Development of a Quality Framework for Cancer Multidisciplinary Team meetings in Victoria

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Background:

In 2014 a survey of 140 Victorian cancer multidisciplinary team meetings (MDMs) conducted by the Department of Health and Human Services (DHHS) identified significant variation in their operation. Development of a quality framework was recommended, which health services could use to measure their activities against state-wide standards. In response, Integrated Cancer Services (ICS) supported a project to develop this MDM Quality Framework.

Method:

The Framework is an agreed set of standards, indicators and measures, and a set of quality monitoring tools, for all Victorian cancer MDMs. It was drafted with reference to peer-reviewed MDM literature, DHHS policy, and consultation including clinician interviews, surveys, peer review and a test audit in seven tumour streams across five health services. Project validation included input from 25 phase one survey responses, 197 MDM participants, 40 ICS staff and 10 DHHS staff.

Results:

Standards developed included infrastructure support alongside "clinically facing" areas including patient referral and communications, and meeting organisation and conduct. Surveys asked MDM participants to rate recognition of the eight draft standards in their current practice. Three standards (meeting organisation, membership and leadership) received 100% support and a further three standards (infrastructure and organisational support, patient referral and MDM recommendations and communication) received over 90% support.

Table 1: Overview of Quality Standards

QS 1: Infrastructure and organisational support
QS 2: Meeting organisation
QS 3: Membership
QS 4: Leadership
QS 5: Consent
QS 6: Patient referral
QS 7: Streamlining patient discussion – for MDMs which use prioritisation (optional)
QS 8: MDM recommendations and communication

HEALTH SERVICE LEVEL (oversight, resourcing, governance)

STRUCTURE OF MEETING: INPUT (who attends, when, where, how)

WORKFLOW OF MEETING: OUTPUT (referral protocols, data, timeliness, communication)

Table 2: Aggregated Results from MDM Participant Audit [n=88]

Questions from survey of MDM participants	Weighted average [0-7 Likert scale]	% agreed with this statement
I understand my role in actioning patient referrals after the final treatment plan is made, post-MDM.	6.17	96%
Patient management is decided based on broad input from a range of participants.	6.14	96%
Appropriate attempts are made to reach agreement about treatment recommendations.	6.01	94%
I understand my role working with the patient to develop the final treatment plan after MDM.	6	94%
I am satisfied with the way that complex patients are presented.	5.94	93%
The chairperson facilitates group discussion so a variety of team members contribute.	5.89	93%
MDM provides good opportunities for my own learning and professional development.	5.86	84%
I understand my role in presenting MDM treatment recommendations to the patient, including divergent recommendations.	5.85	92%
The chairperson acts fairly and objectively so that all members are supported to raise ideas and receive peer review.	5.82	90%
I am satisfied with the way that routine patients are presented.	5.81	93%
The chairperson mediates disagreements.	5.61	85%
The chairperson creates a culture of support for education and professional development within the MDM.	5.53	83%
The chairperson ensures new research and clinical trials are considered for relevant patients.	5.49	82%
Where there is more than one treatment opinion, divergent treatment recommendations are recorded.	5.27	73%
Presenters are adequately prepared to answer questions about patients they are presenting at MDM.	5.24	73%
I refer relevant patients to external MDMs when more specialised expertise is required.	5.2	70%
Optimal care pathway (OCP) timeframes are considered when making decisions about patient management.	5.09	63%
I refer all my public patients with a new or suspected diagnosis of cancer to MDM.	5.02	70%
The number of late presentations to MDM is acceptable.	4.7	62%
I provide written or verbal information to patients on how they will be informed of MDM recommendations, prior to presenting them.	4.55	52%
I refer all my private patents with a new or suspected diagnosis of cancer to MDM.	4.34	52%
I provide written or verbal information to patients on MDM covering who will be able to view their information, prior to presenting them.	4.18	63%
I give my patients the opportunity to opt-out of presentation at MDM.	3.13	23%

Framework audit tools were designed for auditors with limited understanding of MDM. The tools use a combination of data collection, MDM participant surveying, and interviewing. Organisations planning to improve MDMs will conduct a baseline audit against the Framework using these tools.

This audit will allow comparison of practice between MDMs within a service and against other services. This will establish future work and quality improvement through local and state-wide projects. Auditing will allow health services to align MDMs with existing accreditation activities, provide data to engage executive in change, and underpin business cases for improvement.

Conclusion:

Conducting the planned baseline audit against the framework and initiating state-wide projects for 2019/20 year will support full implementation. Quality improvement via routine auditing against the Framework will map success and future priorities. Improvement activities have already been initiated in two regional and one metropolitan MDM that participated in the test audit.

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