TE AHO O TE KAHU CANCER CONTROL AGENCY

New Zealand Government

Standards for high-quality cancer Multidisciplinary Meetings (MDMs) in Aotearoa New Zealand

March 2024

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Introduction

The cancer Multidisciplinary Meeting (MDM) is a forum for collaboration between health professionals with expertise in the diagnosis and management of cancer. At these meetings, participants collectively review all clinical, psychosocial, and cultural information pertinent to each patient's care, and recommend personalised treatment and care options based on best practice treatment pathways.

These meetings are key to enabling a safe, high-quality, collaborative, and patient-centred approach to identify the optimal and most appropriate treatment and care plans for a person and their whānau.

Effective MDMs support equitable outcomes for all cancer patients. This is particularly important for Māori, Pacific peoples, those who live rurally, and other groups who experience avoidable and unfair differences in cancer outcomes.

The benefits of effective MDMs may include:

- improved treatment planning as health professionals consider the full range of therapeutic options available
- reduce health inequities experienced by Māori, Pacific peoples, people living rurally and other priority patients using a person-centred framework
- improved communication between care providers as clear lines of responsibility are developed between members of the MDM
- improved service coordination
- greater continuity of care and less duplication of services
- more patients being offered the opportunity to take part in relevant clinical trials
- enabling clinicians to share and discuss latest evidence and/or approaches to increase skills and knowledge.

Purpose of this document

This document replaces the *Guidance for Implementing High-Quality Multidisciplinary Meetings* developed by the Ministry of Health in 2012. It recognises that in Aotearoa New Zealand MDMs are now well established but remain under pressure in a resource constrained environment. The document resets the direction of MDMs in Aotearoa and the quality requirements for equitable, efficient and effective MDMs.

The updated document aligns with:

- Te Pae Tata Cancer Action - Develop new, joined-up pathways to facilitate rapid diagnosis of suspected cancer, beginning in primary care to support equitable access to cancer diagnostic and treatment options
- Interim Government Policy Statement on Health 2022-2024.
- New Zealand Cancer Action Plan 2019–2029 Outcome 4: New Zealanders have better cancer survival, supportive care and end-of-life care
- NZS 8134-2021 Ngā paerewa Health and disability service standards, Standards New Zealand | Te Mana Tautikanga O Aotearoa
- Te Aho o Te Kahu values - Equity led, Whānau centred, Knowledge driven, and Outcomes focussed.

The document describes best practice standards across the following quality areas:

- Quality Area 1: MDM governance
- Quality Area 2: MDM resourcing and infrastructure
- Quality Area 3: MDM members and roles
- Quality Area 4: MDM referral
- Quality Area 5: MDM process
- Quality Area 6: MDM data.

While these standards have been developed specifically to guide the functioning of cancer MDMs it can provide guidance for the development of MDMs in other areas of health.

How it was developed

A literature review was undertaken, and a multidisciplinary project Advisory Group and subject matter experts provided advice. Work that has further informed this document is listed below:

- Ministry of Health Cancer services work (prior to the establishment of Te Aho o Te Kahu) including national provisional tumour standards, Lung Cancer Multidisciplinary Toolkit and MDM National Future State Business Requirements and Processes;
- Regional Cancer Network (now Te Aho o Te Kahu regional hubs) initiatives including MDM establishment, quality improvement initiatives, IT procurement and implementation;
- Te Aho o Te Kahu initiatives including:
  - 2021 review of the existing Ministry of Health MDM Guidance (work was commenced but not completed)
  - 2022 review of the HISO (Health Information Standards Organisation) MDM Data Standards
  - 2022-23 Cancer Services Planning Programme
  - Quality Performance Indicator Programme.

Audience for the standards

The document has several audiences:

- Health professionals who run and/or participate in MDMs
- Health New Zealand | Te Whatu Ora hospital and health service operational leads who are responsible for ensuring that individual MDMs are supported and managed appropriately
- National organisations involved in cancer service commissioning and monitoring, and those developing models of care, including Health New Zealand and Te Aho o Te Kahu.

While this is not a public facing document it has been written in plain English that meets the *Communication Standards for Ministry of Health | Manatū Hauora* to ensure it is accessible to patient and whānau.

Key definitions

The following key terms are used in this document:

Term	*Definition*
Equity	*In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.*
Lead Clinician	*The senior health professional who currently has responsibility for an individual patient's care.*
Multidisciplinary Meeting	*The cancer Multidisciplinary Meeting (MDM) is a forum for collaboration between health professionals with expertise in the diagnosis and management of cancer. At these meetings, participants collectively review all clinical, psychosocial, and cultural information pertinent to each patient's care, and recommend personalised treatment and care options based on best practice treatment pathways.* *It is important to note the difference between a cancer MDM which focuses on treatment decision making and the wider Multidisciplinary Team (MDT) which meet with the patient and whānau to discuss, develop and enact care plans.*
Multidisciplinary Team	*A Multidisciplinary Team involves a range of health professionals, from one or more organisations, working together to deliver comprehensive patient care.*
Priority populations	*Priority populations are Māori, Pacific peoples, and other populations who experience a disproportionate impact from cancer and inequities in terms of cancer risk, incidence, treatment and outcomes.*
Proforma	*An electronic or paper-based template consisting of the required data fields for an MDM.*

Cancer MDMs in Aotearoa

Multidisciplinary Meetings (MDMs) are an important component of quality cancer care. These meetings help improve the quality of cancer care people receive and their health outcomes. Cancer MDMs have been a core function within the cancer pathway for treatment planning for over 10 years in Aotearoa. There are more than 300 individual MDMs across Health New Zealand hospitals held weekly, fortnightly, or monthly. MDMs are organised around local, regional, supra-regional or national populations depending on the tumour stream. Ideally MDMs are conducted with the participants meeting face-to-face, however in Aotearoa, MDMs are predominantly delivered in a hybrid environment (with some members attending in person at the host hospital and other members linking in virtually), or in a fully online environment. Infrastructure requirements include dedicated MDM rooms, web based mobile devices, digital image presentation and software for managing referrals and collecting clinical data to inform and record discussions. Experience with the COVID-19 pandemic has also identified that processes need to be in place to transition MDMs to a fully online environment at short notice and to operate in a resource constrained environment.

The State of Cancer in New Zealand Report (Te Aho o Te Kahu 2020) noted issues with MDMs in Aotearoa. These included: a lack of standardised information to help determine which cancers should be prioritised and discussed in MDMs, the inability to collect data and information nationally to allow evaluation and monitoring of cancer care services and ongoing concerns about the increasing demands on clinician time in preparing for and attending MDMs (Ministry of Health 2016b).

Te Tiriti o Waitangi

Māori are more likely than non-Māori to be diagnosed with a range of cancers including breast, liver, lung, pancreatic, stomach and uterine cancers (Te Aho o Te Kahu 2021). Substantial gaps remain in cancer survival rates between Māori and non-Māori (J. K. Gurney et al., 2020; Robson et al., 2010; Te Aho o Te Kahu, 2021). Mortality rates are higher for Māori for most common cancers, with the highest disparities in cancer mortality seen in breast, liver, lung, pancreatic and stomach cancers. Overall Māori are twice as likely as non-Māori to die from their cancer (Te Aho o Te Kahu, 2021). In addition, research has highlighted how racism has been implicated as a major contributing factor to the persistence of Māori health inequities (Borell et al., 2009; Gracey & King, 2009; Harris et al., 2012; Harris et al., 2006; Johnstone & Kanitsaki, 2010; King et al., 2009; Pack et al., 2016; Palmer et al., 2019; Reid & Robson, 2000).

In response to the recent Health Kaupapa Inquiry (WAI 2575), the Waitangi Tribunal recommended the implementation of five Te Tiriti o Waitangi principles to drive the future delivery of health care in Aotearoa (Te Aho o Te Kahu 2023; New Zealand Waitangi Tribunal 2019).

Tino rangatiratanga – which provides for Māori to exercise self-determination in the design, planning, implementation, monitoring, and evaluation of health care for Māori.

Equity – the commitment of the Government to ensure equity in health access and outcomes for Māori.

Active protection – ensuring the Government and its agencies undertake all reasonable actions to achieve equity, as well as to inform Māori of the extent and nature of these efforts and subsequent impact on Māori health outcomes.

Options – ensuring the Government provides support and resourcing of kaupapa Māori services and ensures all mainstream services are delivered in a culturally acceptable and safe manner.

Partnership – ensuring Government agencies work in partnership for the governance, design, delivery, and monitoring of health services for Māori.

Equity

In Aotearoa, people experience differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to receive equitable health outcomes. (Ministry of Health 2020).

There are inequities at every step along the cancer continuum including individual's exposure to risk factors, their likelihood of developing cancer, access to screening, access to timely assessment and diagnosis, and their ability to access appropriate cancer treatment and ongoing care (Dew et al., 2015; J. Gurney et al., 2020; Hill et al., 2010; Seneviratne et al., 2015; Signal et al., 2015; Walker et al., 2008). Inequities are more likely to be experienced by Māori and Pacific, people living in deprived areas, disabled people, SOGIESC diverse peoples and those living in rural areas.

An equity-led focus identifies and addresses drivers of inequity that exist across the cancer pathway, for Māori and other population groups. At every point along the pathway, person/ whānau should be able to access and receive timely, appropriate, and quality care.

The requirements identified in each Quality Area support MDMs to adopt Te Tiriti o Waitangi and equity-led approaches, include:

- Implementing governance and routine audit functions to enable potential inequities in access, process or outputs to be identified and addressed
- Referring patients to the MDM to provide greater visibility of all people on the pathway and provide opportunities for additional interventions if required
- Information required to support the MDM discussion includes wider psychosocial and cultural knowledge of the patient/whānau, including any preferences they may have expressed
- Appointing health professionals with the most direct knowledge of the patient to the MDM
- Developing personalised treatment and care options which are then discussed with patients/whānau.

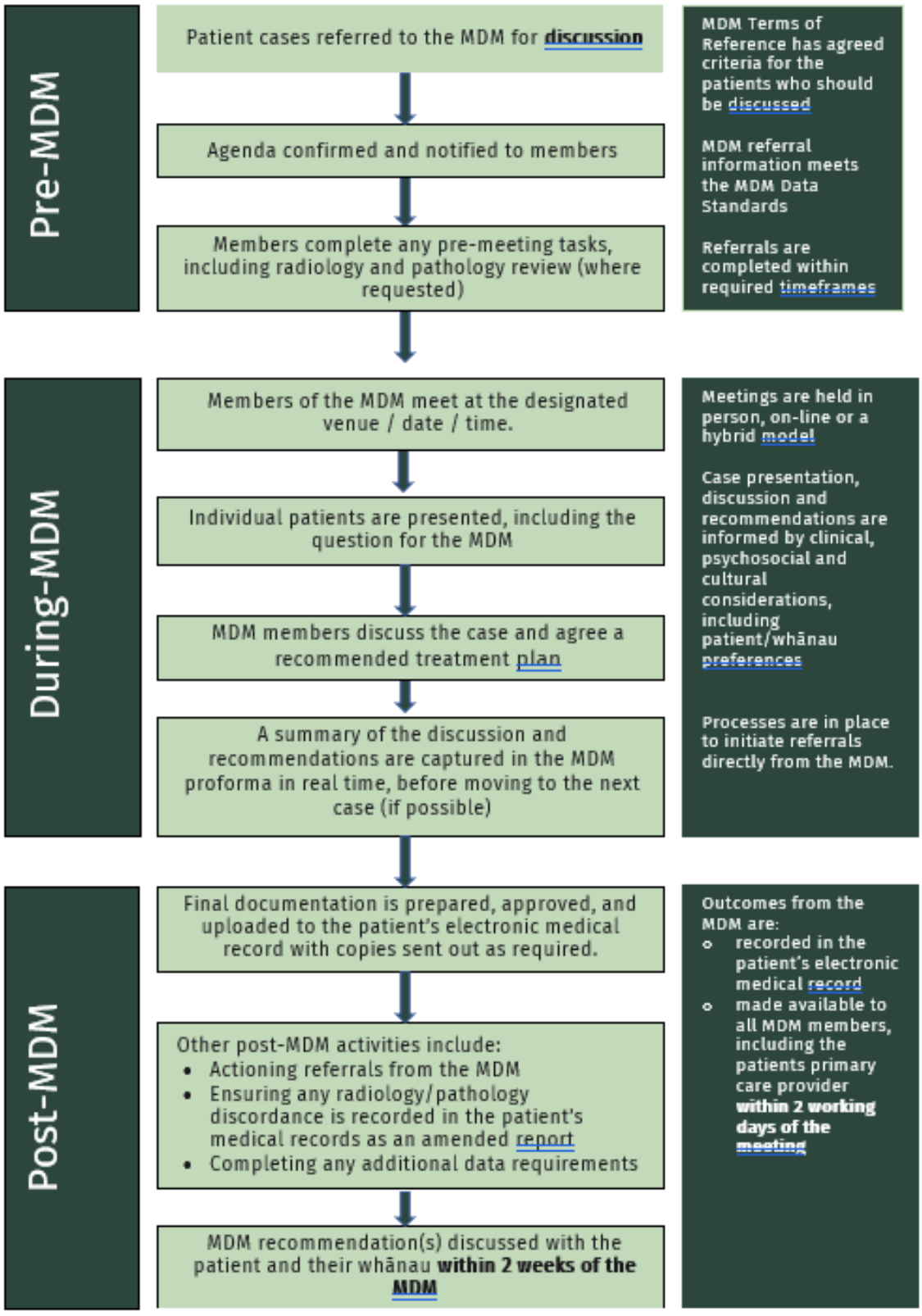
Enabling high-quality MDMs in Aotearoa

MDMs will:

- Ensure patient privacy using secure processes to create and share both patient lists and individual patient information appropriately in face-to-face and online MDMs
- Enable equitable access (geographically and by tumour stream) to the combined expertise that an MDM offers patients with cancer
- Have governance and audit functions in place that support and monitor the efficient and effective operation of MDMs
- Be held in rooms using technology/ tools which meet the technical, privacy, and process requirements of MDMs
- Have the workforce required to ensure MDM membership and attendance meets the clinical need of patients with cancer.

The following sections identify the specific requirements to deliver high quality MDMs.

MDM Process Flowchart



Quality Area 1: MDM governance

Rationale

Clinical governance provides a means for clinicians, managers, and other staff to work together to improve, and be held accountable for, the quality and safety of the health services they provide.

MDM governance needs to provide leadership and direction to achieve efficient, effective, equitable and sustainable MDMs. Governance at an individual MDM level includes undertaking self-review under a programme of continuous quality improvement.

It is important that issues that may affect safety, sustainability, and minimum quality requirements for MDMs can be escalated to regional MDM governance structures. MDMs function in an interdependent environment, meaning any proposed changes to wider hospital scheduling, membership or facilities could impact on other MDMs regionally or nationally, and therefore requires careful management.

Audit of MDMs is essential to the assurance of standards and process indicators should be defined to assess the impact and the performance of MDMs more consistently.

Requirements

1.2 MDM governance functions are required at the individual MDM, regional, and national levels to ensure they are run efficiently and meet the requirements identified in this document.

1.1 Individual MDM governance functions include:

- Undertaking an annual review of the MDM Terms of Reference to ensure they remain fit for purpose – see Resource A
- Undertaking an annual operational audit of the MDM against the MDM standards – see Resource B
- Undertaking an annual survey of MDM members to understand their experience of the MDM and where improvements could be made – see Resource B
- Reviewing the scheduling and duration of the MDM to ensure attendance is maximised and adapt to changing patient volumes
- Monitoring for major changes to existing diagnostic or treatment pathways including any interim measures that may be required, in discussion with the relevant tumour streams. Details of major changes that influence MDM decision making are to be documented to allow for audit.

1.2 Regional MDM governance functions include:

- Decision making on requirements for implementing new MDMs, amalgamating existing MDMs, extending session times of MDMs or rescheduling of MDMs
- Overseeing the processes to move MDMs to online during emergency periods e.g., pandemic, natural disasters
- Reviewing annual audit results from individual MDMs in the region.

1.3 National MDM governance functions include:

- Decision making about how MDMs will operate in a resource -constrained environment, guided by the NZ Medical Council's *Safe Practice in an Environment of Resource Limitation*. URL **www.mcnz.org.nz/assets/standards/ca25302789/Safe-practice-in-an-environment-of-resource-limitation.pdf**
- Overseeing and addressing any emerging issues for specific tumour streams and/or regions
- Emerging requirements for any additional national MDMs.
- Advising on MDM data standards and quality requirements

Quality Area 2: MDM resourcing and infrastructure

Rationale

MDMs can be time-intensive and costly. By managing these efficiently we can help ensure patients receive timely, accessible treatment options and care, using the often limited resources available. These guidelines embed regular reviews and continual improvement processes so regular MDMs can support patients and whānau, while maximising the resources available.

To function efficiently MDMs require organisational commitment to provide the infrastructure, clinical and administrative resources. These requirements will be reflected in Health New Zealand's Hospital and Specialist Service strategic and operational planning to ensure MDMs continue to be supported by the required workforce and technology.

Most facility requirements are managed by the host hospital however there are also minimum requirements for sites joining remotely that need to be in place. It is important that the host hospital understands the role and importance of the MDM and provides the required resources.

Requirements

2.1 Workforce

2.1.1 All health workers who will be expected to participate in MDMs have the following inclusions in their position descriptions:
- Clinical Section: participate in relevant cancer MDMs and MDM governance functions as required
- Education Section: MDM attendance can be utilised to meet the requirements of peer review or professional development as informed by specialty colleges.

2.1.2 Job sizing, clinical workloads and schedules, and service planning take into account staff requirements for supporting local, regional and/or national MDMs, including leave cover.

2.1.3 For clinicians who are not employed by Health New Zealand | Te Whatu Ora eg, private pathologists, radiologists, palliative care specialists, organisational level contracts must include requirements to support MDMs.

2.1.4 Clinical time requirements for MDM Chairs / radiologists / pathologists also account for their time to undertake identified pre, during and post-MDM functions (see table 1).

2.1.5 MDM Chairs have access to training to support them to run efficient meetings which allow for robust, inclusive discussions, and drives consensus decision making.

2.1.6 Dedicated MDM coordinator roles are required for all hospitals that host MDMs. Coordinators require specialist training (technical / medical terminology / transcription) and there must be equivalently trained cover in their absence.

2.1.7 IT support in all hospitals proactively manage equipment to ensure that online MDMs avoid loss of sound, loss of imaging or other technical issues that can impact on the smooth running of the meeting.

2.2 Facilities

2.2.1 In person, online and hybrid MDMs are hosted in a room that enables confidential discussions and space to accommodate all participants attending in-person. Additional requirements include:

- The room will be easily accessible to attendees and configured to enable clear visualisation of the pathology/radiology presentations, MDM proforma and MDM members joining virtually
- Seating arrangement will promote collaborative discussions
- Microphones and speakers will enable seamless discussions and interactions between in-room and online participants.

2.2.2 Technical equipment to support MDM meetings at host sites includes:

- Computer workstations for displaying relevant high-definition images, electronic patient records, and enabling transcription at the MDM
- Pathology slide cameras
- High-definition equipment eg, monitors, projectors for displaying and viewing pathology/radiology, MDM online participants, MDM proformas
- Audio equipment which is fit for purpose and supports seamless discussion
- Conferencing technology which enables confidential online participation.

2.2.3 Members who are attending online will join from a venue that:

- allows for confidential, uninterrupted discussions
- has high-definition monitors to enable real-time visualisation the pathology/radiology images, the MDM proforma and those present at the MDM
- has audio equipment that enables real-time participation in the MDM.

2.2.4 MDM software incorporating SNOMED-CT medical terminology, FHIR interoperability standard and HISO standards are in place in each region which:

- Provide system-wide access to and visibility of information (across regions and nationally)
- Collect relevant and complete sets of data based on current data standards
- Provide automated data flows and distribution of information
- Support workforce optimisation by streamlining (and where possible automating) processes and ensuring data are captured at critical points
- Provide interface capability that integrates patient information across multiple environments into a consolidated MDM record
- Provide a paperless environment
- Provide reporting capability.

2.2.5 Health New Zealand | Te Whatu Ora has service contracts in place to ensure MDM hardware and software maintenance and upgrades happen in a timely manner. Also required is dedicated support for immediate troubleshooting during an MDM.

Quality Area 3: MDM members and roles

Rationale

The MDM members will comprise the disciplines integral to the provision of care for the cancer type, and will reflect clinical, psychosocial and cultural aspects of care.

To ensure that the patient has access to the full range of therapeutic options, the MDM team may be expanded as required, including but not limited to genetics, psychiatry and nuclear medicine. Members may attend the meeting online or by providing specific information/advice to be tabled at the meeting.

Requirements

3.1 MDM members include:

- radiologists
- pathologists
- radiation oncologists
- medical oncologists
- surgeons
- specialist physicians

(should have sub-specialty interest in the type of cancer being discussed)

- palliative care clinicians (highly recommended for tumour streams with a large proportion of palliative patients e.g., lung, pancreatic)
- nurse practitioners, clinical nurse specialists, cancer nurse coordinators, kaiawhina, equity nurses / navigators
- allied health or psychosocial support professionals
- MDM coordinator at the host site (or equivalent).

The specific representation for every MDM will be recorded in their Terms of Reference.

3.2 Private provider clinicians attending the MDM to discuss their patients are encouraged to participate in the entire meeting to share their expertise and build collaborative relationships.

3.3 If a patient's GP or primary care provider wishes to attend an MDM to advocate for their patient, this may be facilitated by the Lead Clinician and / or MDM co-ordinator.

3.4 Ideally more than one member from each specialty area will attend an MDM to inform discussions however this is not always practicable.

3.5 It is important that no recommendations are made for a patients care in the absence of the relevant diagnostic / treatment specialty.

3.6 A register of attendance for members of the MDM will be kept for each meeting. The names of the members involved in the discussion of individual patients will be recorded and included on post-MDM communications.

3.7 Where members are available for only part of the meeting the MDM Coordinator and / or Chair will be advised so the agenda is organised to ensure relevant patients are discussed while key clinical staff are present.

3.8 MDMs are an identified training / learning opportunity for nursing, medical and allied health students, but those attending are not considered a member of the MDM.

3.9 All attendees must follow Health New Zealand | Te Whatu Ora's confidentiality requirements.

3.10 MDM members with specific functions are identified in the following table:

Table 1: Specific roles and their functions within the MDM

MDM role	Responsible for Pre- MDM	During the MDM	Post-MDM
MDM Chair The MDM has a designated Chair, who will nominate a delegate/deputy to cover in their absence. The Chair is appointed under the MDM Terms of Reference requirements.	• Reviewing patient information prior to MDM • Decisions regarding quorum and appropriateness for the meeting to proceed • Managing late/urgent referrals • Delegating/handing over Chair duties if unable to attend.	The Chair facilitates discussion and oversees that: • the MDM team comprises the necessary disciplines to ensure best practice • all issues relevant to a patient's case are presented and discussed • there is a focus on factors that contribute to equitable outcomes • members participate in the meeting as appropriate to their specialty • an agreed recommendation(s) for a case is reached and accurately documented. Where a consensus on recommendations is not reached this is documented. • the meeting runs in a timely manner and to schedule.	• Approval of final patient documentation prior to uploading to the patient's medical records.
	The Chair initiates an annual review of the Terms of Reference, the MDM audit and reviews results with the team.		
MDM Coordinator (or equivalent) A single point of coordination for MDMs. They provide effective agenda management functions, support the participants and improve	• Receiving referrals and ensuring completeness • Ensuring all mandatory data and information items are documented on the proforma and/or are available for the meeting • Liaising with the MDM Chair where an MDM is oversubscribed • Liaising with radiology and pathology to ensure information is available for the meeting.	These functions may be undertaken by the MDM Coordinator or other administration staff: • Documenting MDM member attendance • Documenting discussions and agreed treatment plan/outcome. Registrars may also do this. • Managing technical issues arising in the meeting (to the best of their ability) or escalates for resolution,	• Communication/dissemination of information following the MDM once the MDM Chair has approved the documentation. • Ensuring data is collected on MDMs to inform audit and reporting.

MDM role	Responsible for Pre- MDM	During the MDM	Post-MDM
communication, maintain standards and ensure timeliness. In larger hospitals, a coordination team may be required.	• Preparing the MDM agenda and sending to members prior to the meeting • Notifying and inviting members to MDM meetings • Preparing and distributing the agenda • Liaising with technical staff as required • Facilitating a process for referrals received after deadline.		
Lead Clinician (or delegated nominee)	Completing all mandatory fields in the MDM referral including: • a clear reason for why the patient is being discussed • the patient's demographics • relevant test results • whether a formal review of the radiology or pathology results is required and why • comorbidities, supportive care requirements (including palliative care needs), performance status • the patient's history and preferences • the name and contact of the referring and presenting clinician.	• Introduces the patient including their ethnicity and where they live • Outlines their history, relevant test results, patient factors including any disabilities, comorbidities, performance status, supportive and cultural requirements and patient preferences • The reason for why the patient is being discussed.	• Discussing recommendations with patient/whānau • Making any other referrals as documented at the MDM and maintaining oversight of the patients pathway.
Radiologist	If a formal radiology review is requested: • obtain and sort images • review selected patient images and reports in relation to the reason for the review.	• Present the findings of their review and associated images. • Clearly state they agree (or not) with the original radiology report. This will be documented in the MDM patient proforma.	Ensure any discordance with previous results is recorded in the patient's medical records as an amended report.

MDM role	Responsible for Pre- MDM	During the MDM	Post-MDM
			Present major radiology discrepancies at an appropriate peer review meetings
Pathologist	If a formal pathology review is requested: • obtain and sort slides • review selected patient slides and reports in relation to the reason for the review.	Present the findings of their review and associated slide and clearly state they agree (or not) with the original pathology report. This will be documented in the MDM patient proforma.	Ensure any discordance with previous results is recorded in the patient's medical records as an amended report Present major pathology discrepancies at an appropriate peer review meetings.
Nurse Practitioners, Clinical Nurse Specialists, Cancer Nurse Coordinators equity nurses/navigators (acknowledging that not all the functions listed will be undertaken by all)	• Completing the MDM referral (Nurse Practitioner / Clinical Nurse Specialist) or on behalf of the Lead Clinician as per the requirements above • Assist MDM Coordinator as necessary to compile agenda and ensuring patients needing review (such as, pre- and post-op, abnormal surveillance scan) are submitted for review • Ensure all relevant information is available, including results / investigations • Liaising with out of region CNSs, Drs and other relevant staff to ensure their patients details/relevant information is provided • Informing patient / whānau of the meeting.	• Present patient information when required • Providing additional knowledge about patient factors (see Lead Clinician functions).	• Ongoing care coordination • Documenting outcomes where appropriate • Discussing recommendations with patient/whānau • Making any referrals documented at the MDM • Maintaining oversight of the patient's pathway.
Allied health and/or psychosocial professionals		Advising about patient factors including psychosocial requirements or clinical interventions that may either be underway or be required eg, dietician, speech language therapy.	Actioning referrals to their services.

Quality Area 4: MDM referral

Rationale

The requirement for patients to be discussed in an MDM is included in national cancer policies and guidelines, including the National Screening Unit standards. Each MDM also has their own Terms of Reference which can also include specific referral guidance / criteria. Across all these documents there are conflicting requirements which is resulting in lack of clarity for MDMs and ultimately inequitable access.

In the face of increasing patient volumes and complexity, the United Kingdom and Australia have implemented stratification processes for managing referrals to MDMs: those patients where full discussion at the MDM is required, for example due to clinical complexity or psycho-social issues, and those cases where a patient's needs can be met by a standard treatment protocol, and so do not require discussion at the MDM. A key enabler for this is the development of standards of care and care pathways.

In Aotearoa individual MDMs already use stratification processes for identifying patients that require an MDM discussion. This process may not be consistent across the country as MDM capacity across regions varies. The level of discussion required depend on whether best practice treatment pathways are in place, for example, cancer screening quality standards. Different tumour streams and different regions may require all patients to be registered to the MDM system to support patient management However this is not driven by data collection reasons only and must provide clinical benefit.

To note patients may be discussed at several time points during their diagnosis and treatment.

Requirements

4.1 MDMs will use nationally consistent criteria (by tumour stream based on clinical, psychosocial and cultural considerations) to identify which patients are referred to the MDM and when, including:

- those new patients who require a full discussion to develop initial treatment plan recommendations;
- those patients who may only require an abridged discussion in relation to specific aspects of their care plan, including new and existing patients.

There may also be benefit in registering all other new patients to the MDM depending on the tumour stream and the MDM system being used. A minimum dataset will need to be identified for patients only registered to the MDM.

Simple non-melanoma skin cancers (SCC/BCC) are excluded.

The specific referral criteria for each MDM will be included in their TOR.

4.2 There are agreed diagnostic and staging pathways (regionally or nationally) underpinned by the Optimal Cancer Care Pathways (under development) which identify at what point(s) patients are presented to the MDM to ensure all the relevant information is available for the discussion.

4.3 Presentation of patients seeking treatment in the private sector at Health New Zealand MDMs is based on clinical need and with the same level of access as public patients. Specific additional requirements for referrals initiated from the private sector include:

- The private sector clinician referring the patient to the MDM must attend and present their patient
- All required pathology and radiology slides / images / reports to be provided directly to the MDM Coordinator
- Patients are made aware that data relevant to the MDM will be captured and stored on Health New Zealand | Te Whatu Ora systems and may be used for audit and reporting purposes.

4.4 MDM referral information must be completed by the referring clinician (or delegate) with all mandatory fields completed – see Resource D for a summary of the MDM data standard fields.

4.5 The Terms of Reference (TOR) will specify the deadlines for receiving referrals before the MDM to ensure radiology / pathology reviews can be undertaken. The TOR will also include a process for managing any urgent late referrals i.e. where a delay will affect a patient's health or treatment outcomes.

4.6 Patients and their whānau must be offered appropriate information regarding the process and purpose of an MDM, including the types of health professionals who will be present and what will be discussed.

4.7 Inevitably, there will be delays to presenting some patients due to demand, so a protocol for prioritising patients is required. Considerations for patient prioritisation will include:
- clinical urgency
- patients with a first cancer diagnosis
- patients who were delayed from a previous MDM
- Māori, Pacific peoples, and other populations who experience a disproportionate impact from cancer.

Quality Area 5: MDM process

Rationale

A cancer MDM is an opportunity to embed processes that will help address inequities by using a patient-centred approach, mitigating implicit bias, and ensuring that all Māori and Pacific patients are discussed and prioritised in every meeting. Cancer MDMs must enable a holistic view of a patient's needs, views, and other impacting factors so that an appropriate treatment and care plan can be formulated. Critical to this holistic approach is embedding the proactive management of co-morbidities into any care plan. These factors should not unnecessarily limit a patient's access to treatment and care options, rather guide comprehensive care plans that include biomedical, socio-economic and other patient-centred information presented at an MDM.

Cancer MDMs must enable timely discussion of referred patients to minimise treatment waiting times and to help achieve the Faster Cancer Treatment (FCT) 62 Day indicator (The maximum target length of time taken for a patient referred with a high suspicion of cancer, where the triaging clinician believes the patient needs to be seen within two weeks, to receive their first treatment (or other management) for cancer).

Factors supporting improved decision making in MDMs
Research on MDM decision making process in Aotearoa found that meeting members categorised cases in varying ways, drew on a range of sources of authority, expressed different value positions and used a variety of strategies to justify their actions. An important dimension of authority was 'encountered authority' – the authority a clinician had because of meeting the patient. The MDM Chair can play an important role in making explicit the sources of authority being drawn on and the value positions of members to provide more clarity to the decision-making process. Attending to issues of process, authority, and values in MDMs has the potential to improve cancer care decision making and ultimately patient health outcomes.

Cancer patients with comorbidities are considerably less likely to be offered active therapy despite growing evidence that such treatments are both tolerated and effective. Comorbidity needs to be systematically discussed in MDM decision-making and how they may be proactively managed will be embedded into any care plan. These factors should not unnecessarily limit a patient's access to treatment and care options, rather guide comprehensive care plans that include biomedical, socio-economic and other patient-centred information presented at an MDM.

Studies looking into the compliance with MDM recommendations generally identify high agreement and reinforce MDMs as an essential part of the decision-making process for the optimal multidisciplinary management of patients with cancer. Reasons given for treatment noncompliance related to patient/whānau decisions, including fear of toxicity, choosing an alternative treatment, and treatment inconvenience. This reinforces the importance of considering patient choice within the MDM discussion and how the post-MDM discussion with the patient is managed.

Requirements

Note: Also see information already covered in Table 1: Specific roles and their functions within the MDM.

5.1 Scheduling of meetings

5.1.1 Meeting frequency should be determined by a combination of patient volumes and timely patient management.

5.1.2 The duration of the meeting will be determined by a combination of patient volumes and the average time required for discussions and to confirm a recommendation. It is important that meetings do not over run their allocated time slots.

5.1.3 Meeting scheduling is reviewed and confirmed at the beginning of each year to ensure alternative arrangements for public holidays and anniversary weekends can be made. This requires a regional lens due to the interdependence of MDMs.

5.2 Case presentation, discussion, and recommendations

5.2.1 The Lead Clinician, or their delegate (who is briefed), presents the patient's case at an MDM including the reason for the MDM review. If a Lead Clinician is unable to attend an MDM, it is expected that they will explicitly delegate their patients to another clinician who will attend on their behalf, to limit any treatment delay to those patients. No case is discussed in the absence of the Lead Clinician or their delegate.

5.2.2 When developing treatment recommendations for each patient, MDM participants ensure:

- the diagnosis and tumour grading are correct and other relevant prognostic factors are available
- the tumour has been adequately staged
- all appropriate treatment modalities are discussed
- psychosocial and medical comorbidities that may influence treatment decisions are taken into account
- the patient's treatment preferences, if known, are taken into account
- relevant clinical trials are considered
- relevant optimal care pathway timeframes are included, including facilitating access for patients in remote areas

5.2.3 To support equity-led and person / whānau centred discussions, information about the following will also be presented:

- whether the patient belongs to any of the population groups who are known to experience inequities in the system including Māori, Pacific, low socio-economic, rural, disabled, and people with diverse sexual orientation, gender identity, gender expression and sex characteristics (SOGIESC)
- any known barriers that have already impacted on the patient's journey to identify if any delays already experienced can be mitigated in the next phase eg, time to start treatment, additional care coordination support
- any known patient / whānau preferences.

5.2.4 MDMs agree by consensus and record recommended options and key points of the discussion during the meeting. Alternative opinions or discussion points must also be documented.

Optimal treatment pathway options for the patient will be clearly identified. This is very important when the treating clinician has not been present for the discussion but receives the referral.

5.2.5 MDM members must have access to an up-to-date list of open and relevant clinical trials.

5.2.6 If issues (e.g., technical, clinician attendance) arise in the meeting that compromise the quality and / or safety of a patient(s) discussion, then the MDM Chair should defer that patient or the MDM meeting as a whole if necessary.

5.3 Communications from the MDM

5.3.1 Outcomes from the MDM are recorded in the patient's electronic medical record and made available to all MDM members, including the patient's primary care provider **within 2 working days of the MDM**. There should be sufficient information provided so clinicians involved in the next stage of care are able to understand the rationale for the recommendations.

5.3.2 The Lead Clinician is responsible for discussing the MDM recommendation(s) with the patient and their whānau **within 2 weeks of the MDM**. This discussion will include:

- outlining the information the MDM recommendation(s) were based on, including any differing opinions offered about treatment options
- advising of any referrals that have been made

5.3.3 If, based on this discussion, the patient decides on a management route that differs from the MDM recommendation(s) this must be recorded in the patients record.

5.3.4 To facilitate timely referrals, processes should be in place to initiate these directly from the MDM.

Quality Area 6: MDM Data

Rationale

The data required to inform the MDM discussion and decision making is mainly data already captured in the patient's medical record and brought together in a formatted way, using auto population technologies where able. However, the MDM itself also generates new data including, patient treatment preferences, know equity considerations at this point, psychosocial requirements relating to treatment decision making and the MDM recommendation itself.

The HISO 10038.4:2021 Cancer Multidisciplinary Meeting Data Standard defines the nationally agreed minimum patient and cancer data to be collected as part of the multidisciplinary meeting process. The standards ensure consistent, accessible, and accurate data and information are available to support informed and equitable decision making during an MDM. The standard can be found at URL: **https://canshare.co.nz/dataStandards.html?cf-1654205531202** (this is an unendorsed draft for reference purposes only).

The HISO MDM standards do not identify requirements for additional tumour specific data that are required to support MDM discussion and decision making eg, PR status for breast cancer; EGFR status for lung cancer. These data are identified in the individual MDM proformas. Te Aho o Te Kahu is working with a range of clinical specialities to transition to an interoperable digital health environment through the development and subsequent national adoption of data standards over the coming years.

Māori data sovereignty recognises that Māori data is a taonga that requires culturally grounded models of protection and care. Healthcare organisations are working to better understand and implement a nationally consistent approach to national and Māori data governance over the coming years.

Requirements

6.1 MDM data will meet the HISO 10038.4 Cancer Multidisciplinary Meeting Data Standards where appropriate (see Resource C: MDM Data Standards - summary table).

6.2 Tumour specific data fields are agreed nationally and meet SNOMED-CT terminology.

6.3 Hospitals record and report on MDM attendances via the MDM Purchase Unit Code M50033 (implemented 1 July 2022).

6.4 Standardised national reporting and data repository system for MDM to be developed within the CanShare environment.

Resource A: Terms of Reference Template

[Tumour stream] Multidisciplinary Meeting (MDM) Terms of Reference

Purpose

The overall aim of the [insert tumour stream] cancer multidisciplinary meeting is to facilitate multidisciplinary input into treatment planning and ongoing management and care of patients with this type of cancer.

The objectives of the meeting are to:

- provide an opportunity for multidisciplinary discussion of cases of [insert tumour stream] cancer, with access to all available information about that case
- collectively determine, in the light of all available information and evidence, the most appropriate treatment and care plan for each individual patient
- document treatment recommendations for each patient discussed, in their medical records, and communicate these to relevant team members including the referring clinician, General Practitioner and patient / whānau
- provide an education opportunity for senior and junior medical, nursing and allied health staff

Governance and reporting

Individual MDMs undertake the following governance and reporting functions:

- An annual review of the TOR to ensure they remain fit for purpose.
- Undertaking an annual MDM audit of operational aspects and member experience to identify where improvements could be made. (see audit tools in Standards for High-Quality Multidisciplinary Meetings (MDMs) in Aotearoa New Zealand (Te Aho o Te Kahu, 2024)
- Proactively reviewing the scheduling and duration of the MDM to accommodate public holidays, ensure attendance is maximised and changes in patient volumes are accommodated.
- Maintaining a watching brief on major changes to existing diagnostic or treatment pathways including any interim measures that may be required, in discussion with the relevant tumour streams.

At a regional level MDMs will be overseen by [insert name of committee, for example 'Acute Executive Group']. This oversight role includes:

- Decision making on the requirements for implementing new MDMs, amalgamating existing MDMs, extending session times of MDMs or rescheduling of MDMs
- Processes are in place to transition MDMs to fully online meetings during emergency periods eg, pandemic, natural disasters

- Review annual meeting outcomes and audit results from individual MDMs in the region ensuring that MDM-related risks are recorded in the appropriate risk logs and that any quality activities are recorded appropriately.

Meeting time and place

Time of meetings

Meetings will be held on [insert the day of the week], unless otherwise notified, and will begin promptly at [insert time] and finish at [insert time].

Cancellation of meetings must be documented on a log of meeting cancellations or via the MDM software. It can be located [insert location].

Meeting timetables can be located [describe where timetables will be published, for example].

Meeting venues

The meeting venue, unless otherwise notified, will be [insert hospital name and location, room number, telephone number].

Clinicians at the following sites will join in to the meeting online [list all of the relevant sites

MDM membership and roles

Chair

The MDM Chair is [insert name and contact details]. The MDM Deputy Chair is [insert name and contact details].

The process for appointing the Chair and Deputy Chair is determined locally with a minimum review bi-annually. [Describe process including term of office].

Meeting Coordinator

The meeting is coordinated by [insert name(s) and contact details].

MDM members

Specialty	Name	Contact details

All MDM attendees must be covered by Health New Zealand | Te Whatu Ora's confidentiality requirements.

See Table One for pre-, during and post-MDM functions for specific members of the team.

There may be a roster so membership can be rotated around a wider group of specialists, supporting individual knowledge building and expanded leave coverage.

Members of the MDM provide advice and support to the team undertaking the patients care, as required.

Technical support roles

If technical or equipment issues arise during an meeting, the MDM coordinator (or delegate) will contact the relevant person/team for support:

- **IT** - contact [insert IT department contact and phone number].
- **MDM IT software** - contact [insert MDM IT contact and phone number].
- **Projection hardware** - contact [insert supplier contact and phone number].
- **Videoconferencing** - contact [insert supplier contact and phone number].

The MDM coordinator will document all technical and equipment issues on a Technical and Equipment Downtime Log. The log can be located at [insert file location].

Attendance / quorum

The preference is that more than one member from each specialty area will attend an MDM, however this is not always achievable. It is important that no recommendations are made for a patients care in the absence of the involved diagnostic / treatment specialty. In the event a regular member of the MDM is unable to attend they will organise for an appropriate representative from their discipline to attend.

The MDM Chair will determine whether a quorum is present and whether there is sufficient representation to discuss each case.

A register of attendance is maintained by the MDM Coordinator

Patient referral

Insert tumour specific referral criteria

Mandatory referral information is included in the HISO MDM standards. **https://canshare.co.nz/dataStandards.html?cf-1654205531202** (this is an unendorsed draft for reference purposes only).

For the [tumour] MDM the following additional data is also required:

- insert tumour specific

Agreed standardised treatment protocols can be found at [insert file location of treatment protocols or add to the appendix].

The referring clinician will ensure they or their representative are present at the MDM and are adequately prepared to describe the patient(s) they have referred. They are also responsible for ensuring the patient is informed about their information being discussed at the MDM, including who will be viewing their information and why.

The process for referring a patient to the MDM is [insert process including software, login and how they can access a software user manual].

The cut-off time for referrals to be received prior to the meeting is [insert timeframe].

Presentation of patients seeking treatment in the private sector at Health New Zealand | Te Whatu Ora MDMs is based on clinical need and with the same level of access as public patients. Specific requirements for patient referrals initiated from the private sector include:

- The private sector clinician referring the patient to the MDM must attend and present their patient's details

- All required pathology and radiology slides /images / reports to be provided directly to the MDM Coordinator
- Patients are made aware that data relevant to the MDM will be captured and stored on Health New Zealand | Te Whatu Ora systems and may be used for audit and reporting purposes.

Late referrals

Where a delay will compromise patient's treatment/health outcomes urgent or late additions will be added to the meeting agenda with approval from the MDM Chair, radiologist and pathologist. Their approval is needed to ensure that any required radiology/pathology review can be undertaken.

The process for urgent late referrals is [insert process, including evidencing Chair, pathologist and radiologist agreement].

The standard of information required for late presentation of patients must be such that the MDM is able to make a recommendation. The Chair has the discretion to allow or defer late presentation of patients.

Oversubscribed agenda

To ensure that there is adequate time for discussing patients the Chair will use the following considerations to prioritise patients for the meeting:

- Clinical urgency
- Patients with a first cancer diagnosis
- Patients who were delayed from a previous MDM
- Māori, Pacific peoples, and other populations who experience a disproportionate impact from cancer.

A log of how many patients are deferred for each meeting due to capacity is kept by the MDM Coordinator (to inform the annual audit).

Meeting agenda

Agenda distribution

A meeting agenda will be distributed to members [insert timing (at least 48 hours before the meeting)].

If there are late additions, the updated agenda will be distributed by [insert role] at [insert timing].

Agenda order

Where members are available for only part of the meeting the MDM Coordinator and/or Chair will be advised in advance, so the meeting agenda can be organised to ensure relevant patients are discussed with key clinical staff present

MDM discussion

See Appendix One for MDM etiquette for online or hybrid meetings.

Decisions regarding the MDM recommendations should made based on consensus opinion from team members.

When developing treatment recommendations, the MDM team must ensure the following:

- The diagnosis and tumour grading are correct and other relevant prognostic factors are available
- The tumour has been adequately staged
- All appropriate treatment modalities are discussed
- Psychosocial and medical comorbidities that may influence treatment decisions are taken into account
- The patient's treatment preferences, if known, are taken into account
- Any relevant clinical trials are discussed
- Relevant optimal cancer care pathway timeframes are included, including facilitating access to treatment for patients in remote areas.

To support equity-led and person / whānau centred discussions, information about the following should also be presented:

- Whether the patient belongs to any of the population groups who are known to experience inequities in the system including Māori, Pacific, low socio-economic, rural, disabled, and people with diverse sexual orientation, gender identity, gender expression and sex characteristics (SOGIESC)
- Any known barriers that have already impacted on the patient's journey to identify if any delays already experienced can be mitigated in the next phase eg time to start treatment, additional care coordination support
- Any known patient/ whānau preferences.

Meeting documentation and communication

A summary of the discussion and recommendations will be documented in real time during the meeting as per the HISO MDM standards.

Outcomes from the MDM are recorded in the patient's electronic medical record and made available to all MDM members, including primary care **within 2 working days of the MDM**. There should be sufficient information provided so clinicians involved in the next stage of care are able to understand the rationale for the recommendations.

The Lead Clinician is responsible for discussing the MDM recommendation(s) with the patient and their whānau **within 2 weeks of the MDM**, including:

- outlining the information the MDM recommendation(s) were based on, including any differing opinions offered about treatment options
- advising of any referrals that have been made.

Terms of Reference review

These Terms of Reference (TOR) will be reviewed annually.

A current copy of the TOR can be found at [insert file location] and will be accessible to all members.

The TOR will be reviewed next by [insert date].

Appendix one: MDM etiquette for online or hybrid meetings

Requirements for anyone attending an MDM:

- Remain on mute unless speaking
- Turn mobile phones to silent
- Maintain the confidentiality of patient information by:
  - joining from a private space (such as closed office/room/home). Do not join from a public space such as, staff meeting room, cafe or public library.
  - using headphones instead of your speakers, so others do not overhear the discussions
  - ensuring your video feed cannot be viewed by others
  - not recording the meeting.

MDM Chair

- Provide a clear summary at the end of each patient of the recommendation/care plan.
- Ensure participants joining the MDM via Teams/online are involved in discussions and can hear others.
- Designate one person to be the meeting "Controller". This could be the MDM Coordinator, Co-Chair or another member of the MDM.

The meeting "Controller" is responsible for:

- Monitoring online participants to ensure everyone knows one another, and asking people to introduce themselves as needed
- Muting participants if needed to reduce background noise which can affect meeting discussions
- Monitoring the "Chat" feed and questions as indicated by the "Raised hand" symbol (or equivalent depending on the system being used).
- End the meeting for all participants (if appropriate).

Tips for all participants

Optimise the flow and quality of the meeting

- Be ready to speak when needed
- Use the "raised hand" symbol or "chat" if you wish to contribute/ask a question
- Avoid distractions, interruptions, or side conversations when unmuted. This includes phones ringing while you are speaking.
- Be respectful to other participants experience by paying attention to your own behaviour
- Avoid echo by not having two devices on in same room
- Reduce background noise in your own environment where possible
- Use a good quality microphone, camera and appropriately sized monitor for discussions and viewing radiology/pathology imaging
- Using your camera when attending MDMs provides visual feedback of your response to the discussions, however, please consider if your location is appropriate

Troubleshooting:

- If your audio is poor, turn off your video feed and this should improve
- The quality of the call depends on the strength and quality of your Wi-Fi
- To remove the icons from the middle of your screen – click outside of the icon bar
- There will be a Help button in the online application which will have additional tips and tricks.

When selecting a device to join an online or hybrid meeting please consider:

- Will you attend from a closed-door office, shared office space or conference room
- Will others be joining you in the same room?
- Does your device have enough battery life?
- If speaking, do you have a noise cancelling device?

Is your device compatible with the online application being used e.g., Teams?

Are you able to test your audio and video ahead of time?

Table 1: Specific roles and their functions within the MDM

MDM role	Responsible for Pre- MDM	During the MDM	Post-MDM
MDM Chair The MDM has a designated Chair, who will nominate a delegate/deputy to cover in their absence. The Chair is appointed under the MDM Terms of Reference requirements.	• Reviewing patient information prior to MDM • Decisions regarding quorum and appropriateness for the meeting to proceed • Managing late/urgent referrals • Delegating/handing over Chair duties if unable to attend.	The Chair facilitates discussion and oversees that: • the MDM team comprises the necessary disciplines to ensure best practice • all issues relevant to a patient's case are presented and discussed • there is a focus on factors that contribute to equitable outcomes • members participate in the meeting as appropriate to their specialty • an agreed recommendation(s) for a case is reached and accurately documented. Where a consensus on recommendations is not reached this is documented. • the meeting runs in a timely manner and to schedule.	• Approval of final patient documentation prior to uploading to the patient's medical records.
	The Chair initiates an annual review of the Terms of Reference, the MDM audit and reviews results with the team.		
MDM Coordinator (or equivalent) A single point of coordination for MDMs. They provide effective agenda management functions, support the participants and improve	• Receiving referrals and ensuring completeness • Ensuring all mandatory data and information items are documented on the proforma and/or are available for the meeting • Liaising with the MDM Chair where an MDM is oversubscribed • Liaising with radiology and pathology to ensure information is available for the meeting.	These functions may be undertaken by the MDM Coordinator or other administration staff: • Documenting MDM member attendance • Documenting discussions and agreed treatment plan/outcome. Registrars may also do this. • Managing technical issues arising in the meeting (to the best of their ability) or escalates for resolution,	• Communication/dissemination of information following the MDM once the MDM Chair has approved the documentation. • Ensuring data is collected on MDMs to inform audit and reporting.

MDM role	Responsible for Pre- MDM	During the MDM	Post-MDM
communication, maintain standards and ensure timeliness. In larger hospitals, a coordination team may be required.	• Preparing the MDM agenda and sending to members prior to the meeting • Notifying and inviting members to MDM meetings • Preparing and distributing the agenda • Liaising with technical staff as required • Facilitating a process for referrals received after deadline.		
Lead Clinician (or delegated nominee)	Completing all mandatory fields in the MDM referral including: • a clear reason for why the patient is being discussed • the patient's demographics • relevant test results • whether a formal review of the radiology or pathology results is required and why • comorbidities, supportive care requirements (including palliative care needs), performance status • the patient's history and preferences • the name and contact of the referring and presenting clinician.	• Introduces the patient including their ethnicity and where they live • Outlines their history, relevant test results, patient factors including any disabilities, comorbidities, performance status, supportive and cultural requirements and patient preferences • The reason for why the patient is being discussed.	• Discussing recommendations with patient/whānau • Making any other referrals as documented at the MDM and maintaining oversight of the patients pathway.
Radiologist	If a formal radiology review is requested: • obtain and sort images • review selected patient images and reports in relation to the reason for the review.	• Present the findings of their review and associated images. • Clearly state they agree (or not) with the original radiology report. This will be documented in the MDM patient proforma.	Ensure any discordance with previous results is recorded in the patient's medical records as an amended report.

MDM role	Responsible for Pre- MDM	During the MDM	Post-MDM
			Present major radiology discrepancies at an appropriate peer review meetings
Pathologist	If a formal pathology review is requested: • obtain and sort slides • review selected patient slides and reports in relation to the reason for the review.	Present the findings of their review and associated slide and clearly state they agree (or not) with the original pathology report. This will be documented in the MDM patient proforma.	Ensure any discordance with previous results is recorded in the patient's medical records as an amended report Present major pathology discrepancies at an appropriate peer review meetings.
Nurse Practitioners, Clinical Nurse Specialists, Cancer Nurse Coordinators equity nurses/navigators (acknowledging that not all the functions listed will be undertaken by all)	• Completing the MDM referral (Nurse Practitioner / Clinical Nurse Specialist) or on behalf of the Lead Clinician as per the requirements above • Assist MDM Coordinator as necessary to compile agenda and ensuring patients needing review (such as, pre- and post-op, abnormal surveillance scan) are submitted for review • Ensure all relevant information is available, including results / investigations • Liaising with out of region CNSs, Drs and other relevant staff to ensure their patients details/relevant information is provided • Informing patient / whānau of the meeting.	• Present patient information when required • Providing additional knowledge about patient factors (see Lead Clinician functions).	• Ongoing care coordination • Documenting outcomes where appropriate • Discussing recommendations with patient/whānau • Making any referrals documented at the MDM • Maintaining oversight of the patient's pathway.
Allied health and/or psychosocial professionals		Advising about patient factors including psychosocial requirements or clinical interventions that may either be underway or be required eg, dietician, speech language therapy.	Actioning referrals to their services.

Resource B: MDM Audit

There are a number of validated tools that can be used to assess the operational aspects of the MDM, the quality of decision making and member experience. They use a range of audit approaches including self-assessment, checklists, observational assessment, and peer feedback.

Table 1 provides information on how to audit MDMs against the MDM Standards. Some of these audit activities maybe one-off, while others will be undertaken annually.

Below are validated tools for assessing the quality of decision making and member's experience of the MDM:

- MDT-MODe (Metric of Decision-Making) measures the quality of presented patient information, contribution to case review per specialty, and team ability to reach a decision in the meeting. URL **www.imperial.ac.uk/media/imperial-college/medicine/surgery-cancer/pstrc/mdtmode28a711.pdf**
- MDT-MOT (Meeting Observational Tool) assesses team attendance, leadership/chairing of the MDM, teamwork, and culture. URL **www.ncbi.nlm.nih.gov/pmc/articles/PMC5892160/**
- MDT-FIT (Feedback for Improving Team Working) allows self-assessment of team working, combined with expert feedback from facilitator, and sharing of the outcome with the team as part of a team-reflective discussion. URL **www.mdtfit.co.uk/**

Useful references:

- Successful strategies in implementing a Multidisciplinary Team working in the care of patients with cancer: an overview and synthesis of the available literature. URL **www.ncbi.nlm.nih.gov/pmc/articles/PMC5783021/**
- Quality and efficacy of Multidisciplinary Team (MDT) quality assessment tools and discussion checklists: a systematic review.URL **www.ncbi.nlm.nih.gov/pmc/articles/PMC8928609/**

Table 1: MDM Standards Audit

Quality requirement	How to audit
Quality Area 1: MDM governance	
1.1 Individual MDM governance functions	Evidence includes: • Annual meeting minutes • Results of MDM standards audit • Results of MDM member experience audit • Terms of Reference is up to date • Documentation relating to significant changes to the diagnostic or treatment pathway.
1.2 Regional MDM governance functions	Evidence includes: • Meeting minutes relating to regional MDM governance requirements including any changes to the MDMs in the region

Quality requirement	How to audit
1.3 National MDM governance functions	Evidence includes: • Meeting minutes relating to national MDM governance requirements including how MDMs might function in a resource constrained environment, emerging issues relevant nationally or changes to national MDMs
Quality Area 2: MDM resourcing and infrastructure	
2.1 Workforce	Evidence includes: • MDM requirements are included in all relevant position descriptions • MDM requirements are included in all relevant external contracts for services eg, pathology • MDM workforce requirements that have been included in any job sizing or service planning that has been undertaken • Records of relevant training undertaken by MDM Chairs and Coordinators • MDM Coordinator cover is in place.
2.2 Facilities (Host hospital is responsible for this area)	Evidence includes: • MDM venue meets requirements • Technical equipment meets requirements including any service contracts • MDM software meets requirements • Response time for internal/external technical support for trouble shooting • Records of any disruptions to MDMs due to facility issues.
Quality Area 3: MDM members and roles	
3.1 Membership 3.5 Attendance 3.8 Confidentiality	Evidence includes: • MDM membership is recorded in the Terms of Reference • Records of MDM attendance • Record of how many patients have been deferred due to the relevant members not being available for the discussion • Completed confidentiality forms for MDM attendees who are not employed by Health New Zealand | Te Whatu Ora .
Quality Area 4: MDM referral	
4.1 Who is referred 4.2 When patients are referred 4.5 Referral information 4.6 Timeframes 4.8 Oversubscribed meetings	Evidence includes: • Database review of patients diagnosed with cancer compared with those discussed in the MDM • Records of how many patients are deferred due to there not being sufficient information to inform the discussion • Auditing a sample number of referrals for completeness • Information about how patients are prioritised when a meeting is oversubscribed is included in the Terms of Reference (TOR)

Quality requirement	How to audit
	• Records of how many patients are deferred due to the meeting being oversubscribed.
Quality Area 5: MDM process	
5.1 Schedule of meetings 5.2.6 Technical issues 5.3 Communication from the MDM	Evidence includes: • Are meetings frequent enough to ensure that patients are not being delayed unnecessarily – time from the patient being referred to the date of the meeting • Is meeting long enough to ensure all patients that require discussion are discussed – number of patients deferred on the day due to meeting running over time • Number of meetings interrupted due to technical issues • Review a sample of clinical records to measure how long it takes for the MDM summary to appear in the clinical records • Review a sample of clinical records to measure how long from the MDM date does the contact with the patient happen
Quality Area 6: MDM data	
6.1 MDM Data Standards 6.2 Tumour specific data 6.3 Purchase Unit Code	Evidence includes: • MDM IT system compliance with National Data Standards • Additional tumour specific data requirements are included in the TOR • Purchase Unit Code data is consistent with MDM system data

Resource C: MDM Data Standards - summary table

The HISO 10038.4 Cancer Multidisciplinary Meeting Data Standards can be found at URL: **canshare.co.nz/dataStandards.html?cf-1654205531202** This is a unendorsed draft for reference purposes only.

Please contact **info@teaho.govt.nz** if further information on this data standard

Patient Details	NHI Family name / Given Name Date of Birth Gender / Sex Ethnicity Address
General Practice	General Practice status (if yes then practice details required)
Referrer	Requested MDM tumour group Requested MDM facility name/identifier Requested MDM date Patient discussion status Referrer name/identifier Lead health care practitioner name/identifier Presenter name/identifier Source of referral Key question for MDM Radiology review required: • if yes then question for radiology, radiology type, radiology date, facility name/identifier, radiology accession number Pathology review required: • if yes - then question for pathology, pathology specimen type, pathology date, facility name/identifier, radiology accession number • if no - outline why a pathology review is not required
Patient Summary	Clinical History Patient Comorbidities BMI Site of interest (including laterality if relevant) ECOG status Additional personal history of cancer Family history of cancer Patient factors includes patient preferences, psychosocial services and non-clinical support requirements
Previous MDM details	Relevant previous MDM record including date, tumour group, previous MDM discussion summary and recommendations
Radiology Review	Radiology review including reviewer name/identifier
Pathology Review	Pathology review including reviewer name/identifier
Cancer staging	Staging information relevant to the tumour, date of staging
MDM Discussion and Recommendations	Diagnosis including date, basis of diagnosis, histological tumour type, histopathological grade

	Treatment intent (if palliative then reason why curative treatment has not been recommended as the intent for a care plan) Summary of the MDM discussion and key outcomes reached Outline of follow-up actions including recommendations, further investigations, referrals and discussion with the patient Full name/identifier of the individual contributing to the care of the patient. Details of further investigations or diagnostics recommended for the patient and the name/identifier of who is actioning this. Where the patient is recommended for referral post-MDM, including clinician name/identifier Clinician name/identifier responsible for informing patient
MDM Administration	MDM referral status including declined reason MDM record status Deferral reason Date record created, last modified and by whom
MDM meeting details	MDM facility name/identifier MDM date MDM tumour group MDM Chair name/identifier MDM attendee name/identifier

Contributors

Thank you to the following individuals for their valuable contribution to this work:

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References

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Canberra Health Services Operational Procedure - Cancer Multidisciplinary Meeting (Adults Only)

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