MULTIDISCIPLINARY TEAMS IN SOUTH WESTERN SYDNEY LOCAL HEALTH DISTRICT

2011 SUMMARY REPORT

Cancer Institute NSW
Australian Technology Park
Biomedical Building
Suite 101
1 Central Avenue
Eveleigh NSW 2015
PO Box 41
Alexandria NSW 1435
Telephone (02) 8374 5600
Facsimile (02) 8374 5700
Email information@cancerinstitute.org.au
Website www.cancerinstitute.org.au/publications

TRIM reference number: E11/20237

Published by the Cancer Institute NSW, October 2011

Table of contents

List of Tables

List of Figures

Glossary of Abbreviations

Abbreviation	Referent
AYA	Adolescent and Young Adult
GI	Gastrointestinal
GP	General Practitioner
LHD	Local Health District
MDT	Multidisciplinary Team
n	Number of MDTs (frequency / 'count', or sample size / 'base')
NSW	New South Wales
%	Proportion of MDTs

Introduction

1.1 Background

A cancer patient may receive treatment at a number of different centres, making the provision of coordinated and multidisciplinary care for all cancer patients challenging. Improving coordination of care was incorporated as an objective of the "Better Coordination of Patient Care" program of the NSW Cancer Plan 2007-2010. A central aim of this program was to further develop and utilise Multidisciplinary Teams (MDTs), together with key funded clinical infrastructure positions and piloting clinical networks, as a platform to deliver coordinated patient care across all geographical locations.

In order to understand the status of MDTs in NSW, and establish a baseline to measure the ongoing development of MDTs, a profiling survey was undertaken in 2006. This profiling survey was re-administered in 2008 and 2011 to monitor the status of MDTs in NSW. Data obtained from the survey also provide valuable information on the development of MDTs over recent years of extensive funding and will assist in identifying gaps in MDTs in NSW, and the areas requiring further development.

1.2 Methodology

The methodology employed for the 2008 and 2011 surveys was based on the 2006 baseline study in relation to all key aspects, to ensure comparability of the results. The Cancer Institute NSW provided an updated contact list of MDTs in NSW. The detailed survey questionnaire (developed in 2006) was designed to capture information to assess the operation of MDTs in light of identified best practice in multidisciplinary care for cancer patients. Some new questions were added in 2011 to cover particular areas of interest (see Appendix A for 2011 questionnaire). Fieldwork was conducted from 22nd September to 15th November 2008, and from 5th April to 30th May 2011. Nominated contacts were invited by email to complete the survey online, although a hard copy alternative was available to those who preferred it. Where required, follow-ups were conducted via phone and email, including further encouragement by the Cancer Institute NSW and Cancer Service Development Managers. Data cleaning was undertaken, including phone verification, to ensure there was only one response per MDT and check service classification accuracy, any patient number anomalies, and compare changes in overall population size over time.

1.3 This report

On 1 January 2011, 18 Local Health Districts (LHDs) were established, in the place of the previous Area Health Services. This report presents a summary of the 2008[1] and 2011 survey findings, in relation to MDTs in South Western Sydney LHD. The figures for South Western Sydney LHD are based on *public* sector MDTs only, unless otherwise specified. Key findings for South Western Sydney LHD are compared with the corresponding totals or averages for NSW MDTs overall (including both public and private NSW MDTs). A detailed monograph report on the 2011 study is available from the Cancer Institute NSW.

Note that all percentages have been rounded to the nearest whole number for presentation in tables throughout this report. Any discrepancies that may occur are the result of rounding.

Characteristics of MDTs in South Western Sydney LHD

2.1 Number of MDTs

Population and sample size

In 2011, there are 14 MDTs in the population within South Western Sydney LHD, of which 13 participated in the survey. The number of MDTs in the South Western Sydney LHD population remained constant between 2008 and 2011. A detailed list of all MDTs in South Western Sydney LHD is included at Appendix B.

Table 1: Number of MDTs in the population versus the survey sample

	South Western Sydney LHD		NSW	
	2008	**2011**	**2008**	**2011**
Number of MDTs in population	14	**14**	160	**170**
Number of MDTs in survey sample	12	**13**	131	**145**
Survey response rate	**86%**	**93%**	**82%**	**85%**

Note: The data above include *only public* sector MDTs for South Western Sydney LHD, but *both public and private* sector MDTs for NSW overall. The NSW population totals shown above include 14 private sector MDTs in 2008, and 16 private sector MDTs in 2011.

[1] While LHDs were not established in 2008, historical data has been reanalyzed as a baseline comparison. As such, data from the first study in 2006 is not relevant for this LHD summary report.

MDTs by tumour stream

The following table shows the breakdown of MDTs in the population by the cancer type or tumour stream on which they focus. In 2011, South Western Sydney LHD had two Lung and two Breast MDTs (each representing 14% of all MDTs in this LHD), and all other tumour streams had one MDT (except Bone & Soft Tissue, Melanoma, Paediatric/AYA, and Thyroid/Endocrine, for which there were no MDTs).

Table 2: Number of MDTs in population by tumour stream

Tumour stream	South Western Sydney LHD				NSW			
	2008		2011		2008		2011	
	n	%	n	%	n	%	n	%
Bone & Soft Tissue	0	0%	0	**0%**	4	3%	5	**3%**
Breast	2	14%	2	**14%**	23	14%	22	**13%**
Colorectal	1	7%	1	**7%**	9	6%	11	**6%**
Gastrointestinal[2]	1	7%	1	**7%**	7	4%	6	**4%**
General Cancer	1	7%	1	**7%**	19	12%	19	**11%**
Gynaecological	1	7%	1	**7%**	7	4%	6	**4%**
Haematological	1	7%	1	**7%**	13	8%	13	**8%**
Head and Neck	1	7%	1	**7%**	10	6%	10	**6%**
Lung	2	14%	2	**14%**	15	9%	17	**10%**
Melanoma (Skin)	0	0%	0	**0%**	3	2%	4	**2%**
Neurological	1	7%	1	**7%**	4	3%	6	**4%**
Paediatric / AYA	0	0%	0	**0%**	8	5%	8	**5%**
Palliative Care	1	7%	1	**7%**	16	10%	14	**8%**
Thyroid / Endocrine	0	0%	0	**0%**	0	0%	1	**1%**

[2] Gastrointestinal MDTs discuss both Colorectal patients and Upper GI patients (i.e., a combined MDT, covering two tumour streams).

Upper GI	1	7%	1	**7%**	7	4%	9	**5%**
Urological	1	7%	1	**7%**	15	9%	16	**9%**
Other	0	0%	0	**0%**	0	0%	3	**2%**
Base (number of MDTs)	**14**	**100%**	**14**	**100%**	**160**	**100%**	**170**	**100%**

MDTs by service type

The following table shows the breakdown of MDTs in the population by location (metropolitan or regional/rural)[3], and whether or not they have access to radiotherapy facilities. The composition of South Western Sydney LHD MDTs in 2011 is entirely metropolitan, with 79% having access to radiotherapy facilities.

Table 3: Number of MDTs in population by location and access to radiotherapy services

Service type	**South Western Sydney LHD**				**NSW**			
	2008		**2011**		**2008**		**2011**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Metropolitan	14	100%	14	**100%**	119	74%	130	**76%**
Regional or rural	0	0%	0	**0%**	41	26%	40	**24%**
With radiotherapy facilities	11	79%	11	**79%**	110	69%	123	**72%**
No radiotherapy facilities	3	21%	3	**21%**	50	31%	47	**28%**
Base (number of MDTs)	**14**	**100%**	**14**	**100%**	**160**	**100%**	**170**	**100%**

[3] Location is based on the ARIA+ classification (Accessibility-Remoteness Index of Australia Plus), which is the standard Australian Bureau of Statistics endorsed geographic measure of remoteness, derived from measures of road distance (i.e., accessibility) between populated localities and service centres. For analysis purposes, 'Major City' locations were treated as Metropolitan, and 'Inner Regional', 'Outer Regional', 'Remote', and 'Very Remote' were treated as Regional/Rural.

2.2 Comparison with NSW incidence and mortality data

The incidence and death data reported in this section were extracted from the NSW Central Cancer Registry. The collection of incidence and death data is based on the address of usual residence of the patient (rather than address of the treating hospital/s), to enable establishment of links between cancer incidence and place of residence. Given that the following analysis compares the number of MDTs in the population with corresponding incidence and death data for a particular area, the total number of MDTs *includes private sector MDTs located within the South Western Sydney LHD region* to ensure a more accurate and realistic comparison.

It is important to note that each tumour stream varies in its complexity, incidence, mortality and survival rates, and therefore the number and timing of patients' presentation at an MDT meeting will differ. Consequently, interpretation of the results presented in this report should be considered within a wider framework, reflecting the characteristics of each cancer type.

Number of MDTs versus incidence of new cancer cases

The two figures on the following page compare the number of MDTs in the population within South Western Sydney LHD (including private sector MDTs) for each tumour stream, with the incidence of new cancer *diagnoses* for the same tumour stream[4] within that region. The first figure presents the *actual* number of new cancer cases for 2008, whereas the second figure presents the *projected* number of new cancer cases for 2010 (as actual 2011 data were not available at the time, and 2010 data were the most current projected data available in 2011).

[4] Incidence and death data were not available for some MDT categories (i.e., Bone and Soft Tissue, Palliative Care, General Cancer, and Paediatric/AYA), so these MDTs are not represented in the charts within this section.

Figure 1: Number of MDTs in South Western Sydney LHD versus actual incidence of new cancer cases – 2008

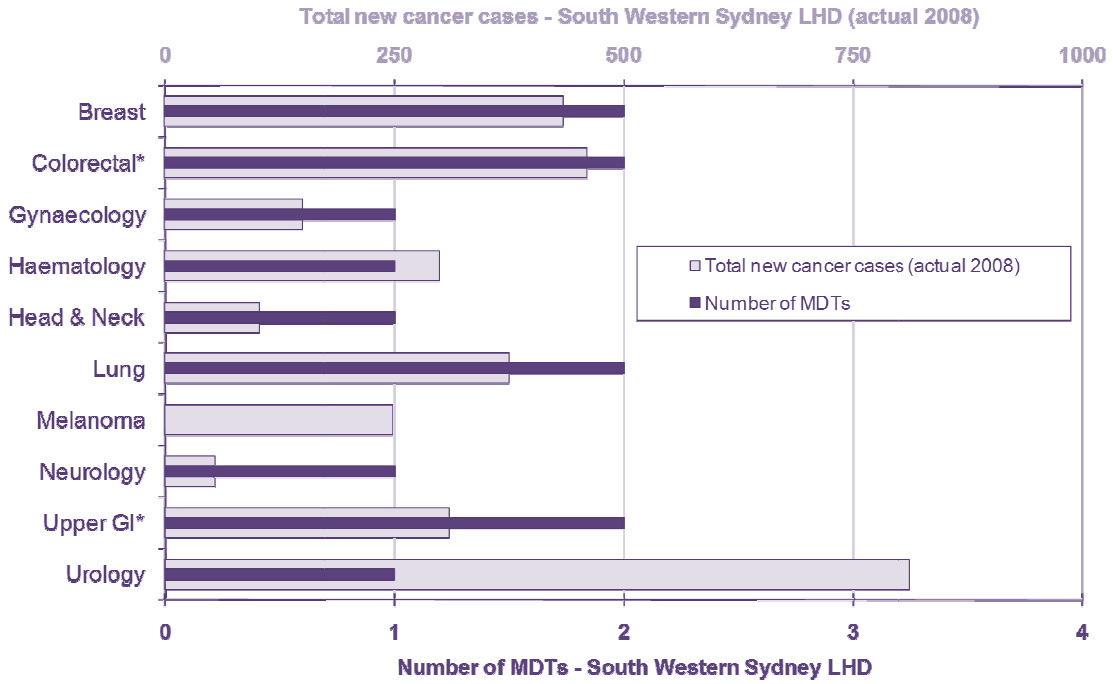
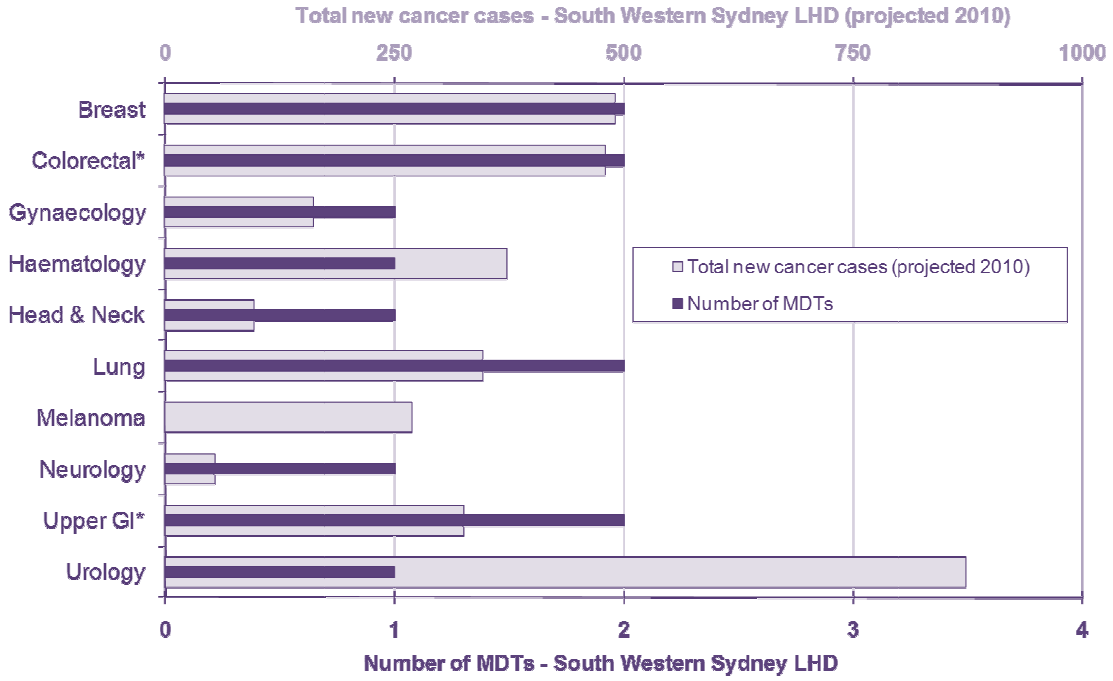


Figure 2: Number of MDTs in South Western Sydney LHD in 2011 versus projected incidence of new cancer cases in 2010

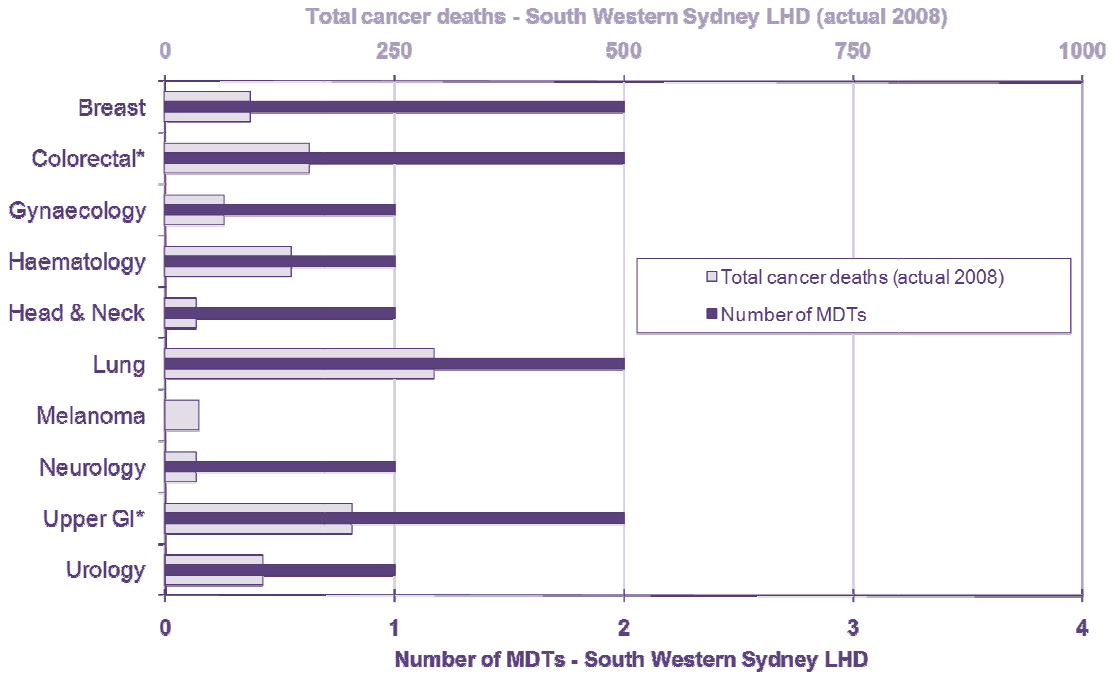


*Including one combined Gastrointestinal MDT in 2008, and one in 2011. The lower axis (0 - 5) relates to the number of MDTs in South Western Sydney LHD (thin bar), and the upper axis (0 - 1,500) relates to the number of new cancer cases in South Western Sydney LHD (thick bar). South Western Sydney LHD had a total of 15 MDTs in 2008 and 15 MDTs in 2011 (NB: including one private MDT in this geographical area in 2008 and one in 2011), although the MDTs represented by the thin bars above exclude those tumour streams for which incidence data were not available (an additional three in both 2008 and 2011), and count the aforementioned Gastrointestinal MDT twice (i.e., within both Colorectal and Upper GI tumour streams).

Number of MDTs versus cancer deaths

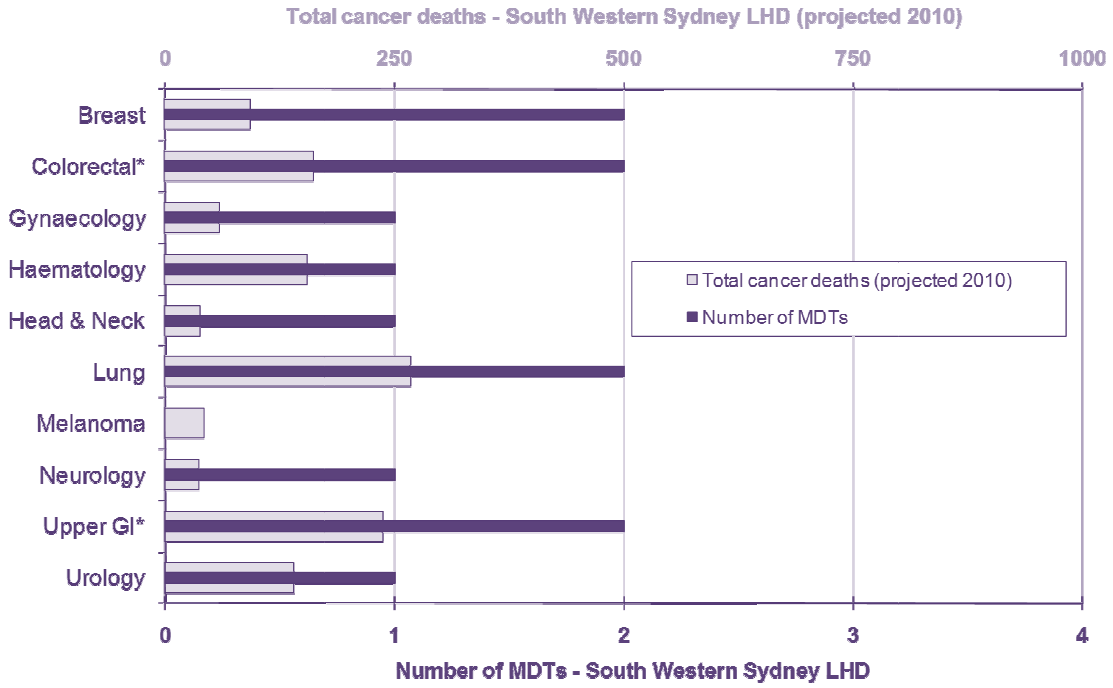
The following two figures present the number of MDTs in the population within South Western Sydney LHD (including private sector MDTs) for each tumour stream, relative to the number of cancer *deaths* within the same tumour stream. Again, the figures reported for 2008 are actual figures, whereas those presented for 2010 are projected figures only.

Figure 3: Number of MDTs in South Western Sydney LHD versus actual cancer deaths – 2008



*Including one combined Gastrointestinal MDT in 2008. The lower axis (0 - 5) relates to the number of MDTs in South Western Sydney LHD (thin bar), and the upper orange axis (0 - 1,500) relates to the number of cancer deaths in South Western Sydney LHD (thick bar). South Western Sydney LHD had a total of 15 MDTs in 2008 (NB: including one private MDT), although the MDTs represented by the thin bars above exclude those tumour streams for which mortality data were not available (an additional three in 2008), and count the aforementioned Gastrointestinal MDT twice (i.e., within both Colorectal and Upper GI tumour streams).

Figure 4: Number of MDTs in South Western Sydney LHD in 2011 versus projected cancer deaths in 2010



*Including one combined Gastrointestinal MDT. The lower axis (0 - 5) relates to the number of MDTs in South Western Sydney LHD (thin bar), and the upper axis (0 - 1,500) relates to the number of cancer deaths in South Western Sydney LHD (thick bar). South Western Sydney LHD had a total of 15 MDTs in 2011 (NB: including one private MDT), although the MDTs represented by the thin bars above exclude those tumour streams for which mortality data were not available (an additional three in 2011), and count the aforementioned Gastrointestinal MDT twice (i.e., within both Colorectal and Upper GI tumour streams).

Proportion of newly diagnosed patients discussed at MDT meetings

The following table outlines the proportion of all new cancer cases[5] that are discussed by MDTs[6], for each tumour stream. Averaged across all tumour streams, the data suggest that 125% of all new cancer cases diagnosed in South Western Sydney LHD in 2011 were discussed by MDTs. Based on the 2011 data, Neurological MDTs and Colorectal MDTs appear to discuss the highest proportion of all new diagnoses in their tumour streams, within South Western Sydney LHD.

[5] As above, the total number of new cancer cases within South Western Sydney LHD is extracted from the NSW Central Cancer Registry, including actual 2008 figures and projected 2010 figures (the latest data available for comparison with the 2011 survey results).

[6] The number of newly diagnosed patients discussed by MDTs in the last 12 months is drawn from the survey responses (Question A5b). Given that some MDTs did not complete the survey, population-level estimates were calculated for the number of newly diagnosed patients discussed by all MDTs. To this end, the number of newly diagnosed patients discussed, as reported by survey participants, was adjusted based on the response rate, to extrapolate the survey findings to the population level.

Table 4: Estimated number of newly diagnosed patients discussed by all MDTs, as a proportion of the total number of new cancer cases diagnosed, by tumour stream

Tumour stream	South Western Sydney LHD		NSW	
	2008	2011	2008	2011
	%	%	%	%
Breast	169%	**104%**	113%[7]	**93%**
Colorectal	157%	**168%**	39%	**49%**
Gynaecology	81%	**DNP**	86%	**134%**
Haematology	67%	**161%**	59%	**66%**
Head & Neck	89%	**151%**	108%	**151%**
Lung	114%	**136%**	56%	**70%**
Melanoma (Skin)	0%	**0%**	10%	**24%**
Neurological	85%	**170%**	50%	**89%**
Upper GI	99%	**148%**	67%	**97%**
Urology	25%	**23%**	29%	**25%**
Total	**93%**	**125%**	**61%**	**77%**

Note: The numerator is based on survey data extrapolated as an estimate of population level data for the number of newly diagnosed patients discussed by MDTs within South Western Sydney LHD. Therefore, the bases for South Western Sydney LHD for 2008/2011 are the actual/projected incidence figures, as follows: Breast, 433/490; Colorectal, 459/479; Gynaecology, 149/160; Haematology, 298/372; Head & neck, 101/96; Lung, 374/345; Melanoma, 247/269; Neurology, 53/53; Upper GI, 309/325; Urology, 810/872; Total 3535/3737. 'DNP' refers to 'did not participate' (i.e., where MDTs of this tumour stream exist within South Western Sydney LHD, but none participated in the survey, so we cannot estimate the number of patients discussed at the population level as no survey data were provided).

[7] Where particular tumour streams reportedly discussed more newly diagnosed patients than there were actual or projected cases in the state (i.e., a result greater than 100%), this is potentially due to inaccuracies in respondents' estimations of patient numbers, as well as the fact that some MDTs discuss patients from different (yet related) tumour streams.

2.3 MDT meetings

From this section onwards, the data presented are based on survey responses (i.e., only the responses of those MDTs that participated in the survey, rather than the population as a whole).

Section 2.3, below, describes the nature of MDT meetings, including meeting frequency, meeting administration, availability of relevant information, data collection, quality assurance activities, and professional development.

Meeting frequency

In 2011, 62% of participating MDTs in South Western Sydney LHD conduct meetings weekly, and the remaining 38% conduct them fortnightly.

Table 5: Frequency of MDT meetings

MDT meeting frequency	South Western Sydney LHD		NSW	
	2011		2011	
	n	%	n	%
Once a week	8	**62%**	66	**46%**
Once a fortnight	5	**38%**	60	**41%**
Once a month	0	**0%**	17	**12%**
Less than once a month	0	**0%**	2	**1%**
Irregularly – as needed	0	**0%**	0	**0%**
Base (number of MDTs)	**13**	**100%**	**145**	**100%**

MDT meeting administration and resources

Typically, within South Western Sydney LHD, the responsibility for organising MDT meetings (e.g., preparing meeting agendas and providing other administrative support prior to meetings) lies with the MDT coordinator (46%) and/or medical staff (38%).

Table 6: Disciplines responsible for organising MDT meetings

Responsibility for organising MDT meetings	South Western Sydney LHD		NSW	
	2011		2011	
	n	%	n	%
MDT coordinator	6	**46%**	97	**67%**
Cancer Nurse Coordinator / Cancer Care Coordinator	4	**31%**	61	**42%**
Other nurse	2	**15%**	15	**10%**
Other MDT-specific administration staff	2	**15%**	16	**11%**
Other general administration staff	3	**23%**	16	**11%**
Other project staff	0	**0%**	0	**0%**
Medical staff	5	**38%**	40	**28%**
Other clinician	0	**0%**	4	**3%**
Other	2	**15%**	4	**3%**
Base (number of MDTs)	**13**	**-**	**145**	**-**

Where a particular discipline or role was selected as being responsible for organising MDT meetings, respondents were asked to state whether or not this provision of administrative support is a *formal* part of the job description for this role. The results are presented in the table below, with this responsibility most likely to be a formalised responsibility among those MDT coordinators and/or other MDT-specific administration staff who perform this role within South Western Sydney LHD MDTs.

Table 7: Whether MDT administrative support is a formal part of job description

Where responsible, is this a formal part of their job description?	South Western Sydney LHD		NSW	
	2011		2011	
	n	%	n	%
MDT coordinator	6	**100%**	80	**82%**
Cancer Nurse Coordinator / Cancer Care Coordinator	3	**75%**	36	**59%**
Other nurse	1	**50%**	3	**21%**
Other MDT-specific administration staff	2	**100%**	13	**81%**
Other general administration staff	0	**0%**	2	**13%**
Other project staff	-	**-**	-	**-**
Medical staff	2	**40%**	9	**23%**
Other clinician	-	**-**	1	**25%**
Other	**0**	**0%**	**2**	**40%**

Note that the base for each proportion above only includes those MDTs reporting each role as responsible for MDT support. Refer to the table above for corresponding base sizes for each role (excluding any MDTs that did not answer the second part of this question, relating to formalisation).

Availability of test results

More than three-quarters (77%) of participating MDTs in South Western Sydney LHD report that test results, reports and films are *usually* available at MDT meetings, with the remaining 23% reporting that they are *always* available. No MDTs report that test results are *never* available.

Table 8: Availability of all relevant test results, reports and films at MDT meetings

Availability of test results, reports and films	South Western Sydney LHD		NSW	
	2011		2011	
	n	%	n	%
Always	3	**23%**	35	**24%**
Usually	10	**77%**	93	**64%**
Sometimes	0	**0%**	13	**9%**
Rarely	0	**0%**	2	**1%**
Never	0	**0%**	2	**1%**
Base (number of MDTs)	**13**	**100%**	**145**	**100%**

Availability of staging information

Over two-thirds (69%) of participating MDTs in South Western Sydney LHD report that staging information is *usually* available at MDT meetings, with the remaining 31% reporting that it is *always* available. No MDTs report that staging information is *never* available.

Table 9: Routine availability of staging information at MDT meetings

Routine availability of staging information	South Western Sydney LHD		NSW	
	2011		2011	
	n	%	n	%
Always	4	**31%**	37	**26%**
Usually	9	**69%**	85	**59%**
Sometimes	0	**0%**	14	**10%**
Rarely	0	**0%**	4	**3%**
Never	0	**0%**	5	**3%**
Base (number of MDTs)	**13**	**100%**	**145**	**100%**

Data collection

In 2011, the data and statistics most commonly reported as being recorded by MDTs in South Western Sydney LHD are number of patients discussed at each meeting and treatment plans recorded in the patient's hospital notes, each mentioned by 62-85% of respondents.

Table 10: Data and statistics recorded by MDTs

Data and statistics collected	South Western Sydney LHD		NSW	
	2011		2011	
	n	%	n	%
No data recorded	2	15%	11	8%
Treatment plans recorded in the patient's hospital notes	8	62%	73	50%
Treatment plans sent to referring clinicians – including referring GPs	5	38%	72	50%
Treatment plans are sent to the patient's GP - if GP is not referring clinician	3	23%	41	28%
Treatment plans are provided to patients	0	0%	21	14%
Disciplines represented at each meeting	4	31%	92	63%
Team members present at each meeting	4	31%	103	71%
Number of patients discussed at each meeting	11	85%	116	80%
Number of patients discussed at each meeting by week, month or year	5	38%	63	43%
Number of patients discussed as proportion of total patients treated for tumour type in Area Health Service	4	31%	9	6%
Number of patients with documented consent for their case to be discussed at the MDT meeting	0	0%	27	19%
Proportion of patients managed according to agreed protocols	0	0%	13	9%
Number of patients suitable for clinical trials	1	8%	41	28%
Patient survival	1	8%	16	11%
Patient mortality	1	8%	25	17%
Patient morbidity	1	8%	15	10%
Other	1	8%	11	8%
Base (number of MDTs)	13	-	145	-

For each of those types of data or statistics that were noted as being recorded by an MDT, respondents were asked to specify the format in which they are collected and recorded: either electronic, hard copy, or some electronic and some in hard copy. The results are presented in the following table.

Table 11: Format in which data and statistics are recorded by MDTs

Format of data collection	South Western Sydney LHD						NSW					
	2011						2011					
	Electronic		Hard copy		Both		Electronic		Hard copy		Both	
	n	%	n	%	n	%	n	%	n	%	n	%
Treatment plans recorded in the patient's hospital notes	6	**75%**	2	**25%**	0	**0%**	25	34%	34	47%	14	**19%**
Treatment plans are sent to referring clinicians	3	**60%**	2	**40%**	0	**0%**	18	25%	35	49%	18	**25%**
Treatment plans are sent to the patient's GP - if GP is not referring clinician	2	**67%**	1	**33%**	0	**0%**	11	27%	20	49%	10	**24%**
Treatment plans are provided to patients	-	**-**	-	**-**	-	**-**	1	5%	12	57%	8	**38%**
Disciplines represented at each meeting	2	**50%**	2	**50%**	0	**0%**	20	22%	54	59%	18	**20%**
Team members present at each meeting	2	**50%**	2	**50%**	0	**0%**	26	25%	59	57%	18	**17%**
Number of patients discussed at each meeting	8	**73%**	2	**18%**	1	**9%**	56	48%	40	34%	20	**17%**
Number of patients discussed at each meeting by week, fortnight, month or year	4	**80%**	1	**20%**	0	**0%**	35	56%	18	29%	10	**16%**

Number of patients discussed as proportion of total patients treated for tumour type in Area Health Service	4	**100%**	0	**0%**	0	**0%**	7	78%	2	22%	0	**0%**
Number of patients with documented consent for their case to be discussed at the MDT meeting	-	**-**	-	**-**	-	**-**	10	37%	9	33%	8	**30%**
Proportion of patients managed according to agreed protocols	-	**-**	-	**-**	-	**-**	6	46%	3	23%	4	**31%**
Number of patients suitable for clinical trials	1	**100%**	0	**0%**	0	**0%**	18	44%	17	41%	6	**15%**
Patient survival	1	**100%**	0	**0%**	0	**0%**	10	63%	5	31%	1	**6%**
Patient mortality	1	**100%**	0	**0%**	0	**0%**	12	48%	12	48%	1	**4%**
Patient morbidity	0	**0%**	1	**100%**	0	**0%**	7	47%	6	40%	2	**13%**
Other	**0**	**0%**	**1**	**100%**	**0**	**0%**	**3**	**27%**	**4**	**36%**	**4**	**36%**

Note that the base for each set of proportions above only includes those MDTs reporting collecting each particular type of data. Refer to the table above for corresponding base sizes for each type of data (excluding any MDTs that did not answer the second part of this question, relating to format).

Overall, 61% of MDTs in South Western Sydney LHD report having some central data collection system (including 15% with a review process, and 46% without). An additional 23% report having no central data collection, but that individual clinicians contribute to audits coordinated by professional colleges. The remaining 15% reported no data collection at all, either centrally or by individual clinicians.

Table 12: System for collection and review of data for audit purposes

System for collection and review of data for audit purposes	South Western Sydney LHD		NSW	
	2011		2011	
	n	%	n	%
Central data collection and process for team to review data	2	**15%**	43	**30%**
Central data collection, but no review process	6	**46%**	40	**28%**
No central data collection, but individual clinicians contribute to audit coordinated by professional college	3	**23%**	30	**21%**
No data collection, either centrally or by individual clinicians	2	**15%**	15	**10%**
Not sure	0	**0%**	17	**12%**
Base (number of MDTs)	**13**	**100%**	**145**	**100%**

Quality assurance activities

The most common quality assurance activities reported to occur in South Western Sydney LHD MDT meetings are review of patient outcomes and review of unexpected morbidity or mortality (each mentioned by 23% of respondents). A further 38% of MDTs report that quality assurance activities occur elsewhere.

Table 13: Quality assurance activities occurring in MDT meetings

Quality assurance activities	South Western Sydney LHD		NSW	
	2011		2011	
	n	%	n	%
Relevance to guideline development and compliance	2	**15%**	39	**27%**
Review of patient outcomes	3	**23%**	53	**37%**
Review of unexpected morbidity or mortality	3	**23%**	52	**36%**
Other	1	**8%**	14	**10%**
None – occurs elsewhere	5	**38%**	43	**30%**
None – does not occur at all	2	**15%**	18	**12%**
Base (number of MDTs)	**13**	**-**	**145**	**-**

Professional development

The most common professional development activities held for South Western Sydney LHD MDT members take the form of reports from medical or scientific meetings (77%), followed by discussions or presentations of recent research results (62%) and journal club (54% of participating MDTs in South Western Sydney LHD).

Table 14: Professional development activities held for MDT

Nature of professional development activities	South Western Sydney LHD		NSW	
	2011		2011	
	n	%	n	%
Journal club	7	**54%**	36	**25%**
Case studies	1	**8%**	34	**23%**
Guest speaker	5	**38%**	49	**34%**
In-service	3	**23%**	27	**19%**
Recent research results discussed or presented	8	**62%**	78	**54%**
Reports from medical or scientific meetings	10	**77%**	73	**50%**
Registrar presentations	6	**46%**	58	**40%**
None	1	**8%**	37	**26%**
Other	1	**8%**	5	**3%**
Base (number of MDTs)	**13**	**-**	**145**	**-**

Participating MDTs in South Western Sydney LHD are most likely to hold professional development activities for members on a quarterly basis (46%). Only 8% report that their MDT *never* holds such activities.

Table 15: Frequency of professional development activities for MDT members

Frequency of professional development activities	South Western Sydney LHD		NSW	
	2011		2011	
	n	%	n	%
Weekly	2	**15%**	22	**15%**
Fortnightly	1	**8%**	9	**6%**
Monthly	1	**8%**	17	**12%**
Quarterly	6	**46%**	25	**17%**
Less often	2	**15%**	39	**27%**
Never	1	**8%**	32	**22%**
Base (number of MDTs)	**13**	**100%**	**144**	**100%**

2.4 Treatment plans

This section covers various aspects of treatment plans, including whether or not they are generated, whose responsibility this is, content and format, and communication with General Practitioners (GPs) and regional/local treatment centres.

The majority (92%) of participating MDTs in South Western Sydney LHD report that treatment plans or documented recommendations for each patient are generated at MDT meetings.

Table 16: Treatment plans or documented recommendations generated in MDT meetings

	South Western Sydney LHD		NSW	
	2011		2011	
	n	%	n	%
Treatment plans generated	12	**92%**	122	**84%**
Not generated	1	**8%**	23	**16%**
Base (number of MDTs)	**13**	**100%**	**145**	**100%**

Within South Western Sydney LHD, for those MDTs where treatment or management plans are generated, registrars are most likely to be responsible for completing or documenting them (42%), followed by the referring clinician / patient's principal clinician (25%).

Table 17: Disciplines with responsibility for completing treatment plans

Responsibility for completing treatment plans	South Western Sydney LHD		NSW	
	2011		2011	
	n	%	n	%
MDT coordinator	1	**8%**	54	**44%**
Cancer Nurse Coordinator / Cancer Care Coordinator	2	**17%**	45	**37%**
Other nurse	1	**8%**	17	**14%**
Other MDT-specific administration staff	0	**0%**	6	**5%**
Other general administration staff	0	**0%**	2	**2%**
Other project staff	0	**0%**	0	**0%**
Referring clinician / Patient's principal clinician	3	**25%**	21	**17%**
Surgeon	1	**8%**	18	**15%**
Radiation oncologist	2	**17%**	22	**18%**
Medical oncologist	0	**0%**	27	**22%**
Registrar	5	**42%**	35	**29%**
Other medical	1	**8%**	8	**7%**
Allied health professional (e.g., social worker)	2	**17%**	9	**7%**
Other	2	**17%**	9	**7%**
Base (number of MDTs)	**12**	**-**	**122**	**-**

The types of information most commonly reported as included in treatment plans or documented recommendations among participating MDTs in South Western Sydney LHD are surgical treatment plans and radiotherapy treatment plans, with 83% of those South Western Sydney LHD MDTs that generate treatment plans reporting that each of these types of information is included.

Table 18: Information included in treatment plans

Information included in treatment plans	South Western Sydney LHD		NSW	
	2011		2011	
	n	%	n	%
Diagnosis	9	**75%**	110	**90%**
Histopathological results	8	**67%**	99	**81%**
Imaging results	6	**50%**	84	**69%**
Stage	6	**50%**	88	**72%**
Relevant medical history	7	**58%**	80	**66%**
Surgical treatment plan	10	**83%**	98	**80%**
Radiotherapy treatment plan	10	**83%**	110	**90%**
Medical oncology treatment plan	9	**75%**	107	**88%**
Psychosocial treatment plan	3	**25%**	54	**44%**
Further investigations required	6	**50%**	91	**75%**
Referral to allied health	5	**42%**	60	**49%**
Referral to palliative care	4	**33%**	57	**47%**
Suitability for clinical trials	5	**42%**	72	**59%**
Referral to other disciplines	6	**50%**	36	**30%**
Base (number of MDTs)	**12**	**-**	**122**	**-**

Most treatment plans are recorded by MDTs in South Western Sydney LHD in electronic format (58%).

Table 19: Format in which treatment plans are recorded

Treatment plan format	South Western Sydney LHD		NSW	
	2011		2011	
	n	%	n	%
Electronically	7	**58%**	43	**35%**
Hard copy	3	**25%**	39	**32%**
Some electronically, some hard copy	2	**17%**	40	**33%**
Base (number of MDTs)	**12**	**100%**	**122**	**100%**

Two-thirds (67%) of MDTs in South Western Sydney LHD report that treatment plans or documented recommendations are *always* recorded in the patient notes, with another 17% reporting that this *usually* occurs. A further 16% of MDTs in South Western Sydney LHD report that this either *rarely* or *never* occurs.

Table 20: How often treatment plans are recorded in patient notes

Frequency of recording treatment plans in patient notes	South Western Sydney LHD		NSW	
	2011		2011	
	n	%	n	%
Always	8	**67%**	52	**43%**
Usually	2	**17%**	33	**27%**
Sometimes	0	**0%**	18	**15%**
Rarely	1	**8%**	10	**8%**
Never	1	**8%**	9	**7%**
Base (number of MDTs)	**12**	**100%**	**122**	**100%**

Just under half (46%) of participating MDTs in South Western Sydney LHD report that GPs are informed of the clinical management recommendations arising from the MDT meeting *some* of the time, with an additional 38% reporting that this occurs *all* of the time. Only 8% MDTs report that GPs are *never* informed.

Table 21: How often GPs are informed of recommendations arising from MDT meeting

Frequency of informing GPs	South Western Sydney LHD		NSW	
	2011		2011	
	n	%	n	%
All of the time	5	**38%**	56	**39%**
Some of the time	6	**46%**	52	**36%**
For specific patients only	1	**8%**	26	**18%**
Never	1	**8%**	10	**7%**
Base (number of MDTs)	**13**	**100%**	**144**	**100%**

Almost half (46%) of participating MDTs in South Western Sydney LHD report that regional/local treatment centres are informed of the clinical management recommendations arising from the MDT meeting *all* of the time. Almost a third (31%) of MDTs report that they do not receive referrals from regional areas, rendering this issue *not applicable*.

Table 22: How often regional/local treatment centres are informed of recommendations arising from MDT meeting

Frequency of informing regional/local treatment centres	South Western Sydney LHD		NSW	
	2011		2011	
	n	%	n	%
All of the time	6	**46%**	77	**53%**
Some of the time	2	**15%**	16	**11%**
For specific patients only	1	**8%**	18	**12%**
Never	0	**0%**	2	**1%**
Not applicable: no referrals from regional areas	4	**31%**	32	**22%**
Base (number of MDTs)	**13**	**100%**	**145**	**-**

2.5 Criteria for MDTs

Background

In 2006, the Cancer Institute NSW developed a set of criteria for MDTs based on the work undertaken by the National Breast and Ovarian Cancer Centre, the Victorian Department of Health, and the United Kingdom National Health Service (NHS). The criteria relate to communication, team membership, patient involvement, number of patients discussed, data collection and treatment planning. The purpose of the criteria was to provide guidance to MDTs and act as a measure of the stage of development of MDTs in NSW. The criteria were divided into 'essential', 'desirable' and 'high level' (as shown in the following table), based on the ease of achievement and perceived level of development of the MDTs at that time. The research findings in relation to these criteria will assist with monitoring the progress of MDT development over time. In addition, the intention is to reclassify the criteria better to reflect the actual work of an MDT, where appropriate.

Table 23: Best practice criteria for MDTs[8]

No.	Principle	Criterion
Essential		
E1	Regular meetings	MDT meetings take place at least once a month
E2	All patients have access to relevant services	Referral links with ANY non-core services
E3	Patient allied health needs identified through MDT	Process at MDT meetings for identifying patients who need psycho-oncology AND other allied health referral
E4	Protocols and clinical pathways are available	MDT utilises Clinical Practice Guidelines or Standard / Evidence-based Treatment Protocols OR treatment recommendations made by consensus
E5	Patient preferences discussed	Patient preferences ALWAYS OR USUALLY discussed in MDT meetings
E6	Relevant test results, reports and films available	Relevant test results, reports and films ALWAYS OR USUALLY available at MDT meetings
E7	Patients offered information about all aspects of their treatment choices	Patients informed IN SOME WAY about clinical management recommendations discussed at MDT meetings
E8	Patients given information about supportive care services	Patients' psychosocial and supportive care needs ALWAYS, USUALLY OR SOMETIMES discussed in MDT meetings
E9	Patients informed that their case will be discussed in MDT setting	Patients ALWAYS informed that they are to be discussed in a multidisciplinary forum
E10	Patient consent obtained according to local protocol	Patients' VERBAL CONSENT OR WRITTEN CONSENT obtained to discuss their case in a multidisciplinary forum
Desirable		
D1	Protocol for which patients should be discussed	Established criteria for the referral of patients to MDT meetings
D2	If number of cases are small then links with larger units	IF MDT has discussed less than 20 patients in the last 12 months, THEN it needs to have established links with other cancer specialists or MDTs in rural/regional areas. IF MDT has 20 patients or more, THEN it automatically meets this criteria
D3	Patients advised of all opinions arising from the MDT	Patients ALWAYS OR USUALLY informed of dissenting or alternative views among MDT members

[8] The original set of criteria included three additional measures, relating to the proportion of all newly diagnosed patients in NSW that are discussed by an MDT. However, the number of new diagnoses is not available at the individual MDT level (i.e., by both facility and tumour stream) and, as such, these three criteria have been excluded from this analysis.

D4	Patients given access to services to meet supportive care needs	Patients' psychosocial and supportive care needs ALWAYS, USUALLY OR SOMETIMES influence recommendations for treatment
D5	Patients informed who is part of the MDT	Patients ALWAYS informed of who or which disciplines are part of the MDT[9]
D6	Clinical trials	Patient suitability for clinical trials discussed at MDT meetings[10]
D7	Data collected by the MDT	ANY data/statistics recorded by the MDT
D8	Treatment plans are written for each patient	Treatment plans for each patient are generated at MDT meetings
High level		
H1	All new patients are referred for discussion at the MDT meeting	All patients diagnosed with the relevant cancer are referred to the MDT OR MDT has a palliative care focus
H2	Professional development for the MDT	Professional development activities made available for MDT members WEEKLY, MONTHLY OR QUARTERLY
H3	Quality activities undertaken	ANY quality assurance activity in MDT meetings
H4	Data analysis	MDT has a system for central data collection (with or without a process for the team to review data)
H5	Documentation of treatment plans	Treatment plans are ALWAYS OR USUALLY recorded in patients' medical notes
H6	Treatment plan changes	There is a process for changing/considering changes to treatment plans after discussion with patients (i.e., patient preferences are taken into account and acted upon; patient not just encouraged to accept proposed plan)

The table below presents the average number of essential, desirable and high level criteria being implemented by participating MDTs in 2008 and 2011.[11] In 2011, participating MDTs in South Western Sydney LHD are meeting, on average, 18.3 of the 24 criteria (that is, 76% of all best practice criteria). More specifically, South Western Sydney LHD MDTs are meeting 7.9 of the 10 essential criteria, 5.9 of the 8 desirable criteria, and 4.5 of the 6 high level criteria, on average.

[9] In 2008, criterion D5 also included the following requirement: "AND always, usually or sometimes informed of who the MDT leader is". In 2011, however, this question (Question 23) was omitted from the survey and, consequently, from the criterion requirements. Therefore, the 2008 datafile was re-analysed to ensure that this criterion and relevant mean scores were comparable with the 2011 requirements.

[10] In 2008, criterion D6 also included the following requirement: "AND open clinical trials known to all key members of the MDT". In 2011, however, this question (Question 16b) was omitted from the survey and, consequently, from the criterion requirements. Again, the 2008 datafile was re-analysed to ensure comparability with the 2011 requirements.

[11] Where a respondent failed to answer a particular question, resulting in missing data for the relevant criterion, the total number of criteria met by their MDT was calculated based on the sum of all other criteria (for which data was available).

Table 24: Average number of criteria met by MDTs

Categories of criteria	South Western Sydney LHD		NSW	
	2008	2011	2008	2011
	Average no. criteria met	Average no. criteria met	Average no. criteria met	Average no. criteria met
Essential (/10)	8.0	**7.9**	8.1	**7.9**
Desirable (/8)	6.1	**5.9**	5.8	**5.9**
High level (/6)	4.3	**4.5**	3.9	**3.9**
All criteria (/24)	18.4	**18.3**	17.8	**17.7**
Base (number of MDTs)	**12**	**13**	**131**	**145**

The following sections explore each individual criterion in turn.

Individual essential criteria

The following table shows the proportion of participating MDTs meeting each essential criterion in 2008 and 2011. In 2011, South Western Sydney LHD MDTs are having some difficulty (relative to 2008) with regard to criteria E5 (patient preferences discussed) and E10 (patient consent obtained according to local protocol). However, South Western Sydney LHD MDTs have improved over time in relation to criteria E6 (relevant test results available), E8 (psychosocial / supportive care needs discussed) and E9 (patients informed that their case will be discussed in MDT), compared with the previous results for this LHD. Further, in 2011, South Western Sydney LHD MDTs are having some difficulty (relative to NSW MDTs overall) with regard to criteria E5 (patient preferences discussed), E9 (patients informed that their case will be discussed in MDT) and E10 (patient consent obtained according to local protocol). However, South Western Sydney LHD MDTs are doing relatively well on criteria E3 (psycho-oncology / allied health referral needs identified through MDT), E6 (relevant test results available) and E7 (patients offered information about recommendations), when compared with the overall results for NSW MDTs.[12]

[12] Finite population correction was applied to the analysis of key criteria and core discipline data throughout Section 2.5.

Table 25: Number of MDTs meeting each essential criterion

Essential criteria	South Western Sydney LHD				NSW			
	2008		2011		2008		2011	
	n	%	n	%	n	%	n	%
E1 - Regular meetings	12	100%	13	**100%**	127	97%	143	**99%**
E2 - Referral links with non-core services / disciplines	12	100%	13	**100%**	110	84%	138	**98%**
E3 – Psycho-oncology / allied health referral needs identified through MDT	9	75%	9	**69%**	86	66%	90	**62%**
E4 – Guidelines / protocols (or consensus) used	12	100%	13	**100%**	125	98%	145	**100%**
E5 - Patient preferences discussed	10	83%	8	**62%**	105	80%	99	**68%**
E6 - Relevant test results available	11	92%	13	**100%**	111	85%	128	**88%**
E7 - Patients offered information about recommendations	12	100%	13	**100%**	130	99%	138	**97%**
E8 – Psychosocial / supportive care needs discussed	7	58%	10	**77%**	108	82%	115	**79%**
E9 - Patients informed that their case will be discussed in MDT	1	8%	3	**23%**	56	43%	42	**29%**
E10 - Patient consent obtained according to local protocol	10	83%	8	**62%**	104	81%	106	**74%**
Base (number of MDTs)	**12**	**-**	**13**	**-**	**131**	**-**	**145**	**-**

Individual desirable criteria

The following table shows the proportion of participating MDTs meeting each desirable criterion in 2008 and 2011. In 2011, South Western Sydney LHD MDTs are having some difficulty (relative to 2008) with regard to criteria D3 (patients advised of alternative opinions arising from the MDT) and D7 (data / statistics collected by the MDT). However, South Western Sydney LHD MDTs have improved over time in relation to criteria D6 (suitability for clinical trials discussed) and D8 (treatment plans generated for each patient), compared with the previous results for this LHD. Further, the results suggest that criteria D3 (patients advised of alternative opinions arising from the MDT), D5 (patients informed who / which disciplines are part of MDT) and D7 (data / statistics collected by the MDT) are causing some difficulty for South Western Sydney LHD MDTs, when compared with all NSW MDTs in 2011. However, South Western Sydney LHD MDTs are doing comparatively better than other NSW MDTs overall on criteria D6 (suitability for clinical trials discussed) and D8 (treatment plans generated for each patient).

Table 26: Number of MDTs meeting each desirable criterion

Desirable criteria	**South Western Sydney LHD**				**NSW**			
	2008		**2011**		**2008**		**2011**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**
D1 - Protocol for which patients should be discussed	10	83%	11	**85%**	99	76%	120	**83%**
D2 - If few cases discussed, then links with larger units	12	100%	13	**100%**	131	100%	143	**99%**
D3 - Patients advised of alternative opinions arising from the MDT	6	50%	5	**38%**	64	49%	69	**48%**
D4 – Psychosocial / supportive care needs influence recommendations	11	92%	11	**85%**	113	88%	121	**83%**
D5 - Patients informed who / which disciplines are part of MDT	1	8%	1	**8%**	24	18%	27	**19%**
D6 – Suitability for clinical trials discussed	11	92%	13	**100%**	103	79%	116	**80%**
D7 – Data / statistics collected by the MDT	12	100%	11	**85%**	121	92%	134	**92%**
D8 - Treatment plans generated for each patient	10	83%	12	**92%**	105	80%	122	**84%**
Base (number of MDTs)	**12**	**-**	**13**	**-**	**131**	**-**	**145**	**-**

Individual high level criteria

The following table shows the proportion of participating MDTs meeting each high level criterion in 2008 and 2011. There have been no changes over time for South Western Sydney LHD MDTs in relation to high level criterion. In 2011, South Western Sydney LHD MDTs are slightly below the overall figures for NSW MDTs with regard to criterion H3 (quality activities undertaken in MDT). However, South Western Sydney LHD MDTs perform relatively strongly on criteria H1 (all new patients of cancer type are referred to MDT), H2 (professional development for the MDT) and H5 (treatment plans recorded in patient notes), compared with all NSW MDTs.

Table 27: Number of MDTs meeting each high level criterion

High level criteria	South Western Sydney LHD				NSW			
	2008		2011		2008		2011	
	n	%	n	%	n	%	n	%
H1 - All new patients of cancer type are referred to MDT	10	83%	11	**85%**	83	63%	105	**72%**
H2 - Professional development for the MDT	8	67%	10	**77%**	68	53%	73	**51%**
H3 - Quality activities undertaken in MDT	6	50%	6	**46%**	82	64%	84	**58%**
H4 - Central data collection system	8	67%	8	**62%**	68	53%	83	**57%**
H5 - Treatment plans recorded in patient notes	8	67%	10	**77%**	85	66%	85	**59%**
H6 - Process for changes to treatment plan after discussion with patient	12	100%	13	**100%**	127	98%	141	**98%**
Base (number of MDTs)	**12**	**-**	**13**	**-**	**131**	**-**	**145**	**-**

2.6 Participation of core disciplines

Respondents were provided with a list of medical and non-medical disciplines, and were asked to indicate whether each discipline attends MDT meetings (either on a regular, occasional or patient-specific basis), or has referral links to the MDT, or has no interaction with the MDT. Responses were compared with a list of core disciplines for each tumour stream[13], adapted from those listed in the Victorian Patient Management Frameworks (as outlined in Appendix C).

The series of tables in this section indicate, for each tumour stream:

1. whether all core medical disciplines attend the MDT (either on a regular, occasional or patient-specific basis);[14]

2. whether all core non-medical disciplines attend the MDT; and

3. whether all core disciplines attend the MDT (i.e., all relevant medical and non-medical disciplines).

Key findings for 2011 indicate that 54% of participating MDTs in South Western Sydney LHD involve all core medical disciplines (an improvement since 2008), and 31% involve all core non-medical disciplines. Together, these results mean that 15% of the participating South Western Sydney LHD MDTs involve all disciplines considered to be core for their tumour stream (i.e., both medical and non-medical disciplines). While the result for medical disciplines is better than for other NSW MDTs, South Western Sydney LHD appears to be having some difficulty with attendance by non-medical disciplines relative to other NSW MDTs.

The series of tables below present the medical, non-medical and overall results in turn, for each tumour stream.

[13] For each cancer stream, different disciplines (and different numbers of disciplines) constitute the 'core' team. As a consequence, it is more difficult for some tumour streams to involve all relevant core disciplines in their MDTs.
[14] General Practitioners (GPs) were deemed to be involved in the MDT process if respondents reported that GPs are informed of the MDT's clinical management recommendations either all of the time, some of the time or for specific patients only (based on question Mod_C18a of the survey).

Table 28: Number of MDTs where all core *medical* disciplines attend MDT meetings, by tumour stream

All core medical disciplines attend MDT	South Western Sydney LHD				NSW			
	2008		2011		2008		2011	
	n	%	n	%	n	%	n	%
Bone & Soft Tissue	-	-	-	**-**	3	75%	2	**50%**
Breast	0	0%	0	**0%**	3	14%	4	**19%**
Colorectal	-	-	0	**0%**	3	50%	5	**56%**
Gastrointestinal	1	100%	1	**100%**	3	43%	4	**80%**
General Cancer	-	-	1	**100%**	2	20%	5	**33%**
Palliative Care	1	100%	1	**100%**	11	85%	8	**80%**
Gynaecology	1	100%	-	**-**	3	50%	3	**60%**
Haematology	0	0%	0	**0%**	1	9%	0	**0%**
Head & Neck	0	0%	1	**100%**	1	13%	3	**43%**
Lung	0	0%	0	**0%**	7	50%	10	**63%**
Melanoma (Skin)	-	-	-	**-**	1	33%	3	**75%**
Neurological	0	0%	1	**100%**	0	0%	1	**20%**
Paediatric	-	-	-	**-**	3	50%	5	**63%**
Upper GI	1	100%	1	**100%**	2	29%	3	**38%**
Urology	0	0%	1	**100%**	6	50%	10	**77%**
Total	4	33%	7	**54%**	49	37%	66	**47%**
Base for total (number of MDTs)	**12**	**-**	**13**	**-**	**131**	**-**	**141**	**-**

Note that the base for each row only includes those MDTs in each tumour stream that participated in the survey (excluding any missing responses).

Table 29: Number of MDTs where all core *non-medical* disciplines attend MDT meetings, by tumour stream

All core non-medical disciplines attend MDT	South Western Sydney LHD				NSW			
	2008		2011		2008		2011	
	n	%	n	%	n	%	n	%
Bone & Soft Tissue	-	-	-	**-**	1	25%	1	**25%**
Breast	0	0%	2	**100%**	9	43%	12	**57%**
Colorectal	-	-	0	**0%**	1	17%	0	**0%**
Gastrointestinal	0	0%	0	**0%**	2	29%	1	**20%**
General Cancer	-	-	0	**0%**	8	80%	11	**73%**
Palliative Care	0	0%	1	**100%**	1	8%	5	**50%**
Gynaecology	1	100%	-	**-**	2	33%	2	**40%**
Haematology	1	100%	0	**0%**	3	27%	3	**27%**
Head & Neck	0	0%	0	**0%**	2	25%	1	**14%**
Lung	0	0%	0	**0%**	3	21%	7	**44%**
Melanoma (Skin)	-	-	-	**-**	0	0%	1	**25%**
Neurological	1	100%	1	**100%**	1	33%	1	**20%**
Paediatric	-	-	-	**-**	3	50%	5	**63%**
Upper GI	0	0%	0	**0%**	1	14%	1	**13%**
Urology	0	0%	0	**0%**	5	42%	3	**23%**
Total	3	25%	4	**31%**	42	32%	54	**38%**
Base for total (number of MDTs)	**12**	**-**	**13**	**-**	**131**	**-**	**141**	**-**

Note that the base for each row only includes those MDTs in each tumour stream that participated in the survey (excluding any missing responses).

Table 30: Number of MDTs where *all core disciplines* attend MDT meetings, by tumour stream

All core disciplines attend MDT	**South Western Sydney LHD**				**NSW**			
	2008		**2011**		**2008**		**2011**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Bone & Soft Tissue	-	-	-	**-**	1	25%	1	**25%**
Breast	0	0%	0	**0%**	1	5%	2	**10%**
Colorectal	-	-	0	**0%**	0	0%	0	**0%**
Gastrointestinal	0	0%	0	**0%**	1	14%	0	**0%**
General (Other)	-	-	0	**0%**	2	20%	3	**20%**
Palliative Care	0	0%	1	**100%**	1	8%	5	**50%**
Gynaecology	1	100%	-	**-**	1	17%	1	**20%**
Haematology	0	0%	0	**0%**	0	0%	0	**0%**
Head & Neck	0	0%	0	**0%**	0	0%	1	**14%**
Lung	0	0%	0	**0%**	0	0%	6	**38%**
Melanoma (Skin)	-	-	-	**-**	0	0%	1	**25%**
Neurological	0	0%	1	**100%**	0	0%	1	**20%**
Paediatric	-	-	-	**-**	3	50%	3	**38%**
Upper GI	0	0%	0	**0%**	0	0%	0	**0%**
Urology	0	0%	0	**0%**	2	17%	3	**23%**
Total	1	8%	2	**15%**	12	9%	27	**19%**
Base for total (number of MDTs)	**12**	**-**	**13**	**-**	**131**	**-**	**141**	**-**

Note that the base for each row only includes those MDTs in each tumour stream that participated in the survey (excluding any missing responses).

Appendix A: 2011 questionnaire

Dear (Name of MDT Contact),

The Cancer Institute NSW has been conducting biennial surveys of all MDTs since 2006 to:

- Identify changes in the number, characteristics, dynamics and stage of development of MDTs in NSW;
- Plan future initiatives to improve equity of access to quality multidisciplinary care for cancer patients; and,
- In 2011, explore key factors associated with effective MDTs and how these affect outcomes for patients, health professionals and the health system.

Thank you to those clinicians who have participated in previous years – we appreciate your commitment to MDTs. If you have not completed the CINSW MDT survey before, you have been nominated by your cancer service to complete the survey on behalf of your MDT.

Cancer Australia is currently undertaking research into MDTs. To prevent clinicians having to complete two overlapping surveys, two processes are occurring:

- This COMBINED Cancer Institute NSW and Cancer Australia survey requires your completion on behalf of your MDT; and,
- We will also approach OTHER members of your MDT, on behalf of Cancer Australia, to complete a subset of questions.

It will be critical to the study's success that feedback is received from all MDTs. This survey will take approximately 20 minutes. Local results will be provided to each Local Hospital Network and full results made available publicly.

The survey can be accessed at the link below. You may stop the survey at any time and then continue it later by clicking on the link in this email:

[link]

Please note, this link refers to the following MDT: [MDT] If you are the nominated contact for more than one MDT, please complete a separate survey for each MDT by clicking on the unique link in each email.

We would appreciate you completing the survey by FRIDAY 29 APRIL.

Please do not reply to this email. If you have queries about the study, you may contact Robyn Thomas at the Cancer Institute NSW (robyn.thomas@cancerinstitute.org.au or 02 8374 5621). If you experience technical difficulties or cannot access the survey online, please email Ben Barnes at Ipsos-Eureka Social Research Institute (ben.barnes@ipsos.com or 02 9900 5100).

Thank you for your valued contribution to the provision of quality multidisciplinary care.

Yours sincerely,

Sanchia Aranda
Director of Cancer Services and Information
Cancer Institute NSW

Introduction screen for online version

Thank you for agreeing to participate in this important survey of MDTs. It should take approximately 20 minutes. Please answer on behalf of the following MDT: [MDT]

If you wish to take a break, please click the "Finish later" button at the bottom of the page. You can restart the survey at a later time by clicking on the link in the email you received. You cannot go back to change your answers.

Please click the "Next>>" button below to start the survey.

For your information, throughout the survey…

- *Multidisciplinary care refers to a 'team approach to the provision of healthcare by all relevant medical, nursing and allied health disciplines' (Zorbas 2003)*

- *Multidisciplinary team (or MDT) refers to an 'integrated team approach to health care in which medical, nursing and allied health care professionals consider all relevant treatment options and develop collaboratively an individual treatment plan for each patient' (National Breast Cancer Centre 2005).*

- *Multidisciplinary team meeting (or MDT meeting) refers to 'designated meetings for the purpose of treatment planning' (National Breast Cancer Centre 2005).*

- *Core team refers to MDT members whose attendance at MDT meetings is essential in order to ensure that all disciplines integral to good patient care are represented (i.e. essential that core team members attend all MDT meetings).*

Questionnaire

Features of the MDT

These questions ask for basic details about your MDT - that is, [insert name of MDT].

Mod_I1 On what cancer type(s) is this MDT focused? Please tick all that apply

☐ Bone & soft tissue cancers
☐ Breastcancers
☐ Colorectal cancers
☐ Genito-urinary cancers (including prostate cancer)
☐ Gynaecological cancers
☐ Haematological cancers
☐ Head & neck cancers
☐ Lung cancers
☐ Neurological cancers
☐ Skin cancers (melanoma)
☐ Thyroid & endocrine cancers
☐ Upper gastrointestinal cancers
☐ Other – General cancer MDT
☐ Other – Paediatric / Adolescent and Young Adult MDT
☐ Other – Palliative care MDT
☐ Other (please specify) _____

This survey will provide a snapshot of multidisciplinary care activity. Your responses should reflect your MDT's **current** practices.

A1 How often does the MDT meet?

☐ At least once a week
☐ At least once a fortnight
☐ At least once a month
☐ Less frequently – please specify: _____
☐ Irregularly – as needed

A1b What is the average duration of the MDT meetings (in minutes)?

☐ 0-30 mins
☐ 31-60 mins
☐ 61 – 90 mins
☐ 91-120 mins
☐ More than 120 mins

A1c What is the average amount of time spent discussing each patient within a given MDT meeting?

☐ Up to 4 minutes

☐ 5-9 minutes

☐ 10-14 minutes

☐ 15 minutes or more

Mod_A2a How are MDT meetings conducted?

☐ Face-to-face, with meeting room set up lecture theatre style

☐ Face-to-face, with meeting room set up board room style

☐ Face-to-face, in clinic rooms

☐ Via teleconference or video link or web conferencing link (e.g. WebEx)

☐ Combination

A2b Is your centre a:

☐ Main host site (hub)

☐ Satellite site (spoke)

Mod_A3ab Please indicate which of the following disciplines are represented in the MDT meetings. Please include <u>all core and extended disciplines</u>, even if involved only occasionally or for specific patients. Please tick all that apply.

	Attend MDT meetings regularly	Attend MDT meetings occasionally	Patient specific attendance	Have referral links to the team	No interaction with MDT
Surgical specialists					
General Surgeon	☐	☐	☐	☐	☐
Breast Surgeon	☐	☐	☐	☐	☐
Ear Nose & Throat Surgeon	☐	☐	☐	☐	☐
Head & Neck Surgeon	☐	☐	☐	☐	☐
Neuro Surgeon	☐	☐	☐	☐	☐
Plastic Surgeon	☐	☐	☐	☐	☐
Reconstructive Surgeon	☐	☐	☐	☐	☐
Thoracic Surgeon	☐	☐	☐	☐	☐

	Attend MDT meetings regularly	Attend MDT meetings occasionally	Patient specific attendance	Have referral links to the team	No interaction with MDT
Urologist	☐	☐	☐	☐	☐
Medical specialists					
Dermatologist	☐	☐	☐	☐	☐
Endoscopist	☐	☐	☐	☐	☐
Fertility Physician	☐	☐	☐	☐	☐
General Practitioner	☐	☐	☐	☐	☐
Gynaecological Oncologist	☐	☐	☐	☐	☐
Gynaecologist	☐	☐	☐	☐	☐
Haematologist	☐	☐	☐	☐	☐
Medical Oncologist	☐	☐	☐	☐	☐
Medical Trainees	☐	☐	☐	☐	☐
Nuclear Medicine Physician	☐	☐	☐	☐	☐
Pain Management Clinician	☐	☐	☐	☐	☐
Palliative Care Physician	☐	☐	☐	☐	☐
Pathologist	☐	☐	☐	☐	☐
Psychiatrist	☐	☐	☐	☐	☐
Radiation Oncologist	☐	☐	☐	☐	☐
Radiologist	☐	☐	☐	☐	☐
Respiratory Physician	☐	☐	☐	☐	☐
Nursing					
Cancer Nurse Coordinator/ Cancer Care Coordinators	☐	☐	☐	☐	☐
Nursing Trainees	☐	☐	☐	☐	☐

	Attend MDT meetings regularly	Attend MDT meetings occasionally	Patient specific attendance	Have referral links to the team	No interaction with MDT
Other Nurse	☐	☐	☐	☐	☐
Allied Health and Other Health Professionals					
Allied Health Trainees	☐	☐	☐	☐	☐
Continence/Erectile Dysfunction Clinician	☐	☐	☐	☐	☐
Dietician	☐	☐	☐	☐	☐
Genetic Counsellor	☐	☐	☐	☐	☐
Lymphoedema Therapist	☐	☐	☐	☐	☐
Occupational Therapist	☐	☐	☐	☐	☐
Pastoral Carer	☐	☐	☐	☐	☐
Pharmacist	☐	☐	☐	☐	☐
Physiotherapist	☐	☐	☐	☐	☐
Psychologist	☐	☐	☐	☐	☐
Sexual Health Counsellor	☐	☐	☐	☐	☐
Social Worker	☐	☐	☐	☐	☐
Stomal Therapist	☐	☐	☐	☐	☐
Any other discipline (surgical, medical, nursing, allied health, etc)	☐	☐	☐	☐	☐

Mod_A3c You indicated that other disciplines are represented in the MDT meetings. Please specify which other disciplines below. Please include <u>all other disciplines</u>, even if involved only occasionally or for specific patients. _____

A4a Who or which discipline(s) is (are) responsible for organising the MDT meetings (e.g., preparing meeting agendas and other administrative support prior to meetings)? Please tick all that apply.

- ☐ MDT coordinator
- ☐ Cancer Nurse Coordinator / Cancer Care Coordinator
- ☐ Other nurse
- ☐ Other MDT-specific administration staff
- ☐ Other general administration staff
- ☐ Other project staff
- ☐ Medical Staff
- ☐ Other Clinician
- ☐ Other – please specify all others responsible: _____

A4b For each of those ticked above) Is this provision of administrative support to the MDT a formal part of the job description for this(these) role(s)?

	Yes	**No**
MDT coordinator	☐	☐
Cancer Nurse Coordinator / Cancer Care Coordinator	☐	☐
Other nurse	☐	☐
Other MDT-specific administration staff	☐	☐
Other general administration staff	☐	☐
Other project staff	☐	☐
Medical Staff	☐	☐
Other Clinician	☐	☐
Other role(s) as noted in previous question	☐	☐

A5a In total, over the last 12 months, approximately how many different patients have been discussed by the MDT? If unsure, please make your best estimate.

A5b Of those patients, how many had been *diagnosed* with cancer within the last 12 months? If unsure, please make your best estimate. (That is, the number of patients, not the proportion.) (NB: Your response should not exceed the number you entered at the previous question.)

A5c Of *all patients discussed* at the MDT in the last 12 months, what percentage was discussed … (NB: Your responses should add to 100%.)

Once (within the last 12 months) _____%

Twice (within the last 12 months) _____%

Three or more times (within the last 12 months) _____%

Quality Assurance

Mod_B6a Which of the following data and statistics are recorded by the MDT? Please tick all that apply.

☐ No data recorded **(Skip to Question B7)**

☐ When the MDT recommended treatment plans are recorded in the patients' hospital notes

☐ When the MDT recommended treatment plans are sent to referring clinicians (including referring general practitioners)

☐ When the MDT recommended treatment plans are sent to the patient's general practitioner (GP) if the GP is not the referring clinician

☐ When the MDT recommended treatment plans are provided to patients

☐ Disciplines represented at each meeting

☐ Team members present at each meeting

☐ Number of patients discussed at each meeting

☐ Number of patients discussed at each meeting by week, fortnight, month or year

☐ Number of patients discussed as proportion of total patients treated for tumour type in Area Health Service

☐ Number of patients with documented consent for their case to be discussed at the MDT meeting

☐ Proportion of patients managed according to agreed protocols

☐ Number of patients suitable for clinical trials

☐ Patient survival

☐ Patient mortality

☐ Patient morbidity (please specify what is recorded): _____

☐ Other (please specify): _____

Mod_B6b How is this data collected and recorded?

	Electronically	Hard copy	Some electronically, some hard copy
When the MDT recommended treatment plans are recorded in the patients' hospital notes	☐	☐	☐
When the MDT recommended treatment plans are sent to referring clinicians (including referring general practitioners)	☐	☐	☐
When the MDT recommended treatment plans are sent to the patient's general practitioner (GP) if the GP is not the referring clinician)	☐	☐	☐
When the MDT recommended treatment plans are provided to patients	☐	☐	☐
Disciplines represented at each meeting	☐	☐	☐
Team members present at each meeting	☐	☐	☐
Number of patients discussed at each meeting	☐	☐	☐
Number of patients discussed at each meeting by week, fortnight, month or year	☐	☐	☐
Number of patients discussed as proportion of total patients treated for tumour type in Area Health Service	☐	☐	☐
Number of patients with documented consent for their case to be discussed at the MDT meeting	☐	☐	☐
Proportion of patients managed according to agreed protocols	☐	☐	☐
Number of patients suitable for clinical trials	☐	☐	☐
Patient survival	☐	☐	☐
Patient mortality	☐	☐	☐
Patient morbidity (as noted in previous question)	☐	☐	☐
Other(s) as noted in previous question	☐	☐	☐

B7 Does the MDT have a system for the collection and review of data for audit purposes?

- ☐ There is central data collection and a process for the team to review data
- ☐ There is central data collection, but no process for the team to review data
- ☐ There is no central data collection (individual clinicians contribute to audit coordinated by professional college)
- ☐ There is no data collection at the hospital, either centrally or by individual clinicians
- ☐ Not sure

B8 What quality assurance activity occurs in MDT meetings? Please tick all that apply.

- ☐ Relevance to guideline development and compliance
- ☐ Review of patient outcomes
- ☐ Review of unexpected morbidity or mortality
- ☐ Other – please specify: _____
- ☐ None – occurs elsewhere
- ☐ None – does not occur at all

B9 How often are all relevant test results, reports and films available at MDT meetings?

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

B10 Is staging information routinely available at the MDT meetings?

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

Standards of Care

Mod_C10a Meetings utilise Clinical Practice Guidelines or Standard Treatment Protocols or Evidence-based Treatment Protocols relevant to the diagnosis, treatment and psychosocial/ supportive care of cancer patients? If YES, please tick all that apply

- ☐ No
- ☐ Yes – Diagnosis **(Skip to Question Mod_C11a)**
- ☐ Yes – Treatment **(Skip to Question Mod_C11a)**
- ☐ Yes – Psychosocial/ supportive care (e.g. palliative care, counselling, social work) **(Skip to Question Mod_C11a)**

C10b If no or unsure, on what basis are treatment recommendations made?

- ☐ Consensus
- ☐ Other (please specify) _____

Mod_C11a Are there established criteria for the referral of patients to MDT meetings?

- ☐ Yes, formal criteria
- ☐ Yes, informal criteria
- ☐ No
- ☐ Not sure

Mod_C11b Which of the following patient groups are commonly referred for MDT discussion? Please tick any that apply.

- ☐ All patients diagnosed with the relevant type of cancer
- ☐ All patients of the relevant patient group (e.g. Paediatric/AYA, palliative care)
- ☐ Suspected cancer cases
- ☐ All newly diagnosed early cancer
- ☐ All newly diagnosed advanced cancer
- ☐ Recurrent/ relapsed cases
- ☐ Difficult cases
- ☐ Screen detected cancers or premalignant lesions
- ☐ Cases referred for a second opinion
- ☐ Patients with disease progression
- ☐ Cases requiring multimodality treatment
- ☐ Patients for whom standard protocol treatment is not appropriate
- ☐ Other (please specify)_____
- ☐ No protocol – individual clinician's choice

Mod_C12 At which point(s) along the treatment pathway is patient management discussed by the MDT? Please tick any that apply.

- ☐ Initial diagnosis and referral
- ☐ Determination of treatment
- ☐ After surgery but before other treatment
- ☐ During treatment
- ☐ At the time treatment is changed (e.g. disease progression)
- ☐ At time of cancer recurrence
- ☐ At each hospital admission
- ☐ Follow-up care
- ☐ End of life care
- ☐ Other (please specify) _____

Mod_C13a Are treatment plans or documented recommendations for each patient generated at MDT meetings?

- ☐ Yes
- ☐ No **(Skip to Question Mod_C14)**

Mod_C13b Who or which discipline(s) is(are) responsible for completing patient treatment or management plans, or documenting the treatment recommendations in medical notes? Please tick all that apply.

- ☐ MDT coordinator
- ☐ Cancer Nurse Coordinator / Cancer Care Coordinator
- ☐ Other nurse
- ☐ Other MDT-specific administration staff
- ☐ Other general administration staff
- ☐ Other project staff
- ☐ Referring clinician / Patient's principal clinician
- ☐ Surgeon
- ☐ Radiation oncologist
- ☐ Medical oncologist
- ☐ Registrar
- ☐ Other medical
- ☐ Allied health professional (e.g. Social worker)
- ☐ Other (please specify all others responsible) _____

Mod_C13c What information is included in the treatment plans or documented recommendations provided to referring clinicians, GPs or regional treatment centres? Please tick any that apply.

- ☐ Diagnosis
- ☐ Histopathological results
- ☐ Imaging results
- ☐ Stage
- ☐ Relevant medical history
- ☐ Surgical treatment plan
- ☐ Radiotherapy treatment plan
- ☐ Medical oncology treatment plan
- ☐ Psychosocial treatment plan
- ☐ Further investigations required
- ☐ Referral to allied health
- ☐ Referral to palliative care
- ☐ Suitability for clinical trials
- ☐ Referral to other disciplines/services (please specify) _____

Mod_C13d How are treatment plans or documented recommendations recorded?

- ☐ Electronically
- ☐ Hard copy
- ☐ Some electronically and some hard copy

Mod_C13e How often are treatment plans or documented recommendations recorded in patients' medical notes?

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

Mod_C14 How often are patients' psychosocial and supportive care needs (e.g. financial or other needs) discussed in MDT meetings?

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

Mod_C15 How often do the psychosocial and supportive care needs of patients influence recommendations for treatment?

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

Mod_C16a Is patient suitability for clinical trials discussed at MDT meetings?

- ☐ Yes
- ☐ No

Mod_C18a How often are general practitioners (GP) informed of the MDT's recommendations for clinical management?

- ☐ All of the time
- ☐ Some of the time
- ☐ For specific patients only
- ☐ Never **(Skip to Question Mod_C17a)**

Mod_C18b How is a patient's GP informed of the MDT's recommendations for clinical management? Please tick all that apply.

- ☐ Email
- ☐ Individualised letter
- ☐ Standardised letter
- ☐ Written treatment plan
- ☐ Attendance at meeting
- ☐ Verbally/phone: directly through clinician
- ☐ Indirectly through the clinician
- ☐ Other (please specify) _____

Mod_C17a Is there a process at MDT meetings for identifying patients who need a referral …

	Yes	No
a) for a psycho-oncology consultation?	☐	☐
b) to other allied health service(s)?	☐	☐
c) to a regional hospital?	☐	☐
d) to cancer genetics services	☐	☐
e) to palliative care	☐	☐

C18c If the patient was referred from a regional area, are MDT recommendations for clinical management communicated to the patients regional/local treatment centre?

- ☐ All of the time
- ☐ Some of the time
- ☐ For specific patients only
- ☐ Never **(Skip to C19a)**
- ☐ Not applicable, no patients were referred from a regional area **(Skip to C19a)**

C18d How is a patient's regional treatment centre informed of the MDT's recommendations for clinical management? Please tick all that apply.

- ☐ Email
- ☐ Individualised letter
- ☐ Standardised letter
- ☐ Written treatment plan
- ☐ Attendance at meeting
- ☐ Verbally/phone – directly through clinician
- ☐ Indirectly through the clinician
- ☐ Other (please specify) _____

C19a Does the team have established links with other cancer specialists, cancer services or other MDTs in …

	Yes	No
(i) regional or rural areas?	☐	☐
(ii) metropolitan areas?	☐	☐

C19b Does your MDT have any of the following links across cancer services or MDTs? Please tick any that apply.

- ☐ Joint MDT meetings to discuss cases
- ☐ Individual working mainly for another cancer service provides fly-in services
- ☐ Individual from another service participates in MDT, as a member

- ☐ Individual from another service participates in MDT, but not as a member
- ☐ Site visits, presentations and other educational activities **from** people external to your MDT
- ☐ Site visits, presentations and other educational activities **to** people external to your MDT
- ☐ Ready access for your MDT to external specialists in order to discuss difficult cases, or to provide a second opinion
- ☐ Other (please specify) _____
- ☐ None of these links across cancer services or MDTs (Skip to **Question c19e**)

C19d How were these links across cancer services or MDTs established? Please tick all that apply.

- ☐ Formal agreement
- ☐ Informal agreement
- ☐ Previous relationship with the service/staff member
- ☐ Other (please specify) _____

C19e Are medical clinicians representing a private organisation linked to this MDT meeting?

- ☐ Yes
- ☐ No
- ☐ Don't know

Patient Involvement in the Multidisciplinary Team

D20 How often are patients informed that they are to be discussed in a multidisciplinary forum?

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Never **(Skip to Question Mod_D22)**

D21 Is patient consent obtained for discussion of their case in a multidisciplinary forum?

- ☐ Yes – verbal consent
- ☐ Yes – written consent
- ☐ No

Mod_D22 Are patients informed of who or which disciplines are part of the MDT?

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

D24b How often do patients attend MDT meetings?

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

D25 How often are patient preferences discussed in MDT meetings?

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

Mod_D26 How are patients informed of clinical management recommendations discussed at MDT meetings? Please tick all that apply.

- ☐ Verbal – face-to-face
- ☐ Verbal – telephone
- ☐ Written treatment plan or documented recommendations
- ☐ Entered in hand-held patient record
- ☐ Not informed of MDT recommendations
- ☐ Other (please specify)_____

Mod_D27 Who is usually responsible for informing patients of MDT recommendations? Please tick as many as apply

- ☐ Referring specialist/ Patient's principal clinician who is an MDT team member and attended the meeting
- ☐ Referring specialist/ Patient's principal clinician who is not an MDT team member (may not have attended the MDT meeting)
- ☐ Designated member of the MDT who attended the meeting (e.g. MDT Coordinator)
- ☐ General practitioner (may not have attended the MDT meeting)
- ☐ Other (please specify) _____

D28 When there are dissenting or alternative views among MDT members, how often are patients informed of these views?

- ☐ Always
- ☐ Usually
- ☐ Sometimes

- ☐ Rarely
- ☐ Never

Mod_D29 Following discussion with patients, how are any changes to the MDT recommended treatment plan dealt with? Please tick all that apply.

- ☐ Clinician consults with another individual team member before changing plan
- ☐ Team discusses different treatment plans at next meeting
- ☐ Patient strongly encouraged to accept proposed plan (no alternative discussed)
- ☐ Plan changed and reason noted
- ☐ Plan changed and team informed at a subsequent meeting
- ☐ Other (please specify) _____

Professional Development

Mod_E30 What professional development activities have been arranged by your MDT for its members? Please tick as many as apply

- ☐ Journal club
- ☐ Case studies
- ☐ Guest speaker
- ☐ In-service
- ☐ Recent research results discussed/presented
- ☐ Reports from medical or scientific meetings
- ☐ Registrar presentations
- ☐ None
- ☐ Other (please specify) _____

Mod_E31 How often are professional development activities made available for MDT members?

- ☐ Weekly
- ☐ Fortnightly
- ☐ Monthly
- ☐ Quarterly
- ☐ Less often
- ☐ Never

Final comments

E32 Do you feel there are any barriers to the implementation or improvement of multidisciplinary care in your hospital/ facility? If so, please list these barriers below.

_____

_____

E33 Finally, do you have any additional comments about MDTs, MDT meetings or your cancer care centre? Otherwise, please click "Next>>" to finish.

_____

_____

Thank you for completing the survey.

Appendix B: List of MDTs in South Western Sydney LHD in 2011

The following table lists all MDTs in the South Western Sydney LHD population, as of May 2011. MDTs that did not participate in the 2011 survey are indicated by [DNP]. Any new MDTs (i.e., those not established at the time of the previous 2008 survey) are noted with *.

Table 31: Description of all MDTs in South Western Sydney LHD in 2011

Facility	Tumour stream	LHD	Metropolitan or Regional/ Rural	Public or private sector	With or without radiotherapy
Bankstown-Lidcombe Hospital	Gastrointestinal	South Western Sydney	Metropolitan	Public	**No**
Bankstown-Lidcombe Hospital	General cancer	South Western Sydney	Metropolitan	Public	**No**
Bowral Day Surgery	General cancer	Private	Regional/Rural	Private	**No**
Braeside Hospital	Palliative care	South Western Sydney	Metropolitan	Public	**No**
Liverpool Hospital	Breast	South Western Sydney	Metropolitan	Public	**Yes**
Liverpool Hospital	Colorectal	South Western Sydney	Metropolitan	Public	**Yes**
Liverpool Hospital [DNP]	Gynaecological	South Western Sydney	Metropolitan	Public	**Yes**
Liverpool Hospital	Haematological	South Western Sydney	Metropolitan	Public	**Yes**
Liverpool Hospital	Head and neck	South Western Sydney	Metropolitan	Public	**Yes**
Liverpool Hospital	Lung	South Western Sydney	Metropolitan	Public	**Yes**
Liverpool Hospital	Neurological	South Western Sydney	Metropolitan	Public	**Yes**
Liverpool Hospital	Upper GI	South Western Sydney	Metropolitan	Public	**Yes**

Liverpool Hospital	Urological	South Western Sydney	Metropolitan	Public	**Yes**
Macarthur	Breast	South Western Sydney	Metropolitan	Public	**Yes**
Macarthur	**Lung**	**South Western Sydney**	**Metropolitan**	**Public**	**Yes**

Appendix C: Core disciplines for each tumour stream

Source: Victorian Patient Management Frameworks

http://www.dhs.vic.gov.au/health/cancer/pmfsnew.htm

Cancer Stream	Core disciplines
Breast Cancer	**– breast care nurse** **– general practitioner** **– medical oncologist** **– pathologist** **– radiation oncologist** **– radiologist** **– social worker** **– surgeons—breast** **– plastics if reconstruction is a consideration** **with access to:** **– allied health services where appropriate** **– palliative care service for patients with locally advanced cancers and metastatic disease** **– psycho-oncology services where appropriate (psychologist/psychiatrist)**
Colorectal (Colon and Rectal Cancer)	**– dietician** **– general practitioner** **– medical oncologist** **– nurse** **– pathologist** **– radiation oncologist** **– radiologist** **– social worker** **– surgeon (colorectal surgeon for rectal cancer)** **with access to:** **– allied health services (including dietician) where appropriate** **– stomal therapist prior to surgery** **– palliative care service for patients with locally advanced cancers and metastatic disease** **– psycho-oncology services where appropriate (psychologist/psychiatrist)**
Gynaecological (Ovarian Cancer)	**– certified gynaecological oncologist (lead role)** **– general practitioner** **– gynaecologist**

	– medical oncologist **– nurse** **– pathologist with expertise in gynaecological oncology** **– radiation oncologist** **– social worker** **with access to:** **– allied health services where appropriate** **– geneticist and counsellors** **– palliative care services where appropriate** **– pharmacist** **– psycho-oncology services where appropriate (psychologist/psychiatrist)**
Head and Neck (Larynx, Pharynx and Oral Cancer)	**– diagnostic radiologist** **– dietician** **– general practitioner** **– ENT/HN surgeon** **– medical oncologist** **– nurse** **– radiation oncologist** **– reconstructive surgeon** **– social worker** **– speech pathologist** **with access to:** **– dentist/dental specialist familiar with cancer treatment** **– pathologist with experience in head and neck cancer** **– palliative care service where appropriate** **– psycho-oncology services where appropriate (psychologist/psychiatrist)** **– other allied health services where appropriate.**
Lung (Non-Small Cell Lung Cancer)	**– general practitioner** **– medical oncologist** **– nurse** **– pathologist** **– radiation oncologist** **– radiologist/imaging specialist** **– respiratory physician** **– social worker** **– thoracic surgeon**

	with access to: **– allied health services where appropriate (for example, self-care, rehabilitation, management of symptoms (shortness of breath, cough, nutrition, fatigue, pain)** **– palliative care service where appropriate** **– psycho-oncology services where appropriate (psychologist/psychiatrist)**
Skin (Melanoma)	**– dermatologist** **– general practitioner** **– medical oncologist** **– nurse** **– pathologist** **– radiation oncologist** **– social worker** **– surgeon** **with access to:** **– allied health services where appropriate** **– palliative care services where appropriate** **– psycho-oncology services where appropriate (psychologist/psychiatrist)**
Genitourinary (Prostate Cancer)	**– general practitioner** **– medical oncologist** **– nurse** **– pathologist** **– radiation oncologist** **– radiologist** **– social worker** **– urologist (lead clinician)** **with access to:** **– allied health services where appropriate** **– palliative care services where appropriate** **– psycho-oncology services where appropriate (psychologist/psychiatrist)**
Genitourinary (Testicular Cancer)	**– general practitioner** **– medical oncologist** **– nurse** **– radiation oncologist** **– social worker** **– urologist**

	with access to: **– allied health services where appropriate** **– palliative care services where appropriate** **– psycho-oncology services where appropriate (psychologist/psychiatrist).** **– Post-chemotherapy retroperitoneal lymph node dissection (RPLND) may involve surgical teams with training and ongoing expertise in this operation, including cardio-thoracic, urology and neurosurgery.**
Upper Gastrointestinal (Pancreatic Cancer)	**– dietician** **– endoscopist (expertise in endoscopic retrograde cholangiopancreatography +/- endoscopic ultrasound)** **– general practitioner** **– medical oncologist (expertise in gastrointestinal oncology)** **– nurse** **– pathologist (expertise in gastrointestinal pathology)** **– radiation oncologist (expertise in gastrointestinal radiation therapy)** **– radiologist (expertise in hepatopancreaticobiliary interventional procedures)** **– social worker** **– surgeon (expertise in hepatopancreaticobiliary surgery)** **with access to:** **– allied health services where appropriate** **– palliative care services where appropriate** **– psycho-oncology services where appropriate (psychologist/psychiatrist)**
Upper Gastrointestinal (Oesophagogastric Cancer)	**– dietician** **– endoscopist (may be the surgeon or gastroenterologist)** **– general practitioner** **– medical oncologist (expertise in oesophagogastric oncology)** **– nurse** **– pathologist (expertise in gastrointestinal pathology)** **– radiation oncologist (expertise in oesophagogastric radiation treatment)** **– radiologist (expertise in oncological radiology)** **– social worker** **– surgeon (expertise in oesophagogastric surgery)** **with access to:** **– allied health services where appropriate** **– palliative care services where appropriate** **– psycho-oncology services where appropriate (psychologist/psychiatrist)**

Central Nervous System (Malignant Glioma)	**– general practitioner** **– medical oncologist or neuro-oncologist** **– neurologist** **– neuropathologist** **– neuroradiologist** **– neurosurgeon** **– nurse** **– palliative care service** **– radiation oncologist** **– social worker** **with access to:** **– allied health services where appropriate (physiotherapy, speech pathology, occupational therapy, dietician and pharmacist)** **– psycho-oncology services where appropriate (psychologist/psychiatrist)**
Central Nervous System (Cerebral Metastases)	**– general practitioner** **– medical oncologist** **– neurosurgeon** **– nurse** **– palliative care service** **– pathologist** **– radiologist** **– radiation oncologist** **– social worker** **with access to:** **– allied health services where appropriate (physiotherapy, speech pathology, dietician, occupational therapy)**
Haematological (Acute Myeloid Leukaemia)	**– clinical haematologist (adequate experience in the management of acute leukaemia)** **– general practitioner** **– nurse** **– pharmacist** **– social worker,** **with access to:** **– a clinical haematologist expert in stem cell transplantation, to be consulted to enable early consideration and planning for allogeneic transplantation (including unrelated donor transplantation), if appropriate** **– infectious diseases physician, immediately the diagnosis is established**

	– allied health services where appropriate (physiotherapist, occupational therapist, dietician) **– oral medicine specialist (for example, dentist for some patients)** **– palliative care services or pain management specialists where appropriate** **– psycho-oncology services where appropriate (psychologist/psychiatrist)**
Haematological (Intermediate Grade Non-Hodgkin Lymphoma)	**– general practitioner** **– haematologist/medical oncologist** **– nurse specialist** **– pharmacist** **– radiation oncologist** **– social worker** **– surgeon** **– symptom management specialists, such as palliative care or pain specialists** **with access to:** **– allied health services where appropriate (dietician, physiotherapist, occupational therapist)** **– infectious diseases physician** **– psycho-oncology services where appropriate (psychologist/psychiatrist)**
Palliative Care	**– general practitioner** **– palliative care physician** **– nurse** **– social worker** **– pharmacist** **with access to:** **– allied health services where appropriate (dietician, physiotherapist, occupational therapist)** **– pain specialist** **– psycho-oncology services where appropriate (psychologist/psychiatrist)**
General Cancer	**– general practitioner** **– medical oncologist** **– nurse** **– radiation oncologist** **– social worker** **– palliative care service** **with access to:** **– allied health services where appropriate (physiotherapy, speech pathology, dietician, occupational therapy)**

	– psycho-oncology services where appropriate (psychologist/psychiatrist)
Paediatric	**– general practitioner** **– medical oncologist** **– nurse** **– radiation oncologist** **– social worker** **– palliative care service** **– pharmacist** **with access to:** **– allied health services where appropriate (dietician, physiotherapist, occupational therapist)** **– psycho-oncology services where appropriate (psychologist/psychiatrist)**

NB: Core disciplines for other tumour streams that are not specified in the Victorian Patient Management Frameworks (i.e., Bone and Soft Tissue MDTs, and Neurological MDTs) were developed by the Cancer Institute NSW at the time of the 2008 study, and are listed below.

Cancer Stream	Core disciplines
Bone and Soft Tissue Cancer (Sarcoma)	**– surgeon** **– radiation oncologist** **– medical oncologist** **– general practitioner** **– pathologist** **– radiologist** **– nurse** **– social worker**
Neurological Cancer	**– neuro surgeon** **– radiation oncologist** **– medical oncologist** **– neuro oncologist** **– palliative care service** **– general practitioner** **– pathologist** **– radiologist or neuro radiologist** **– nurse** **– social worker**