
Lung Cancer Multidisciplinary Meeting Toolkit

National Lung Cancer Working Group

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Introduction

The *Standards of Service Provision for Lung Cancer Patients in New Zealand* Standard 9 states that “All patients with lung cancer should be discussed at a multidisciplinary meeting”. However DHBs have expressed concerns about resourcing lung cancer multidisciplinary meetings (MDMs) if all patients with lung cancer are presented and discussed at the MDM. They have requested prioritisation criteria guidance for which patients should be discussed at MDMs while working towards improving coverage of MDMs. The National Lung Cancer Working Group was tasked with developing this guidance recognising that each DHB/region will have different infrastructure and/or resourcing. Each will need to adapt/modify the prioritisation criteria guidance to meet local or regional needs.

In addition to this piece of work the National Lung Cancer Working Group suggested that the prioritisation criteria guidance be incorporated in a document that adapted the *Guidance for Implementing High-Quality Multidisciplinary Meetings* (Ministry of Health, 2012) specifically for lung cancer MDMs. This document *Lung Cancer MDM Toolkit* brings together best practice guidance for a high quality lung cancer MDM but does not include the MDM Checklist or a MDM Coordinator role description contained within the *Guidance for Implementing High-Quality Multidisciplinary Meetings*.

The lung cancer MDM proforma will be a key point for data collection for the lung cancer core data set. This data set is currently being developed and completion is anticipated in 2015.

Multidisciplinary meetings

MDMs are deliberate, regular meetings either face-to-face or via videoconference at which health professionals with expertise in a range of different specialties discuss the options for patients’ treatment and care prospectively. Prospective treatment and care planning involves making recommendations in real time, with an initial focus on the patient’s primary treatment. MDMs facilitate a holistic approach to the treatment and care of the patient.

In some cases, the disease stage or symptoms make it necessary to begin treatment before a patient’s case is presented at an MDM. Instead, a multidisciplinary discussion for ongoing planning is held at the earliest possible time.

If treatment plans need to be reviewed, presentation at subsequent MDMs may be warranted.

International evidence shows that multidisciplinary care is a key part of providing best-practice treatment and care for patients with lung cancer. Multidisciplinary care involves a team approach to planning treatment and providing care for lung cancer patients as they move along the pathway of services they need.

Cancer MDMs are part of the philosophy of multidisciplinary care. Effective MDMs have positive outcomes for patients receiving the care and for the health professionals involved in providing the care and health services. Some of the benefits are that:

- treatment planning is improved because health professionals consider the full range of therapeutic options, which improves outcomes
- improved equality of outcomes for patients with cancer
- more patients are offered the opportunity to take part in relevant clinical trials
- there is greater continuity of care and less duplication of services
- services are better coordinated
- communication between care providers improves, as clear lines of responsibility are developed between members of the multidisciplinary meeting
- time and resources are used more efficiently.

Toolkit for implementing high-quality lung cancer MDMs

This toolkit for implementing high-quality MDMs provides useful examples of the documentation required for a lung cancer MDM:

- lung cancer prioritisation criteria guidance
- terms of reference
- lung cancer proforma
- patient information sheet.

In addition a lung cancer MDM may choose to add any local or regional pathways or guidelines as an appendix.

Each lung cancer multidisciplinary team is responsible for the monitoring of the effectiveness/efficiency of local and/or regional MDMs. This function links to the regional reviews against the national tumour stream standards.

Lung cancer MDM prioritisation criteria guidance

The *Standards of Service Provision for Lung Cancer Patients in New Zealand* Standard 9 states that “All patients with lung cancer should be discussed at a multidisciplinary meeting”.

DHBs have concerns about resourcing MDMs if all patients with lung cancer are presented. DHBs have requested prioritisation criteria guidance for which patients should be discussed at MDMs, while working towards improving coverage of MDMs. The National Lung Cancer Working Group has endorsed the development of the following criteria that identifies the minimum cohort for discussion at the MDM.

On occasions when there are more referrals to the lung cancer MDM than can be discussed within the usual time scheduled for the MDM, then consideration should be given to prioritising the agenda in the following in order:

1. all those to be considered for potential curative treatment
2. post-operative cases
3. good performance advanced disease
4. stage 4 ECOG 3-4 with poor performance referral to palliative care
5. lung metastasis from non-thoracic malignancies to be discussed in their primary tumour MDM and referred direct to cardio thoracic surgeon.

The MDM proforma should record whether each case was discussed at an MDM or was registered only.

Lung cancer MDM terms of reference

1. The overall aim of the lung cancer multidisciplinary meeting is to function as a formal mechanism for multidisciplinary input into treatment planning and ongoing management and care of patients with lung cancer.

The objectives of the meeting are to:

- provide an opportunity for multidisciplinary discussion of all new cases of lung cancer and those post-surgery
- ensure all new patients presenting with a malignancy are registered with the MDM and where possible, have their case discussed by a multidisciplinary team with access to all available information about that case
- private patients may be referred to the MDM with the referring clinician responsible for ensuring completion of the proforma and all radiology and pathology made available to respective specialists
- determine, in the light of all available information and evidence, the most appropriate treatment and care plan for each individual patient
- confirm concordance between the clinical, imaging and pathology information (as requested) for each case
- provide education to senior and junior medical, nursing and allied health staff.

Membership

2. Membership of the multidisciplinary lung cancer meeting comprises medical staff, nursing staff and allied health professionals providing clinical services in relation to lung cancer within **[name/s]** DHB:
 - respiratory physicians
 - medical oncologists
 - radiation oncologists
 - cardiothoracic surgeons
 - cancer nurse specialists
 - radiologists
 - pathologists
 - palliative care clinician
 - MDM Coordinator

A list of regular attendees including medical specialists, nursing and allied health professionals can be accessed by contacting the MDM Coordinator.

Attendance

3. Those who will attend the **[insert DHB]** multidisciplinary lung cancer meeting are:
 - the members of the meeting
 - referring clinicians in person or via videoconference and associated nurse specialists and trainees
 - other health professionals invited by the presenting clinician or chair of the meeting
 - any support staff who may be required to assist meeting implementation. A record of all people who attended each meeting (including registrars, MDM coordinators, clinical nurse specialists) will be kept
 - attendees at the host site MDM and remote referrers are recorded and documented on the proforma
 - a quorum comprises one radiologist, one medical oncologist, one radiation oncologist, one respiratory physician, one cardiothoracic surgeon
 - if a quorum is not present (**insert locally agreed process or**) the referring clinician needs to ensure, independently of the MDM, that an appropriate plan is initiated.

Time of meetings

4. Meetings will be held on **[insert the day of the week]**, unless otherwise notified, and will begin promptly at **[insert time]**.
5. The frequency and duration of the lung cancer MDM enables patients to meet the 31 day and 62 day Faster Cancer Treatment indicators.

Meeting venues

6. The meeting venue, unless otherwise notified, will be **[insert hospital name and address]**.
7. Any change in venue must be notified in writing. This information must be circulated to members of the meeting **[insert number of days if appropriate]** before the meeting day.

Chair of meetings

8. Each meeting will be chaired by a member of the meeting who will be nominated by the membership of the MDM.
9. Where the nominated chair is unable to attend, he or she will organise for a proxy to chair the meeting.
10. The chair decides whether there is adequate representation, by core members, at a single meeting to make safe recommendations about any/all patients.
11. The role of the chair is to facilitate and summarise the MDM discussion. A summary of the MDM discussion will be documented on the proforma in addition to the recommendation.
12. The chair ensures that the clinical protocols are adhered to.
13. The chair is responsible for ensuring all members participate in the meeting as appropriate to their specialty.

Notification of meetings

14. All members of the meeting will receive notification of:
 - the meeting dates and venue at the beginning of the year
 - cases for presentation at least **[insert number]** days prior to the meeting.

Meeting agenda

15. All newly diagnosed cases of lung cancer will be placed on the agenda, along with other cases for multidisciplinary discussion.
16. In instances where it appears not all patients referred to the lung cancer MDM will be able to be discussed within the allocated time, the cases are to be prioritised according to the Lung Cancer Prioritisation Criteria guidance.
17. Clinicians will place cases for presentation onto the meeting agenda by informing the **[insert title of person to receive notification of cases]** of the relevant case details at least **[insert number]** days before the meeting.

18. A lung cancer MDM proforma is to be completed for each patient registered with the lung cancer MDM.
19. Late inclusions to the agenda are acceptable. In such cases, the presenting clinician is responsible for making all appropriate clinical results available to the meeting according to locally agreed processes.

Results

20. Requests on behalf of the presenting clinician for investigation/diagnostic results will be made to the respective diagnostic services by the **[insert title of person]** at least **[insert number]** working days before the meeting. The request for results will include: the requesting doctor's name; the patient's full name, date of birth and NHI number; the test procedure and date; and any other information required by the individual service.

Case discussion

21. No patient should be discussed in the absence of the consulting clinician or his or her delegate.
22. All applicable patient information must be available before the case discussion can proceed and a lung cancer proforma completed.
23. Case discussion should incorporate the patient's age, clinical condition and any psychosocial aspects impacting on clinical management.
24. The chair should articulate a summary of the recommendations arising from the discussion of a case before proceeding to the next case. The recommendation may be documented live into the proforma.

Confidentiality

25. Attendance of medical and other health professionals and the meeting details will remain confidential to the meeting. Clinicians provide information presented in this meeting in confidence. Any clinicians who keep a copy of the agenda are responsible for maintaining the confidentiality of the document. The team can keep a copy of the agenda in an agreed secure manner for audit purposes.

Meeting documentation

26. Treatment and care recommendations from the meeting discussion will be documented in the medical record by completing the lung cancer proforma or **[insert details of other mechanism]**. The person responsible for making and referrals will be documented on the proforma.
27. The general practitioner will be notified of the meeting's recommendations through a standardised letter to be completed by the chair, or sent a copy of the completed MDM proforma as soon as possible after the MDM.

Communication with patients and families

28. An identified member of the multidisciplinary team (as noted on the lung cancer proforma) will effectively convey the recommendations of the meeting to the patient and their family. Their aim will be to assist the patient and family to participate in decision making about ongoing treatment and care.

Review

29. These terms of reference and any associated pathways or guidelines will be reviewed annually or as specified. Indications for early review will include:
- legislative change
 - change to government or hospital policy
 - an absence of key specialty groups from the meeting over at least three consecutive meetings
 - less than 60 percent of meeting members attending over at least three consecutive meetings.

Example of a lung cancer MDM proforma

DEPARTMENT OF RESPIRATORY MEDICINE CHEST CONFERENCE

Demographics & Referral		MDM Date
First name:		Surname:
Referral date:		Domicile DHB:
NHI:		DOB:
Ethnicity:	(Enter no of Ethnicity)	Age:
Previous conference:		
Referring consultant:		
CC (GP):		
CC (Others):		

Diagnosis
Diagnosis:
<input type="text"/>
Other :
Pathology:
Laterality:

Staging	
Clinical: T N M	Stage grouping:
Pathological: T N M	

Co-morbidities

Additional Details:	
Clinical details	(Please include presenting symptoms and length of symptoms e.g. cough, dyspnoea, haemoptysis, lymphadenopathy, chest/shoulder pain, hoarseness, fatigue, weight loss, finger clubbing).

History:
ECOG Status
<input type="text"/>

(Enter: 0,1,2,3,4,5,Unrecorded)

Weight Loss > 10% in last 6 months?	Asbestos Exposure?
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Question for conference

Smoking history		
Status	Number of Cigarettes a Day	Number of years smoked
If ex smoker, for how long?	Pack Year	

Bloods

Date:	CBC	Hb	Platelets	WBC			
Date:	Renal	Na	K	Cr			
Date:	Liver	Alb	Alk Phos	ALT	Ca		cCa
Date:	CEA			INR	APTT		

Molecular markers

Date:
EGFR: ALK:

Lung function Test

Date:
FEV₁: (% Pred.)
FVC: (% Pred.)
DLCO: (% Pred.)
KCO: (% Pred.)

Key Investigations

	Mode of diagnosis? (tick one)
Date	<input type="checkbox"/>
Date	<input type="checkbox"/>
Date	<input type="checkbox"/>
Date	<input type="checkbox"/>
Date	<input type="checkbox"/>
Date	<input type="checkbox"/>

Pathology

Bronchoscopy (Please state date, who it was performed by and a brief report).

Radiology (e.g. CXR, CT, PET .Please state date, location and a brief report).

Other Investigations

Discussion

Plan

Treatment intent:
Reason for non curative Management If Applicable:
Primary management:
Action:
Form completed by:
Person responsible for action:
MDM attendees:

Example of an MDM patient information sheet

What does a multidisciplinary approach mean for me?

Multidisciplinary care is a team approach to health care. Doctors, nurses and other health professionals with skills in diagnosing and managing cancer will meet to discuss options about both your cancer treatment and ongoing care, recommending an individual treatment plan for you. Their recommended plan will be discussed with you.

Research shows that it is beneficial to involve a range of professionals in deciding the best care for you.

- Each member brings a different area of expertise.
- Each member of a multidisciplinary team has a different perspective so the team as a whole can consider a wider variety of social, cultural and emotional needs.
- A multidisciplinary meeting makes it easier to plan treatment, streamline referrals and prevent unnecessary tests, saving time and resources.
- When adults with cancer have information about treatment options, their mental health and wellbeing can improve.

What is a multidisciplinary team?

Our hospital has a team of health professionals involved in the care of patients with cancer. Each team member brings different skills that are important to managing your care. Team members may include:

- radiologist
- pathologist
- radiation and medical oncologists
- general surgeon or physician
- specialist surgeon
- palliative care clinician
- nurse – for example, a clinical nurse specialist or cancer nurse coordinator
- allied health professionals – for example, a dietitian, physiotherapist, cultural support worker or social worker
- medical students may attend as part of their education.

To make sure you are receiving the best possible care, the team will meet to review your case and recommend the most appropriate treatments for you. The team is responsible for:

- recommending your treatment plan
- deciding on further tests
- making appropriate referrals to specialist services
- collecting information and keeping good records.

There may be some people at the meeting who are not involved in your case.

What happens at a multidisciplinary meeting?

During the meeting the team will review your medical history and your test results. Personal or other health information that you have disclosed to any member of the team, including your general practitioner, may be shared at the meeting if relevant to your treatment. If there is a specific issue you would like raised for consideration please discuss this with your doctor. Everyone at the meeting is bound to keep the information confidential, just as they would in a face-to-face consultation with you.

What happens after the meeting?

After the meeting, the person managing your care will tell you what course of action the team recommends. This may be at a follow-up appointment or by phone depending on their arrangement with you. You will have the opportunity to ask questions and indicate any preferences you have for treatment. The final decision about your treatment plan is made in consultation with you.

What if I have a concern or question?

The cancer nurse coordinator or clinical nurse specialist is the link between you and the team. Your consultant will write letters to your general practitioner to keep them informed too.

If you have any questions about your team, or about the meeting at which your case will be discussed, please contact the cancer nurse coordinator or clinical nurse specialist in the first instance.