GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

Effective working in a Lung Cancer MDT - A charter

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Objectives

- **To describe the quality standards for effective MDT working in the lung cancer pathway and create a set of pledges for MDTs to implement**
- **To describe a new protocol for specific clinical scenarios that support early referral for treatment prior to MDT discussion ('Streamlined referral protocol)**

The Pledges

1. The sector MDT will meet at the same agreed time once a week. All MDT members should make every effort to be punctual.

2. The chair is responsible for ensuring the meeting is paced appropriately. It is recommended that sector MDT aims to take no longer than 2 hours.

   - ***The chair is responsible for ensuring a supportive environment that encourages all voices to be heard, respectful behaviour is observed at all times and ensuring efficient use of time. It is important that all health care professionals (e.g. CNS) who have met/interacted with the patient are given the opportunity to express their opinion during the MDT, especially where they feel the information will impact the management decision.***
   - ***The chair will ensure the different teams contributing to the sector MDT rotate in presenting their cases first***
   - ***The chair will remind and ensure all MDT members stay for the duration of the MDT, not just their own patient's discussion. Repeated failure to comply with this will be escalated to the GM Cancer lead clinician for lung cancer***
   - ***To ensure the most efficient use of time and concise discussion the chair will ensure a standardised structure is followed for each case presentation (see Box 1)***

Box 1: Recommended structure of case presentation and discussion in the Thoracic MDT

1. **Very short summary of the case being discussed to focus the MDTs attention** (e.g. 'this is a case of small cell lung cancer to discuss, this is a case of stage 1 lung cancer and a discussion of surgery and radiotherapy')

2. A concise summary of age, performance status, clinical frailty score, presenting symptoms and co-morbidities

3. Radiology presentation (work backwards in the TNM staging to ensure metastatic disease discussed first in cases of stage 4 disease and ensure efficient use of time). Radiologists to use **'Presentation state'** in GM Sectra PACS to capture key images and present key findings.

   - Present the pertinent findings of the M-stage (if MO move straight to N-stage)
   - Present the pertinent findings of the N-stage (if NO move straight to T-stage)
   - Present the pertinent findings of the T-stage
   - Present any additional relevant findings for the MDT to note

4. Pathology presentation - key pathological results and adequacy of tissue for predictive markers / predictive marker results

5. Physiology presentation - as per GM diagnostic algorithms - FEV1, DLCO, ppo-FEV1, ppo-DLCO ISWT/6MWT, echo, renal function as relevant

6. MDT discussion - agree treatment recommendations and management plan

The Pledges

3. Where applicable patient's voice should be heard within MDT either via a patient impact statements or views expressed during consultation.

4. All MDT discussions must have a formal record within a patient's case-notes or electronic record with the content agreed by the MDT an the end of each discussion. An 'MDT scribe' should be assigned with responsibility for recording the MDT discussion and the final recommendations.

   - ***It is recommended that where possible the outcome is visible to all members in real time to ensure accuracy.***

5. The position of sector MDT chair will be held for a maximum of 24 months. The new MDT chair should be from a different trust than the outgoing chair.

6. Each trust will ensure appropriate IT support for audio-visual teleconferencing equipment, able to respond to issues during meetings if required.

7. Each trust should have a full-time MDT co-ordinator supporting the sector MDT with appropriate time in their job plan to attend pre-triage meetings.

8. It is recommended that the MDT lead/lead lung cancer physician or their representative should review/triage the MDT list pre- MDT to ensure appropriate cases have been listed and where needed, cases can be moved forward for further diagnostics or treatment if applicable. This should be adequately job planned

9. The sector MDT will be attended by rotational core team members (as defined by National Peer Review Programme) from each trust. The sector MDT will therefore consist of ≥1 member in each discipline with appropriate cross-cover procedures agreed.

10. The sector MDT chair will be made aware of any absences (and cover arrangements) and/or new attendees in advance, and introduce them at the start of the meeting.

11. All patients from each of the sector trusts will be discussed at the meeting. All sector MDT members are expected to engage in discussions/debate for all patients presented at the meeting.

    - ***All patients from each sector trust will be listed at the MDT however may not require full discussion such as those being registered following death (where a stage only is required) and those already referred for treatment under the 'Streamlined referral protocol'***

12. Patients that fulfil the criteria for 'streamlined referral protocol' require a shortened discussion at the end of the MDT that confirms the eligibility for pre-MDT referral, confirms the staging and MDT agreement with the referral. There are three streamlined referral protocols

    - ***Surgical referral in stage I/II NSCLC with excellent physiological reserve (Appendix 1)***
    - ***Medical oncology referral in Stage IV NSCLC with excellent physiological reserve (Appendix 2)***

13. All patients will be referred to the sector MDT via an agreed proforma to summarise the clinical, radiology, and pathology details required to make a management recommendation.

    - ***All patients referred to the sector MDT must have a completed mandatory data set unless specified on standardised referral proforma.***

14. All patients for discussion at the sector MDT will be under a named consultant member of the MDT team. It is the responsibility of this consultant to ensure the case has been prepared for discussion with appropriate information available (either by themselves or a nominated colleague)

15. The consultant named for a patient will ensure their attendance to present the case details and answer specific questions from the MDT team. If a appropriate deputy is nominated for the presentation then it is the responsibility of the named consultant to ensure the deputy has an adequate understanding of the case to present to the MDT and answer further questions.

16. Patients should not be referred to the sector MDT without the appropriate investigations to enable a recommendation (in line with the minimum standards set out in the GM Diagnostic Algorithms). Appropriate referrals to the lung cancer sector MDT are:

    - ***All patients with a diagnosis of lung cancer or mesothelioma requiring a management recommendation from the lung cancer sector MDT.***

    - ***Patients with known previous lung cancer or mesothelioma, presenting with recurrent or progressive disease. Patients discussed at the sector MDT outside of these indications is at the discretion of the chair***

17. Patients referred inappropriately, or without appropriate information/investigations will not be discussed. The referrer will be informed.

18. The sector MDT will be attended by a research nurse. Every patient discussed should be considered for appropriate/available clinical trials, and this should be recorded.

19. Feedback on the outcome of interesting or challenging cases to the MDT is encouraged and should be agreed by the chair in advance.

20. The sector MDT is considered an education opportunity. Medical students and trainees should be encouraged to attend.

21. Sector MDT teams should meet quarterly to review operational processes, ways of improving the care delivered and assess adherence to these recommendations (a standardised Lung Cancer Sector MDT Business Meeting Agenda is provided in Appendix 3)

    - ***The chair and members of the MDT are encouraged to visit other sector MDTs to provide peer review and constructive feedback as well as share learning for their own MDT workings. The planning and outcome of this should be discussed at the quarterly meetings***

22. Sector MDT members are encouraged to raise any concerns about the functioning of the sector MDT with the MDT chair. The Lung Cancer Pathway director should be informed if the above pledges continue to be unmet

Appendix 1

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Streamlined pre-MDT referral proforma:

Surgical referral in stage I/II NSCLC with excellent physiological reserve.

- Patients that fulfil the criteria as set out in the MDT charter should be referred to the thoracic surgical team without waiting for MDT discussion.
- This proforma should accompany any referral
- The patient should be listed for MDT where an abbreviated discussion can occur if the patient has already been referred and meets the criteria. The abbreviated discussion should include;
    - The eligibility for pre-MDT referral
    - The TNM staging
    - MDT agreement with referral
- **Please note it is the referrer's responsibility to ensure all criteria are met and the referrer should be aware that referral outside of the set criteria may potentially lead to delays in the patient's pathway.**

Patient Details	**Referrer Information**
Name:	Referring Team:
DOB:	Responsible Clinician:
NHS No:	Contact details:
Hospital No:	Key Worker:
	Contact details:
	Date of referral:

Please tick to confirm all of the following criteria have been met:	**Yes**	**No**
Stage I/II NSCLC	☐	☐
Pathologically confirmed NSCLC	☐	☐
Post-operative predicted FEV1 & DLCO >40%	☐	☐
Shuttle walk or 6-minute walk test >400m	☐	☐
Performance status 0/1	☐	☐
Clinical frailty score ≤3	☐	☐
All investigations complete in line with GM Diagnostic Algorithms and GM Lung Cancer Referral SOP (including CT brain in stage II, EBUS if any thoracic lymph node >1cm in short axis)	☐	☐
The patient is aware of this referral and aware that it has been made before an MDT discussion. This means there is a small chance the management plan may change, and this will be communicated to the patient following the MDT by the referring team.	☐	☐

Planned MDT discussion date (Please note it is the responsibility of the referring team to ensure the MDT minutes are sent to the treating team)
Additional comment:

Appendix 2

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Streamlined referral proforma:

medical oncology referral in stage IV NSCLC with excellent physiological reserve

- Patients that fulfil the criteria set out below should be referred directly to the medical oncology team without waiting for MDT discussion.
- This proforma should accompany any referral
- The patient should be listed for MDT where an abbreviated discussion can occur if the patient has already been referred and meets the criteria. The abbreviated discussion should include;
  - The eligibility for pre-MDT referral
  - The TNM staging
  - MDT agreement with referral
- **Please note it is the referrer's responsibility to ensure all criteria are met and the referrer should be aware that referral outside of the set criteria may potentially lead to delays in the patient's pathway.**

Patient Details	**Referrer Information**
Name:	Referring Team:
DOB:	Responsible Clinician:
NHS No:	Contact details:
Hospital No:	Key Worker:
	Contact details:
	Date of referral:

Please tick to confirm all of the following criteria have been met:	**Yes**	**No**
Stage IV non-oligometastatic non-intra-cranial NSCLC (single metastases in a single organ and those with brain metastases are excluded)	☐	☐
Adequate tissue for all predictive markers and predictive marker testing commenced	☐	☐
Performance status 0/1	☐	☐
Clinical frailty score ≤3	☐	☐
eGFR >60mls/min	☐	☐
Normal Liver Function	☐	☐
Significant cardiac disease (significant cardiac disease defined as Moderate or Severe LVSD, Moderate or Severe Valve disease, Unstable Angina) If yes criteria not met.	☐	☐
All investigations complete in line with GM Diagnostic Algorithms and GM Lung Cancer Referral SOP	☐	☐
The patient is aware of this referral and aware that it has been made before an MDT discussion. This means there is a small chance the management plan may change, and this will be communicated to the patient following the MDT by the referring team	☐	☐

Planned MDT discussion date (Please note it is the responsibility of the referring team to ensure the MDT minutes are sent to the treating team)
Additional comment:

Appendix 3

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SECTOR MDT BUSINESS MEETING AGENDA

1. **Welcome, Introduction and apologies**
2. **Minutes of last meeting.**
3. **Action log & summary of any responses from GM Cancer**
4. **Governance**
   a. National audits
      i. National Lung Cancer Audit
      ii. GIRFT recommendations
      iii. Other
   b. GM audits
   c. Sector MDT audits
   d. Sector MDT incidents
   e. Sector MDT risks
   f. Sector MDT Complaints / Incidents
   g. Sector MDT interesting cases for feedback & discussion
5. **Performance (Each organisation)**
   a. 7-day performance
   b. 28 Day FDS performance – (Cancer and Non cancer diagnosis patients)
   c. 62-day performance
   d. 104 Day breach performance and pan organisational RCA findings.
   e. Benign case discussion (less than 10%)
   f. No of MDT discussions per patient.
6. **MDT Charter Compliance (Against each statement)**
7. **Peer review – plans / feedback for visiting for other sector MDTs**
8. **Research – future trials, trials open, recruitment figures**
9. **Summary of any issues to be escalated to GM cancer**
10. **Any Other Business.**
11. **Date and Time of Next Meeting.**