in 2008 to 7 in 2010–11) and the lung tumour stream (from 13 in 2008 to 14 in 2010–11). The most significant decrease in the number of MDT meetings has occurred within the paediatric tumour stream (from 10 in 2008 to five in 2010–11) and breast tumour stream (from 20 in 2008 to 17 in 2010–11).
In 2010–11 only those paediatric meetings that were considered true multidisciplinary medical treatment decision meetings (as per the policy definition) are included. In previous surveys, the paediatric stream included multidisciplinary transplant planning and psychosocial discussion meetings. Therefore there is a noted decrease in the number of paediatric meetings included in this current survey.

The remaining tumour streams have experienced a slight decline in the number of MDT meetings, with the exception of colorectal, which has remained at 14. The decline in the number of general tumour stream meetings is to be expected with the increase in more tumour-specific MDT meetings.

Figure 2: Number of MDT meetings identified by ICS in Victoria, by tumour stream

Base: 2006: 119 tumour stream meetings; 2008: 124 tumour stream meetings; 2010–11: 121 tumour stream meetings. *The combined breast/colorectal MDT meeting and three combined GI/colorectal MDT meetings have been separated for analysis

2.3 Number of MDT meetings in Victoria by ICS

Of all the individual ICS, WCMICS had the most MDT meetings in 2010–11 (with 39 meetings, representing 33 per cent of the state total), followed by NEMICS (with 27 meetings, representing 23 per cent of the total). As would be expected given Victoria’s population and cancer service distribution, the regional ICS had fewer MDT meetings, and regional MDT meetings often covered multiple tumour streams.

Between 2008 and 2010–11, seven new MDT meetings were formed in the NEMICS area, as well as three within WCMICS. SMICS had the largest decrease in MDT meetings over this time. The majority of MDT meetings operated in metropolitan areas (84 meetings in 2010–11, representing 72 per cent of the total). Between 2006 and 2010–11, 15 new MDT meetings were formed in metropolitan areas. Over the same time period there has been a decrease of six MDT meetings in regional areas. While regional ICS may not cover all tumour streams, progress has been made in terms of the number of cases discussed and tumour stream coverage. Figure 3 shows the total number of MDT meetings occurring in each ICS in Victoria in 2006, 2008 and 2010–11. Caution is recommended when interpreting this graph as it does not reflect the number of tumour streams per meeting or meeting frequency.
Figure 3: Number of MDT meetings in Victoria by ICS, 2006, 2008 and 2010–11

2.4 Number of MDT meetings in Victoria versus incidence of new cancer cases

Figure 4 compares the number of MDT meetings in Victoria in each tumour stream with the incidence of new cancer diagnoses in Victoria within the same tumour stream. The data presents the actual number of new cancer cases for 2008 (Cancer Council Victoria 2011) as it enables comparison of the 2008 survey results. As the endocrine and sarcoma tumour streams did not have an MDT meeting in 2008, they have been excluded from Figure 4. While the number of MDT meetings may not be an ideal measure of MDT availability, the estimated number of cases discussed in MDT meetings was not collected in the 2008 survey, hence this analysis is the most appropriate. Data for 2010–11 is not similarly presented because cancer incidence data for this period is not yet available.
3. Patient-centred clinical decision making

3.1 Who to discuss?
MDT protocols provide support and systems for MDT members and may include MDT meeting protocols, communication protocols, referral protocols and treatment protocols. In 2010–11 respondents were asked to identify whether the MDT meeting had developed documented criteria describing which patients should/could be presented for discussion at the MDT meeting. Reported results state that 70 per cent of MDT meetings had developed documented criteria. Where respondents indicated no for this response, respondent comments indicate that policies did exist or there were clear and straightforward guidelines for discussing patients, such as clinicians being able to refer any patient at any time for discussion, with the aim to discuss all new diagnoses and interesting or complex cases. The process required in implementing documented criteria was recognised in the survey as sometimes difficult and time intensive. Results may need to be verified in future reviews in order to develop an updated multidisciplinary toolkit resource to enhance consensus-based decision making in MDT meetings. It should be noted that some tumour stream numbers are small, including the recently established tumour streams meetings such as endocrine and sarcoma, and may be at a different stage of maturation.

Figure 5: MDT meetings with developed documented criteria for patient presentation, by ICS

Base: 2010–11: 100 MDT meetings

Figure 6: MDT meetings with developed documented criteria for patient presentation, by tumour stream

Base: 2010–11: 104 MDT tumour group responses. *The combined breast/colorectal meeting and three combined GI/colorectal meetings, have been separated for analysis
3.2 Patient characteristics

The 2010–11 survey provided a new and interesting opportunity to gather information regarding the characteristics of patients discussed in MDT meetings throughout Victoria. This is the first time this set of questions has been included in the MDT meeting surveys. Respondents were requested to review MDT meeting agendas from the last five consecutive MDT meetings and then answer questions specific to: the current stage of patient treatment; the stage of the patient’s disease at presentation; and the frequency of presentation of the patient’s case at the MDT meeting. Analyses of the data revealed that missing or inconsistent data ranged from 12 per cent to 20 per cent, and responses have been omitted where values were missing. Accordingly, the denominator/number of MDT meetings sampled varies.

While the data provides a good indication of what is occurring at a statewide level, caution is recommended when interpreting the results as some of the figures are estimates only and in some tumour streams the numbers may be small. Furthermore, interpretation of response definitions may have varied by those completing the survey. It should be noted that only two PICS meetings have been included in the analysis due to the reported difficulty in obtaining data and the variation in how patients are discussed compared with other tumour streams.

While some ICS experienced no barriers to data collection, other ICS indicated that gathering information on patient characteristics required too much work to go back and review MDT meeting agendas, and the information requested was not specifically and/or consistently recorded nor easily identifiable simply from a meeting agenda. However, 91 per cent of MDT meetings reported the use of templates and tools to support their meeting. If data was not readily available as reported, then this suggests that some MDT meetings may benefit from reviewing their meeting templates and tools. Other survey responses also indicated that clinician time and/or limited access to information was a significant barrier to data collection.

3.2.1 Treatment discussion

It is expected that MDT meetings discuss patients prospectively prior to commencing treatment. Figure 7 shows the timing of patient treatment discussion at MDT meetings by statewide, regional and metropolitan ICS. Aggregate results show that 62 per cent of patients throughout Victoria are discussed prospectively in MDT meetings compared with retrospective discussion (32 per cent). The results may reflect a higher volume of patients being treated, core staff available to attend the MDT discussion, or the frequency of meetings. Regional ICS may also benefit from reviewing MDT templates and tools due to the large percentage of patients presenting for MDT discussion when their treatment stage is unknown.

Figure 7: Percentage of patients discussed in MDT meetings in 2010–11, by treatment discussion

Base: 2010–11: 89 MDT meetings; n = 3,822
3.2.2 Disease at presentation

Figure 8 shows the disease stage of patients presented for discussion in MDT meetings by statewide, regional and metropolitan ICS. Aggregate results show that 64 per cent of the total numbers of patients discussed were newly diagnosed in comparison with patients who had disease progression (15 per cent). The percentage of newly diagnosed cancer patients discussed by an MDT meeting will continue to be closely monitored. The percentage of newly diagnosed patients discussed by tumour stream is attached as Appendix 3. Again, self-reported results indicate that a large percentage of patients presenting for MDT discussion in the regional ICS have an unknown disease stage.

Figure 8: Percentage of patients discussed in MDT meetings in 2010–11, by disease at presentation

Base: 2010–1: 88 MDT meetings; n = 3,707

3.2.3 Frequency of presentation at MDT meeting

Figure 9 shows the number of times a patient was presented based on the agendas from the preceding five meetings audited by statewide, regional and metropolitan ICS. Aggregate results show that 66 per cent of patients were discussed once compared with 18 per cent who were discussed twice and eight per cent who were discussed three or more times. Patients presented three times or greater were more commonly from a metropolitan ICS, with the majority belonging to the breast tumour stream (34 per cent). While multiple patient presentations at meetings may be appropriate for some complex cases, ICS are encouraged to look at the underlying reasons regarding frequency of patient presentation through local clinical audit.

Figure 9: Frequency of patient presentation at MDT meetings, 2010–11

Base: 2010–11: 80 MDT meetings; n = 3,224
3.3 Referral processes

In 2010–11, 81 per cent of MDT meetings reported that documented processes and protocols were in place for referring patients to MDT meetings, and nine per cent of MDT meetings had processes and protocols currently in development. This has been a significant improvement since 2008 in which only 49 per cent of MDT meetings had referral protocols in place, while 32 per cent were in the process of developing them. The MDT meetings that did not have documented processes and protocols in place in 2010–11 were in the metropolitan ICS and PICS and may relate to the higher proportion of ICS-funded staff within the regional ICS involved with MDT meetings. It may also relate to the fact that the metropolitan and PICS MDT meetings were already in existence and processes and protocols are more difficult to implement in existing practice and culture compared with introducing a new practice. Respondent comments indicate that in some instances internally recognised procedures did exist for the referral of patients; however, these are not formally documented.

Figure 10: Percentage of MDT meetings that have documented processes and protocols in place in 2010–11, by tumour stream

![Figure 10](image)

*Base: 2010–11: 104 MDT tumour group responses. *The combined breast/colorectal meeting and three combined GI/colorectal meetings have been separated for analysis.

3.3.1 Referrals from other health services

If the patient was referred from another health service (such as regional or metro), respondents were asked to indicate whether treatment recommendations are communicated to the patient’s referring health service treatment organisation. Reported results state that treatment recommendations were communicated in 41 per cent of MDT meetings. Respondent comments indicate that this occurred inconsistently and remains the responsibility of the lead clinician. This suggests that the links between referral (from other health services) requirements and the tools, policies and processes used to support the MDT meetings could benefit from a more formalised and systematised approach.

3.3.2 Referrals to local support services outside the geographical location of the treatment organisation

In 2010–11 respondents were asked to indicate whether there is a procedure at the MDT meeting for identifying patients who need a referral to local support services outside of the geographical location of the treatment organisation (closer to the patient’s home). Half of the meetings (50 per cent) responded that there was a procedure for this in place. It is recognised that needs will be dependent on the patient’s...
usual place of residence or their treatment service and that this will vary across tumour streams due to either local access to the MDT meeting or linkages elsewhere. Survey comments indicate that referral to local support services occurred as appropriate, though in most instances without any formalised procedures in place. Regional patients were generally identified on the MDT meeting agenda or at clinician request. In some of the MDT meetings, the liaison nurse/nurse coordinator was responsible for referring patients, and in other instances this occurred at the time of discharge from the inpatient setting.

Figure 11: Percentage of MDT meetings that communicate treatment recommendations to relevant health services in 2010–11, by ICS

3.4 Patient consent

It is important for cancer patients to understand the MDT meeting process. Informed consent means that the patient understands the purpose of the MDT meeting, the different clinicians who may be present at the meeting and what information about their medical history will be disclosed at the meeting. Patients often have more confidence in their treatment if they know a range of health professionals were involved in its planning.

Legal advice sought by the Department of Health regarding patient consent in MDT meeting discussion recommends that patients be provided with a generic information sheet about the MDT meeting before they provide consent to their case being discussed at the meeting. The patient may then provide written or verbal consent, which should be documented on the patient’s file. Alternatively, the patient may provide consent to the possible discussion of their case at an MDT meeting at the time of signing the general consent form (when they are first admitted to hospital for treatment). The consequences of a patient not providing informed consent to the discussion of their case at an MDT meeting is that their treating practitioner may be found to have breached the Health Records Act 2001 by unauthorised disclosure of a patient’s medical information, as well as exposing health services to corporate risk.

In 2010–11 respondents were asked whether the host organisation has a consent and/or privacy policy that includes MDT meeting discussion of patients, whether patients are provided with information about MDT meetings and consented prior to discussion, and whether patient consent is recorded as part of the MDT meeting documentation in the medical record. It should be noted that respondents were able to provide more than one response. Overall the results reported below indicate that further improvement is required to increase documentation of patient consent across the state.
Policy

- 53 per cent of ICS indicated their health organisation has a consent and/or privacy policy in place.
- Survey comments suggest that consent sometimes occurred as part of the hospital consent process or that verbal consent was requested from patients.
- Other MDT meetings had specific processes outlined in their terms of reference, or consent was sometimes left to individual clinicians.
- Some consent guidelines and privacy statements existed within ICS own guidelines, which had been accepted by the relevant health services.

Information

- In 2010–11, 82 per cent of MDTs provided patients with verbal information, compared with 42 per cent in 2006 and 45 per cent in 2008.
- In 2010–11, 33 per cent of MDTs provided written information, while only 29 per cent documented patient consent.
- In 2010–11, 29 per cent of MDT meetings sought patient consent prior to their cases being discussed, compared with 24 per cent in 2006 and 2008.
- In 2010–11, 28 per cent of host organisations did not have any consent or privacy policy in place.
- Survey comments indicate that the majority of MDT meetings see it as the lead clinician’s responsibility to provide information and obtain patient consent.
- In some MDT meetings it is noted that information is provided, but it is unclear how the information is distributed or if it is distributed at all.
- Some ICS have developed an information brochure that is available to patients together with a verbal explanation from the treating clinician.

Recording of patient consent

- In 2010–11, 36 per cent of MDT meetings recorded consent as part of MDT meeting documentation.
- Survey comments indicate that the consent process did not occur routinely in 2010–11. Again, it was seen as the lead clinician’s responsibility to obtain patient consent.
- Some versions of CANMAP meeting software have a field for patient consent, but it is unclear as to whether this gets completed or not for some MDT meetings.
- In two MDT meetings, clinicians were asked to identify patient consent and discussion as part of the process of adding a patient to the agenda for discussion.

Appendix 4 contains a series of graphs that further highlight survey responses by ICS and by tumour stream.

3.5 Clinical decision-making processes

3.5.1 Clinical practice guidelines and/or evidence-based treatment protocols

In 2010–11 respondents were asked to indicate whether the MDT has documented clinical practice guidelines and/or evidence-based treatment protocols relevant to the diagnosis, treatment and supportive care of cancer patients. Almost half (48 per cent) of MDT meetings self-reported that these were in place. Survey comments indicate that the majority of MDT meetings followed the appropriate national or college guidelines relevant to their tumour stream, or in some instances, were associated with the policies, practices and guidelines developed by the health service. One ICS in particular had clinical practice guidelines and evidence-based treatment protocols available in hardcopy at the MDT meeting, while in other ICS these were in development.
3.5.2 Staging information

In 2010–11 respondents were asked if staging information was routinely available and documented during the MDT meeting. Reported results state that 52 per cent of MDT meetings had patient staging information routinely available and documented, while 39 per cent reported that staging information was available and documented sometimes. Seven per cent responded that staging information was not available or documented. The remaining two per cent of responses were not applicable. These findings are consistent with the 2010 cancer service performance indicators, which showed a statewide result of 48 per cent of patients having documented evidence of disease staging in the MDT recommendations, which is below the target of 100 per cent introduced in 2010 and indicates that further improvement is required.

Survey responses indicate that the American Joint Committee on Cancer (AJCC) and International Union Against Cancer (UICC) TNM staging system has been agreed and is in use in 70 per cent of MDT
meetings in Victoria. Sixteen per cent of MDT meetings use a system other than the TNM staging system, such as the FIGO staging system in the gynaecology tumour stream and World Health Organization staging in the neurological tumour stream. The PICS is currently reviewing their staging systems; seven per cent of MDT meetings indicated that staging systems are not used or not applicable.

3.5.3 Psycho-oncology needs

In 2010–11 respondents were asked if patients with psycho-oncology needs are routinely identified and referred for assessment. Reported results state that patients with psycho-oncology needs were routinely identified and referred for assessment in 30 per cent of MDT meetings, while 42 per cent of MDT meetings reported that patients were sometimes identified and referred. Survey comments indicate that the liaison nurse or nurse coordinator generally facilitated referral of patients with psycho-oncology needs. In some instances, this was not directly associated with the MDT meeting but discussed with the appropriate staff member if deemed necessary. Other MDT meetings indicated that psycho-oncology needs were not a strong focus of discussion due to a lack of resources, time or inconsistent processes for identifying these patients. It should also be noted that the endocrine tumour stream and sarcoma tumour stream are new and in a different stage of maturation in MDT processes, which may account for the lower results.

Figure 14: Percentage of MDT meetings that routinely identify and refer patients with psycho-oncology needs in 2010–11, by tumour stream

![Graph showing percentage of MDT meetings that routinely identify and refer patients with psycho-oncology needs in 2010–11, by tumour stream.]

Base: 2010–11: 104 MDT tumour group responses. *The combined breast/colorectal meeting and three combined GI/colorectal meetings have been separated for analysis

3.5.4 Physical, social, spiritual and information needs

Respondents were asked whether patients with physical, social, spiritual or information needs are routinely identified and referred for supportive care assessment. Reported results state that, in 2010–11, these needs were routinely identified and referred in 32 per cent of MDT meetings, while 41 per cent reported these patients were sometimes identified and referred. Survey comments indicate that in some MDT meetings, patient’s needs were not addressed, while other MDT meetings indicate that screening tools were generally used to identify these patients with discussion occurring outside of the MDT meeting due to insufficient time to discuss specific needs of patients.
Figure 15: Percentage of MDT meetings that routinely identify and refer patients with physical, social, spiritual or information needs in 2010–11, by tumour stream

**Base:** 2010–11: 104 MDT tumour group responses. *The combined breast/colorectal meeting and three combined GI/colorectal meetings have been separated for analysis

### 3.5.5 Clinical trials

Respondents were requested to indicate whether eligible patients are considered for current clinical trials in MDT meetings. Sixty-seven per cent of stated responses were affirmative in 2010–11, while 26 per cent indicated that patients were considered sometimes. More than half (55 per cent) of those patients considered for current clinical trials were reported to be from metropolitan ICS.

Figure 16: The number of MDT meetings in which eligible patients are considered for current clinical trials in metropolitan and regional areas, 2010–11

**Base:** 2010–11: 100 MDT meetings
### 3.6 Treatment recommendations

In 2006 treatment recommendations were documented in 31 per cent of patients’ medical records. In 2008 this was shown to increase to 38 per cent. Self-reported results in 2010–11 reveal that 89 per cent of MDTs in Victoria documented patient treatment recommendations in the patient’s medical record. Though the procedure for this varies, the results show a significant reported improvement. Sixteen per cent of MDTs provided a notation in the patient’s medical record, 47 per cent of MDTs used a template to record the recommendations and then placed a copy in the patient’s medical record, 15 per cent used software that prints the recommendations, which was then placed in the patient medical record, and 11 per cent of MDTs used software that automatically uploads the recommendations to the patient’s medical record.

As in previous ICS medical record audits, the 2010 cancer service performance indicators results showed that documentation of MDT recommendations in the medical record are lower than that reported in the survey. The medical record audit conducted in 2010 shows an aggregate statewide result of 38 per cent, which is below the target of 40 per cent. The discrepancy may be a result of perceived practices of the MDT meeting members not matching actual practices, or a consequence of inefficient processes involved in filing the documented MDT treatment recommendations into the patient’s medical record. ICS are encouraged to investigate the discrepancies occurring at a local level to identify any issues and ensure that adequate processes are in place to facilitate the availability of treatment recommendations in the medical record.

**Figure 17: Documentation regarding treatment recommendations in the patient's medical record, 2010–11**

![Diagram showing documentation percentages for different regions and methods](image-url)
3.7 Communication

3.7.1 Communication to the patient

In 2010–11 respondents were asked to comment on who communicates the MDT meeting recommendations to the patient. It should be noted that respondents were able to provide more than one response. The majority of reported responses indicate that the presenting lead clinician (77 per cent) was generally responsible for communicating recommendations from the MDT meeting to the patient, followed by the surgeon (41 per cent), the medical oncologist (37 per cent) and the radiation oncologist (26 per cent). Survey comments also indicate that this task was also sometimes delegated to a nominated person, such as the nurse coordinator, registrar or other such person as appropriate.

Figure 18: Percentage of MDT members who communicate MDT recommendations to the patient in 2010–11, by ICS

Base: 2010–11: 104 MDT tumour stream responses. *The combined breast/colorectal meeting and three combined GI/colorectal meetings have separated for analysis
3.7.2 Communication to the general practitioner

In 2010–11 respondents were asked to indicate whether treatment recommendations are communicated to the GP following MDT meetings. Encouragingly, results indicate that only seven per cent of MDT meetings never communicated treatment recommendations to the general practitioner, compared with 15 per cent in 2008 and 38 per cent in 2006. Survey responses indicate that it is seen to be the responsibility of the lead clinician to communicate MDT recommendations to the patient’s general practitioner and this generally occurred only if the patient had been seen in the outpatient consulting clinic. This indicates that communication may not occur as a result of the MDT meeting but as part of the overall treatment process. Letter is the preferred method for communication to the general practitioner in 73 per cent of responses, which has increased from 57 per cent in 2008.

Figure 19: Percentage of MDT meetings that communicate treatment recommendations to the general practitioner in 2010–11, by ICS

![Figure 19: Percentage of MDT meetings that communicate treatment recommendations to the general practitioner in 2010–11, by ICS](image)

**Base:** 2010–11: 100 MDT meetings

Figure 20: Percentage of MDT meetings that communicate treatment recommendations to the general practitioner in 2010–11, by tumour stream

![Figure 20: Percentage of MDT meetings that communicate treatment recommendations to the general practitioner in 2010–11, by tumour stream](image)

**Base:** 2010–11: 104 tumour stream responses. *The combined breast/colorectal meeting and three combined GI/colorectal meetings have been separated for analysis*
4. The multidisciplinary team

4.1 Membership and attendance

In an MDT meeting, the discussion of treatment options and development of recommendations based upon evidence and best practice is dependent on attendance by the core MDT members for the relevant tumour streams. The actual member composition of MDT meetings may vary for each cancer type. In 2010–11 team membership data was collected by asking chairs to identify defined core members (by discipline) who regularly attended the MDT meeting (at least 75 per cent of the time). Responses to this question were then compared with a list of core disciplines for each tumour stream, adapted from those listed in the PMFs.

Four disciplines (excluding GPs) are considered as core multidisciplinary members in all tumour streams. The survey findings demonstrate the following attendance rates for these four disciplines: medical oncologists, 92 per cent; radiation oncologists, 89 per cent; nurse coordinators, 63 per cent; and social workers, 29 per cent. For other disciplines listed as core members in a number of tumour streams, the attendance rates for these disciplines were: surgeons, 95 per cent; pathologists, 94 per cent; radiologists, 90 per cent; respiratory physicians, 85 per cent; pharmacists, 36 per cent; and non-nursing palliative care, 27 per cent. For the two allied health disciplines listed as core members in a limited number of tumour streams, the attendance rates for these disciplines were: speech pathologists, 100 per cent; and dietitians, 32 per cent.

Respondents reported that more than half (53 per cent) of MDT meetings in 2010–11 were cancelled between one and three times, and 13 per cent were cancelled four to seven times. The majority of meetings were cancelled due to a lack of core members, or due to conference leave or other professional development leave, indicating core members were not available to attend the MDT meeting.

The data suggests that MDT meetings should review their core membership and attendance records to ensure adequate representation from the recommended team members across all disciplines, in particular supportive care professionals. Health services should have support recommendations in place to cover planned (and where possible unplanned) absences so that appropriate cover can be organised if possible.

Figure 21: Proportion of MDT meetings within each tumour stream that involved core members in their MDT, 2010–11

Base: 2010–11: 104 MDT tumour group responses
5. Meeting organisation and logistics

5.1 Templates and tools

The use of templates or tools, such as an agenda or treatment plan, to support MDT meetings has increased from 36 per cent in 2006 to 91 per cent in 2010–11, with a further four per cent in development. This is a significant improvement and the increase in the use of templates and tools to support MDT meetings may be attributable to the proportion of ICS-funded staff and health service administration staff who attend MDT meetings, though it should be noted that their specific roles may vary. Half of all MDT meetings sampled (50 per cent) in Victoria in 2010–11 have their terms of reference, templates or tools reviewed and updated on an annual basis, while 50 per cent are updated less frequently than annually.

Figure 22: The percentage of MDT meetings that use templates or tools to support their meetings, 2006, 2008 and 2010–11

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<tr>
<td>2010</td>
<td>91%</td>
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</tbody>
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Base: 2006: 99 MDT meetings; 2008: 102 MDT meetings; 2010–11: 100 MDT meetings

5.2 Meeting format

In 2010–11 the majority of MDT meetings self-reported that meetings were conducted face to face (99 per cent) compared with 88 per cent in 2008. While 77 per cent of MDT meetings have teleconferencing and videoconferencing facilities available, these were used in 24 per cent of meetings compared with four per cent in 2006 and 12 per cent in 2008. More regional than metropolitan MDT meetings were conducted via teleconference (93 per cent) or videoconference (60 per cent) in 2010–11, with nine per cent of MDT meetings reporting the use of online meeting technology. It should be noted that information regarding online meeting technology was not requested in the previous surveys in 2006 and 2008.

5.3 Frequency and duration

Adequate frequency and duration of MDT meetings aims to facilitate the multidisciplinary discussion and treatment planning of patients prior to commencing treatment as well as increase access where patient numbers are high. Frequency may be dependent upon knowledge of the number of patients diagnosed and treated locally in each tumour stream within the ICS to ensure there is adequate meeting time to discuss newly diagnosed patients. In 2010–11 just under half (45 per cent) of all MDTs sampled conducted meetings at least once a week, and a further 36 per cent conducted them at least once a fortnight.
Survey results indicate a shift away from weekly and monthly meetings towards fortnightly meetings within the metropolitan ICS, while a similar shift from monthly to fortnightly meetings would appear to have occurred within the regional ICS.

The duration of MDT meetings in Victoria was a new question in the 2010–11 survey. The average duration of MDT meetings was also identified from the survey using the upper most timescale represented in the survey responses. The average duration of MDT meetings in 2010–11 and the average number of patients discussed per MDT meeting differed significantly by tumour stream and may give an indication of complexity of MDT discussion. The average duration of MDT meetings was 67 minutes. MDT members were likely to spend an average of eight minutes discussing each patient in the MDT meeting, with only three tumour stream MDTs (endocrine, haematological and neurological) discussing each patient for at least 10 minutes. This survey did not capture the time required to prepare or document the treatment recommendation plan. Time requirements influence health service’s eligibility to claim Items 871 or 872 through the Medicare Benefit Scheme (MBS).

Figure 23: Estimated number of hours spent in MDT discussion in 2010–11, by ICS

Appendix 5 contains a series of graphs that further illustrate the frequency and duration of meetings in Victoria.

5.4 Linkages

The multidisciplinary care policy provides three strategic directions for improving multidisciplinary care in Victoria. The third strategic direction is building effective links across and between MDTs. Team linkage was identified in the 2008 survey report as a recommendation. In 2010–11 respondents were asked to indicate what other health services regularly participate in the MDT meeting (at least 75 per cent of the time), with linkages defined as within and/or across ICS. Since 2006 there has been an increase in the number of linkages occurring in MDT meetings throughout Victoria from 11 per cent (baseline) to 61 per cent in 2010–11. Of the 61 per cent of MDTs in Victoria with linkages, 10 per cent of MDT meetings had linkages external to their own ICS, for example haematology, which had metropolitan and regional ICS linkages between HRICS and WCMICS. This finding suggests improved access to specialist advice in the discussion of treatment and management options for rural patients.
Figure 24: Number of MDT meeting linkages within Victoria, 2006, 2008 and 2010–11

Base: 2006: 99 MDT meetings; 2008: 102 MDT meetings; 2010–11: 100 MDT meetings

Figure 25: Number of MDT meetings with linkages in 2010–11, by ICS

Base: 2010–11: 100 MDT meetings
5.5 Links/referral pathways across MDT meetings

In 2010–11 respondents were asked to indicate how links/referral pathways across MDT meetings, ICS and/or cancer services are established. It should be noted that respondents were able to provide more than one response. The majority of responses indicated links via an informal agreement (60 per cent) or a previous relationship with service/staff (57 per cent). Only nine per cent of MDT meetings had formal agreements in place. Survey comments suggest that links/referrals occurred on an as-needed basis and were organised through the oncologist or referring clinician. Some clinicians also attended multiple MDT meetings. Although the informal links relied on may seem appropriate, more formal links and referrals may increase care coordination and further consideration should be given to this.

Figure 26: Percentage of linkages/referral pathways established across MDT meetings in 2010–11, by ICS

![Bar chart showing the percentage of linkages/referral pathways established across MDT meetings in 2010–11, by ICS.](chart1.png)

Base: 2010–11: 100 MDT meetings

Figure 27: Percentages of linkages/referral pathways established across MDT meetings in 2010–11, by tumour stream

![Bar chart showing the percentages of linkages/referral pathways established across MDT meetings in 2010–11, by tumour stream.](chart2.png)

Base: 2010–11: 104 MDT tumour group responses. *The combined breast/colorectal meeting and three combined GI/colorectal meetings have been separated for analysis.
5.6 Organisational support
Survey results provided data on ICS-funded staff and health service administration staff who attended MDT meetings at least 75 per cent of the time in 2010–11. ICS-funded staff attended 48 per cent of MDT meetings in Victoria and their specific role in the MDT meetings varied across ICS. Health service administration staff attended 30 per cent of MDT meetings. Typically, the regional ICS had a greater proportion of ICS-funded staff attend MDT meetings, while the metropolitan ICS had a greater proportion of health service administration staff in attendance. It should be noted that the survey did not request information on which team member was responsible for organising the MDT such as preparing agendas or providing other administrative support prior to the meetings.

5.7 MBS billing arrangements
MBS item numbers to support attendance by specialists at team planning meetings were introduced by the Australian Government in November 2006 (Wilcoxon et al. 2011). In 2010–11 respondents were asked to indicate whether there were organisational arrangements in place to facilitate MBS billing. Only one metropolitan MDT meeting (NEMICS 1/24) indicated that organisational arrangements were in place for MBS billing (item numbers 871 or 872). Some MDT meetings cited insufficient public patients, predominance of inpatients, or lack of organisational support to be able to implement MBS billing arrangements. Other MDT meetings expressed an interest in exploring this further, or indicated that it is left to the discretion of individual clinicians as to whether they choose to facilitate billing arrangements should the patient meet billing requirements.

It is acknowledged that MBS billing is difficult to implement and does not provide adequate funding to support all core team member attendance. The 2011 Cancer Australia national MDT meeting evaluation is exploring the appropriateness of this funding model. Findings from the state and national evaluations may lead to the development of a business model to implement improved financial support through Medicare.
6. Meeting infrastructure

6.1 Equipment and facilities

In 2010–11 respondents were asked to indicate what equipment and facilities are available for each MDT meeting. Figure 28 shows the total overall use of equipment and facilities in MDT meetings in 2010–11 by metropolitan, regional or statewide ICS. A computer linked to the organisation’s network was available in 91 per cent of MDT meetings, while 75 per cent had a dedicated room/venue to conduct the MDT meeting. Teleconferencing facilities were available in 44 per cent of MDT meetings and videoconferencing facilities were available in 33 per cent of meetings; however, the overall results report that these facilities, although available, were used in only 11 and 13 MDT meetings respectively. There has been good progress with the implementation of meeting management software (56 per cent), with survey responses indicating that some ICS were in the process of implementing or developing MDT meeting software. ICS are encouraged to assess local equipment and facility requirements.

Figure 28: Equipment and facilities used in MDT meetings in 2010–11, by metropolitan and regional ICS

Base: 2010–11: 100 MDT meetings: BSWRICS n = 7; GICS n = 8; GRICS n = 2; HRICS n = 7; LMICS n = 3; NEMICS n = 24; PICS n = 5; SMICS n = 15; WCMICS n = 29
### 6.2 Meeting management software

Figures 29 and 30 show the type of meeting management software and distribution by metropolitan, regional area and statewide ICS. It should be noted that respondents were able to select more than one response. Word processing and spreadsheet applications are not considered meeting management software, however, are commonly used tools in MDT meetings. Of the 56 meetings identified in Victoria that use meeting management software, only 10 meetings indicated the software is linked to the organisations patient information management system. PICS utilises an in-house software database called the HO (haematology and oncology) database. There is an opportunity to increase meeting management software in metropolitan and regional ICS.

**Figure 29: The use of meeting management software by metropolitan and regional areas, 2010–11**

- **CANMAP**: 9% CANMAP, 11% CANMAP, 22% CANMAP, 29% CANMAP, 29% CANMAP, 20% CANMAP, 11% CANMAP, 15% CANMAP, 44% CANMAP
- **Generic database**: 44% Generic database, 44% Generic database
- **In-house software**: 80% In-house software
- **Spreadsheet applications**: 59% Spreadsheet applications
- **Word processing**: 63% Word processing

**Base**: 2010–11: 100 MDT meetings

**Figure 30: The use of meeting management software in 2010–11, by ICS**

- **Metro**: 24% Metro, 5% Metro, 9% Metro, 11% Metro, 15% Metro, 11% Metro, 20% Metro, 63% Metro
- **Regional**: 84% Regional, 95% Regional, 89% Regional, 85% Regional, 84% Regional, 85% Regional, 89% Regional, 95% Regional
- **Statewide**: 100% Statewide

**Base**: 2010–11: 100 MDT meetings
6.3 Data collection

In 2010–11 respondents were asked to indicate what data elements are recorded by the MDT from a list provided. It should be noted that respondents were able to select more than one response. In 2010–11 the data and statistics most commonly recorded by the MDT meeting were the cancer diagnosis, the lead clinician, clinical and histological cancer staging, and the team present at the MDT meeting.

The MDT meeting provides a unique opportunity to capture valuable patient data that can be used for quality or research purposes. The collection of consistently defined data items across tumour streams would be most beneficial and is identified as part of the Victorian CanNET agreement to develop a consensus MDT meeting dataset to promote consistency in data collection. This work was initiated in 2010; a final report of the consensus dataset has now been completed, although it is unclear what the timeframe for implementation is. ICS are encouraged to ensure the collection of data is consistent with this work, which may be a method to address the variation identified in Figure 31.

Figure 31: Data elements recorded by all MDT meetings, 2010–11

Base: 2010–11: 100 MDT meetings
7. Recommendations

The Victorian 2010–11 MDT meeting survey evaluation captured a range of data and information to inform progress against multidisciplinary policy, strategic directions, peer organisations, and previous survey evaluations and recommendations. The following recommendations are made to help drive improvements in the delivery of multidisciplinary care and apply to all ICS.

Characteristics of cancer service MDTs in Victoria
• Further development of MDT meetings may be required for particular tumour streams and regions that have a low number of meetings or limited capacity compared with Victorian cancer incidence.

Patient-centred clinical decision making
• An increase in the proportion of cancer patients presented prospectively for MDT meeting discussion and treatment recommendations is required. This may require criteria for prioritising patient presentation at an MDT meeting, and a change in the frequency and/or length of the meeting to promote prospective discussion. Multiple patient presentations at meetings may be appropriate for some complex cases; however, ICS are encouraged to look at the underlying reasons regarding frequency of patient presentation through local clinical audit.
• Further development of clinical handover processes are required to ensure MDT meeting treatment recommendations are communicated to the patient’s GP and/or referring health service. This may promote enhanced care coordination and patient safety.
• There is a lack of processes to support documentation of patient consent. Further improvement is required to increase the documentation of patient consent across the state.
• Further development of processes to support the use of clinical practice guidelines and/or evidence-based treatment protocols is required to ensure appropriate decision making. One example supported by the Cancer Clinical Network is the use of eviQ Cancer Treatments Online, which is available at <www.eviq.org.au>.
• An increase in the availability of staging information is required to support appropriate multidisciplinary treatment decision making. Staging is the cornerstone of treatment planning.
• Supportive care needs impact on the compliance and outcome of cancer treatment. Further improvement is required to increase relevant supportive care professional attendance and contribution to MDT meeting discussion.

The multidisciplinary team
• An increase in the attendance of core members relevant to each tumour stream is required. Improvement in membership is required across all disciplines including diagnostics, nursing and allied health.

Meeting organisation and logistics
• Further development of effective linkages among health service MDT meetings and ICS should promote specialist multidisciplinary treatment planning for regional patients, offer valuable peer support, promote efficiency, and build capacity among the MDT.
• A review of the Victorian Multidisciplinary meeting toolkit resource should be undertaken to enhance MDT meeting resources, templates and tools.
• Further consideration of available MBS funding for MDT meetings is required by health services.

Meeting infrastructure
• Further consideration should be given to implementing meeting management software across MDT meetings. In particular metropolitan ICS should promote the implementation of meeting management software in member organisations. The use of software can promote efficiencies such as rapid
documentation of a treatment recommendation plan and/or integration in the patient's medical record. Software also promotes the collection of clinical data.

- A multidisciplinary dataset should be established to promote consistent data collection for monitoring and benchmarking cancer service performance. The collection of cancer patient data could align with existing cancer registries and reporting of cancer clinical indicators.
8. Conclusion

The 2010–11 Victorian MDT meeting evaluation was based on 100 survey questionnaires completed by the ICS secretariats in consultation with the chair of the MDT meeting. The evaluation provides evidence to suggest improved progress in comparison to previous survey evaluations and in achieving the strategic directions outlined in policy and VCAP. It is recognised that the ICS secretariats, member health services and tumour groups have implemented strategies to drive improvements in multidisciplinary cancer care across all geographical regions in Victoria. The most significant achievements have been:

- the increase in availability of tools and templates to assist in meeting functioning
- the increase of newly diagnosed cancer patients being appropriately referred for prospective MDT discussion
- the increase in establishment of effective team linkage across and between ICS
- the increase in the proportion of MDT meetings that communicate treatment recommendations to the patient’s GP.

It is acknowledged that the current survey process included only limited private sector meetings. Future statewide evaluation will aim to increase the capture within this sector.

The ongoing evaluation and monitoring of multidisciplinary care in Victoria provides evidence of achievement against the policy framework, strategic directions, peer guidelines, and the VCAP multidisciplinary care action and target. The 2010–11 survey has also provided an opportunity to investigate characteristics of multidisciplinary care that have not previously been considered.

Statewide evaluation allows for achievements to be identified across the cancer service system, ICS and health services. The survey also identifies barriers to service improvement implementation and highlights variation across the state. The 2010–11 survey findings help inform local and statewide improvement activities. Regular local review of MDT meetings and processes and their impact will further strengthen the quality of multidisciplinary care in Victoria.

In 2010–11:
- There were 117 MDT meetings identified in Victoria.
- Seventy-two per cent of MDT meetings were based in metropolitan areas.
- The breast, colorectal, genitourinary, lung and upper gastrointestinal tumour streams had the most multidisciplinary team meetings.
- The sarcoma, skin/melanoma, endocrine, and CNS tumour streams had the fewest multidisciplinary team meetings.
- The upper gastrointestinal, genitourinary, gynaecological, and lung tumour streams had an increase in the number of multidisciplinary team meetings.
- There were relatively few skin/melanoma and urology MDT meetings in relation to cancer incidence.
9. Benchmarking with NSW

In 2009 the Cancer Institute of NSW published a report, Multidisciplinary teams in New South Wales: 2006 and 2008 (Thomas et al. 2009). The 2010–11 Victorian multidisciplinary survey incorporated some of the questions included in the NSW surveys, which has provided an opportunity to benchmark against NSW MDT characteristics. It should be noted the comparison below between states relates to different time periods. NSW has undertaken significant work in multidisciplinary care since their evaluations in 2006 and 2008. Some of the findings are summarised below.

- In NSW in 2006 there were 143 MDT meetings (of which 114 participated in the survey). This increased to 160 MDT meetings in 2008 (of which 131 participated in the survey).
- In NSW there were eight area health services (AHS) based on location. The largest number of MDTs occurred in the Sydney South West AHS (with 30 MDTs, representing 19 per cent of the total) followed by South Eastern Sydney and Illawarra (with 27 MDTs, representing 17 per cent). AHSs with fewer MDTs were those incorporating regional or rural areas.
- In 2008 there were relatively few melanoma and urology MDTs in relation to cancer incidence in NSW. In Victoria in 2010–11 there were relatively few skin/melanoma and urology MDT meetings in relation to cancer incidence.
- The frequency of MDT meetings in NSW in 2008 compared with the frequency of meetings in Victoria in 2010–11 does not vary significantly. In NSW, 46 per cent of MDTs sampled conducted meetings at least once a week (45 per cent in Victoria), and a further 38 per cent conducted them at least once a fortnight (36 per cent in Victoria).
- The average duration of MDT meetings in NSW was 70 minutes and in Victoria 67 minutes. MDT members were likely to spend between five and nine minutes discussing each patient during MDT meetings in NSW, while Victoria reported an average of eight minutes.
- In NSW in 2008, 73 per cent of MDT meetings were conducted face to face, with 24 per cent of meetings utilising a combination of videoconferencing or teleconferencing facilities. In Victoria in 2010–11, 99 per cent of MDT meetings were conducted face to face, with 24 per cent utilising a combination of videoconferencing and teleconferencing facilities. Both NSW and Victoria reported that regional areas are more likely than metropolitan areas to conduct MDT meetings via teleconference or videoconference.
- In NSW in 2008, 39 per cent of MDT meetings reported that GPs were informed of the MDT meetings’ clinical management decisions in all cases, with an additional 34 per cent of MDTs reporting that this occurred in some cases (22 per cent in Victoria in 2010–11). Five per cent of MDT meetings in NSW reported that GPs are never informed, compared with seven per cent in Victoria.
- The most common method by which GPs were informed of the MDT meeting outcome in NSW in 2008 was by letter (62 per cent), with email and GP attendance at the MDT meeting the least common methods used. In Victoria in 2010–11, letter was also the most common method used to inform GPs of MDT meeting outcomes (73 per cent), with email and GP attendance the least common.
- Word processing applications were the tool most commonly reported as being used by NSW MDT meetings in 2008 (60 per cent of respondents). In Victoria in 2010–11, word processing applications were the most commonly used tools in MDT meetings (49 per cent of respondents).
- In NSW in 2008, 82 per cent of MDT meetings sampled reported having some form of link with other cancer services or MDT meetings (compared with 61 per cent in Victoria in 2010–11). A third of MDT meetings in NSW had links that were established through a formal agreement (compared with nine per cent in Victoria), while half of NSW MDT meetings were established via an informal agreement (60 per cent in Victoria).
### Appendix 1: List of health services within ICS

*denotes those health services that submitted an MDT survey

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## Appendix 2: 2010–11 survey

### Multidisciplinary team meeting questionnaire

#### Contact details of the person completing the questionnaire

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<tr>
<td>Chair’s email address</td>
<td></td>
</tr>
<tr>
<td>Name of meeting</td>
<td></td>
</tr>
<tr>
<td>Organisation</td>
<td>Department</td>
</tr>
<tr>
<td>Email</td>
<td></td>
</tr>
</tbody>
</table>

### Section 1: The multidisciplinary team

1. In which ICS is this MDT meeting located?

2. In which organisation is the MDT meeting located? (use allocated VAED codes or state the organisation if not a health service such as a ICS office)

3. Which tumour stream does this meeting discuss? (tick all that apply to this meeting)
   - Breast
   - Central nervous system
   - Colorectal
   - Endocrine
   - Genitourinary
   - Gynaecology
   - Haematology/lymphoma
   - Head and neck
   - Lung/thoracic
   - Multiple tumour streams
   - Paediatrics
   - Sarcoma
   - Skin/melanoma
   - Upper GI
   - Other, please specify

4. What other health services regularly participate in this MDT meeting (at least 75 per cent of the time)? (use allocated VAED codes)
   - Other, please specify

5. Who are the defined core members who attend this meeting regularly (at least 75 per cent of the time), by health sector? (tick all that apply to this meeting)
   - Continence/erectile management
   - Data manager
   - Dietitian
   - General practitioner
   - Genetic counsellor
   - Haematologist
   - ICS-funded staff
   - Lymphoedema services
   - Medical oncologist
   - Nurse – care coordinator (including breast care)
   - Nurse – ward (including chemotherapy)
   - Nurse – palliative care
   - Nurse – research
   - Occupational therapist
   - Organisational administration staff

### Section 2: The process of multidisciplinary team working

#### Section 2.1: Process for local decision-making

<table>
<thead>
<tr>
<th>What is the process for local decision-making?</th>
<th>Not relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of local decision-making</td>
<td></td>
</tr>
<tr>
<td>Decision-making process</td>
<td></td>
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</tbody>
</table>

#### Section 2.2: Decision-making process

<table>
<thead>
<tr>
<th>Decision-making process</th>
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</tr>
</thead>
<tbody>
<tr>
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<td>Not local</td>
</tr>
<tr>
<td>Specialist</td>
<td>Not specialist</td>
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</table>

#### Section 2.3: Local decision-making process

<table>
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<th>Local decision-making process</th>
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</thead>
<tbody>
<tr>
<td>Local</td>
<td>Not local</td>
</tr>
<tr>
<td>Specialist</td>
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#### Section 2.4: Decision-making process

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</tr>
<tr>
<td>Specialist</td>
<td>Not specialist</td>
</tr>
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</table>

#### Section 2.5: Local decision-making process

<table>
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</thead>
<tbody>
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</tr>
<tr>
<td>Specialist</td>
<td>Not specialist</td>
</tr>
</tbody>
</table>

#### Section 2.6: Local decision-making process

<table>
<thead>
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<th>Local decision-making process</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Local</td>
<td>Not local</td>
</tr>
<tr>
<td>Specialist</td>
<td>Not specialist</td>
</tr>
</tbody>
</table>
Palliative care
Pastoral care
Pathologist
Pharmacist
Physiotherapist
Psychiatrist
Psychologist
Radiation oncologist
Radiologist
Registrar(s)
Research fellows
Research staff
Resident(s)
Respiratory medicine
Social worker
Speech pathologist
Stomal therapist
Surgeon
Urologist
Other, please specify

Section 2: Team meeting processes

6. Has the MDT developed documented criteria describing which patients should/can be presented for discussion at the MDT meeting?
   Yes
   No
   If no, comment

7. What is the format of this meeting?
   (tick all that apply)
   - Face to face
   - Online meeting technology (such as WebEx)
   - Teleconference
   - Videoconference
   - Other, please specify

8. What equipment and facilities are available for this MDT meeting?
   (tick all that apply)
   - Computer linked to network
   - Dedicated room/venue
   - Laptop
   - Light box
   - Meeting management software (such as CanMAP)
   - Microscope
   - Online meeting technology (such as WebEx)
   - PACS
   - Projector
   - Teleconference
   - Video conferencing
   - Other/comment

9. What is the frequency of this meeting?
   - Weekly
   - Fortnightly
   - Monthly
   - Other, please specify

10. What is the length of this meeting?
    - 0–30 mins
    - 31–60 mins
    - 61–90 mins
    - 91–120 mins
    - 120+ mins
11. Are there organisational arrangements to facilitate MBS billing (item number 871 or 872)?
   - Yes
   - No
   - Under development
   - Comment

12. If meeting management software is used, what type?
   - CANMAP
   - Generic database (such as Microsoft Access)
   - In-house software program (please name)
   - Spreadsheet applications (such as Microsoft Excel)
   - Word processing applications (such as Microsoft Word)
   - Comment/other, please specify

13. If meeting management software is used, is it linked to the organisation’s patient information management system?
   - Yes
   - No
   - Comment

14. Are the patient’s treatment recommendations documented in the patient’s medical record?
   - Yes, software used automatically uploads to electronic patient medical record
   - Yes, software used prints recommendations and copy placed in patient medical record
   - Yes, template used to record recommendations and copy placed in patient medical record
   - Yes, notation in patient medical record
   - No
   - If no, where are the recommendations documented?

15. Is patient staging information (such as TNM or equivalent) routinely available and documented during the meeting?
   - Yes
   - No
   - Sometimes
   - If no, please comment

16. What staging system has been agreed and is in use in the MDT meeting?

17. Are eligible patients considered for current clinical trials at the MDT meeting?
   - Yes
   - No
   - Sometimes
   - Please comment

18. How many meetings have been cancelled in the past year?
   - 0–3
   - 4–7
   - 8–10
   - Other/unsure

19. What are the main reasons meetings have been cancelled?
   (tick all that apply)
   - Lack of core members
   - Not enough patients on the agenda for discussion
   - Venue issues
   - Information required for treatment decisions not available
   - Public holiday
   - Comment

20. Does the MDT use templates or tools (such as an agenda or treatment plan) to support the MDT meeting?
   - Yes
   - No
   - Currently in development
If ‘No’, when are you planning to do so?

21. How often are meeting terms of reference, templates or tools reviewed and updated?
   Six monthly
   Annually
   Less frequent than annually
   Comments

*Please review the MDT meeting agendas (or equivalent) from the last five meetings to answer the following questions (Q 22–25). A retrospective review of the MDM agenda has been selected to ensure data collection and completion of the survey occurs in 2010.*

22. In total how many patients listed on the five agendas were discussed?
   (consider if all patients listed were discussed or if others were added last minute for discussion)

23. Of the total number of patients presented at the five MDT meetings, and in relation to treatment, how many were:
   Retrospective
   Prospective (prior to any treatment)*
   Unknown (information not documented)
   *Note. Prospective discussion may have been preceded by some surgery for definitive diagnosis/staging purposes.

24. Of the total number of patients presented at the five MDT meetings, how many were:
   Disease progression
   New diagnosis
   Palliative
   Recurrence
   Unknown

25. Of the total number of patients presented at the five MDT meetings, how many were:
   First presentation
   Second presentation
   Third presentation or greater
   Unknown (information not documented)

Section 3: Referral processes

26. Are there documented processes and protocols for the referral of patients to MDT meetings?
   Yes
   No
   Currently in development
   Comment

27. Are patients with psycho-oncology needs routinely identified and referred for assessment?
   Yes
   No
   Sometimes
   Please comment

28. Are patients with physical, social, spiritual or information needs routinely identified and referred for supportive care assessment?
   Yes
   No
   Sometimes
   Please comment

29. Is there a procedure at the MDT meeting for identifying patients who need a referral to local support services outside of the geographical location of the treatment organisation?
   Yes
   No
   Comment
30. How are these links/referral pathways across MDTs, ICS and/or cancer services established? (select all that apply)
Formal agreement
Informal agreement
Previous relationship with service/staff
Other – please specify:

Section 4: Patient-centred clinical decision making

31. Does the host organisation have a consent and/or privacy policy that includes MDT meeting discussion of patients?
Yes
No
Currently in development
If 'No', when are you planning to do so?

32. Are patients provided with information about MDT meetings and consented prior to discussion? (tick all that apply)
Yes, verbal information provided
Yes, written information provided
Yes, consent documented
No information is provided
No consent is documented
Comment

33. Is patient consent recorded as part of MDT meeting documentation in the medical record?
Yes
No
Comment

34. Does the MDT have documented clinical practice guidelines and/or evidence-based treatment protocols relevant to the diagnosis, treatment and supportive care of cancer patients?
Yes
No
In development
Comment and list guidelines or protocols

35. Who communicates the MDT meeting recommendations to the patient? (tick all that apply to this meeting)
General practitioner
Haematologist
Medical oncologist
Presenting lead clinician
Radiation oncologist
Surgeon
Other, please specify

36. Is the treatment recommendation plan communicated to the general practitioner following the MDT meeting?
Yes
No
Not always
Unknown
Comment

37. If treatment plans are communicated to the general practitioner, what is the method for this? (tick all that apply to this meeting)
Email
Telephone
Letter
Fax
Attendance at meeting
Other, please specify
38. If the patient was referred from a regional area or outside health service, are treatment recommendations communicated to the patient’s regional or outside health service treatment organisation?
   Yes
   No
   Not always
   Unknown
   Not applicable
   Comment

39. If treatment recommendations are communicated to the patient’s regional or outside health service treatment organisation, what is the method for this?
   (tick all that apply to this meeting)
   Email
   Telephone
   Letter
   Fax
   Attendance at meeting
   Unknown
   Not applicable
   Other, please specify

Section 5: Team governance

40. Are the following data elements recorded by the MDT?
   (tick all that apply)            Electronic    Manual    No
   Cancer diagnosis
   Cancer stage (clinical)
   Cancer stage (histopathological)
   Clinical trials eligibility
   Clinical trials participation
   Consent obtained
   Date of diagnosis
   ECOG status
   Initial referral source
   Lead clinician
   Patient morbidity
   Team present at meeting
   Treated according to agreed clinical guidelines
   Other, please specify

41. Do you have any additional comments about MDTs or your organisation’s support for multidisciplinary care?

42. Has the chair reviewed the responses to this questionnaire and provide approval?
   Yes
   No
   Comment

Thank you for completing the questionnaire for this MDT meeting.
Appendix 3: Newly diagnosed patients by tumour stream

Figure 32 represents the percentage of patients discussed by MDT meetings who are newly diagnosed by tumour stream.

**Figure 32: Percentage of patients discussed by MDT meetings who are newly diagnosed, 2010–11**

<table>
<thead>
<tr>
<th>Tumour Stream</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total MDTs</td>
<td>64%</td>
</tr>
<tr>
<td>Breast (n=14)</td>
<td>60%</td>
</tr>
<tr>
<td>CNS (n=3)</td>
<td>39%</td>
</tr>
<tr>
<td>Colorectal (n=7)</td>
<td>71%</td>
</tr>
<tr>
<td>Endocrine (n=3)</td>
<td>48%</td>
</tr>
<tr>
<td>General (n=5)</td>
<td>71%</td>
</tr>
<tr>
<td>Genitourinary (n=11)</td>
<td>73%</td>
</tr>
<tr>
<td>Gynaecological (n=4)</td>
<td>70%</td>
</tr>
<tr>
<td>Haematological (n=6)</td>
<td>35%</td>
</tr>
<tr>
<td>Head &amp; Neck (n=5)</td>
<td>68%</td>
</tr>
<tr>
<td>Lung (n=12)</td>
<td>70%</td>
</tr>
<tr>
<td>Paediatrics (n=2)</td>
<td>68%</td>
</tr>
<tr>
<td>Sarcoma (n=1)</td>
<td>71%</td>
</tr>
<tr>
<td>Skin/Melanoma (n=1)</td>
<td>62%</td>
</tr>
<tr>
<td>Upper GI (n=10)</td>
<td>57%</td>
</tr>
<tr>
<td>Combined colorectal/UGI (n=3)</td>
<td>71%</td>
</tr>
<tr>
<td>Combined breast/colorectal (n=1)</td>
<td>83%</td>
</tr>
</tbody>
</table>

**Base:** 2010–11: 88 MDT meetings. The numerator represents the number of new diagnoses, while the denominator represents the total number of patients discussed for each tumour stream: breast n = 316/531; CNS n = 33/84; colorectal n = 282/396; endocrine n = 75/93; general n = 99/206; genitourinary n = 418/572; gynaecological n = 171/245; haematological n = 39/113; head and neck n = 155/229; lung n = 296/423; paediatrics n = 34/59; sarcoma n = 20/28; skin melanoma n = 65/105; upper GI n = 275/485; combined colorectal/UGI n = 82/115; combined breast/colorectal n = 19/23.
Appendix 4: Information and consent

Figures 33 to 36 represent survey responses regarding information provided to patients about MDT meetings and documented patient consent both by ICS and by tumour stream.

**Figure 33:** Percentage of MDT meetings that provide patients with information about MDT meetings and are consented prior to discussion in 2010–11, by ICS

<table>
<thead>
<tr>
<th>ICS</th>
<th>Yes, verbal information provided</th>
<th>Yes, written information provided</th>
<th>Yes, consent documented</th>
<th>No information is provided</th>
<th>No consent is documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>BSR/RICS</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>GICS</td>
<td>98%</td>
<td>98%</td>
<td>98%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>GRCIS</td>
<td>82%</td>
<td>82%</td>
<td>82%</td>
<td>18%</td>
<td>18%</td>
</tr>
<tr>
<td>HRICS</td>
<td>77%</td>
<td>77%</td>
<td>77%</td>
<td>23%</td>
<td>23%</td>
</tr>
<tr>
<td>LMICS</td>
<td>93%</td>
<td>93%</td>
<td>93%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>NEMICS</td>
<td>24%</td>
<td>24%</td>
<td>24%</td>
<td>76%</td>
<td>76%</td>
</tr>
<tr>
<td>PICS</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>SMICS</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td>WCMICS</td>
<td>29%</td>
<td>29%</td>
<td>29%</td>
<td>71%</td>
<td>71%</td>
</tr>
</tbody>
</table>

Base: 2010–11: 100 MDT meetings

**Figure 34:** Percentage of MDT meetings that provide patients with information about MDT meetings and are consented prior to discussion in 2010–11, by tumour stream

<table>
<thead>
<tr>
<th>Tumour Stream</th>
<th>Yes, verbal information provided</th>
<th>Yes, written information provided</th>
<th>Yes, consent documented</th>
<th>No information is provided</th>
<th>No consent is documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast*</td>
<td>16%</td>
<td>16%</td>
<td>16%</td>
<td>84%</td>
<td>84%</td>
</tr>
<tr>
<td>CNS</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>97%</td>
<td>97%</td>
</tr>
<tr>
<td>Colorectal</td>
<td>11%</td>
<td>11%</td>
<td>11%</td>
<td>89%</td>
<td>89%</td>
</tr>
<tr>
<td>Endocrine</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>98%</td>
<td>98%</td>
</tr>
<tr>
<td>General</td>
<td>8%</td>
<td>8%</td>
<td>8%</td>
<td>92%</td>
<td>92%</td>
</tr>
<tr>
<td>Gynecological</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Haematological</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
<td>93%</td>
<td>93%</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>6%</td>
<td>6%</td>
<td>6%</td>
<td>94%</td>
<td>94%</td>
</tr>
<tr>
<td>Lung</td>
<td>15%</td>
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<td>15%</td>
<td>85%</td>
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<tr>
<td>Paediatrics</td>
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<td>5%</td>
<td>5%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>Sarcoma</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>Skin/Melanoma</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>Upper GI*</td>
<td>14%</td>
<td>14%</td>
<td>14%</td>
<td>86%</td>
<td>86%</td>
</tr>
</tbody>
</table>

Base: 2010–11: 104 MDT tumour group responses. *The combined breast/colorectal meeting and three combined GI/colorectal meetings have been separated for analysis
Figure 35: Percentage of MDT meetings that record consent as part of the MDT meeting documentation in 2010–11, by tumour stream

Base: 2010–11: 104 MDT tumour group responses. *The combined breast/colorectal meeting and three combined GI/colorectal meetings have been separated for analysis

Figure 36: Percentage of MDT meetings that have a consent and/or privacy policy in place in 2010–11, by ICS

Base: 2010–11: 100 MDT meetings
Appendix 5: Frequency and duration of MDT meetings

Figure 37: Frequency and duration of MDT meetings in Victoria, 2006, 2008 and 2010–11

Base: 2006: 99 MDT meetings; 2008: 102 MDT meetings; 2010–11: 100 MDT meetings

Figure 38: Duration of MDT meetings by metropolitan and regional area, 2010–11

Base: 2010–11: 100 MDT meetings
Figure 39: Number of patients discussed and time spent discussing each patient in 2010–11, by tumour stream

Base: 2010–11: 104 tumour stream responses. *The combined breast/colorectal meeting and three combined GI/colorectal meetings have been separated for analysis
References


Department of Human Services 2006a, Multidisciplinary meeting toolkit, State Government of Victoria, Melbourne.

Department of Human Services 2006b, Patient management frameworks, State Government of Victoria, Melbourne.


