Improving Lung Cancer Outcomes Through the MDT

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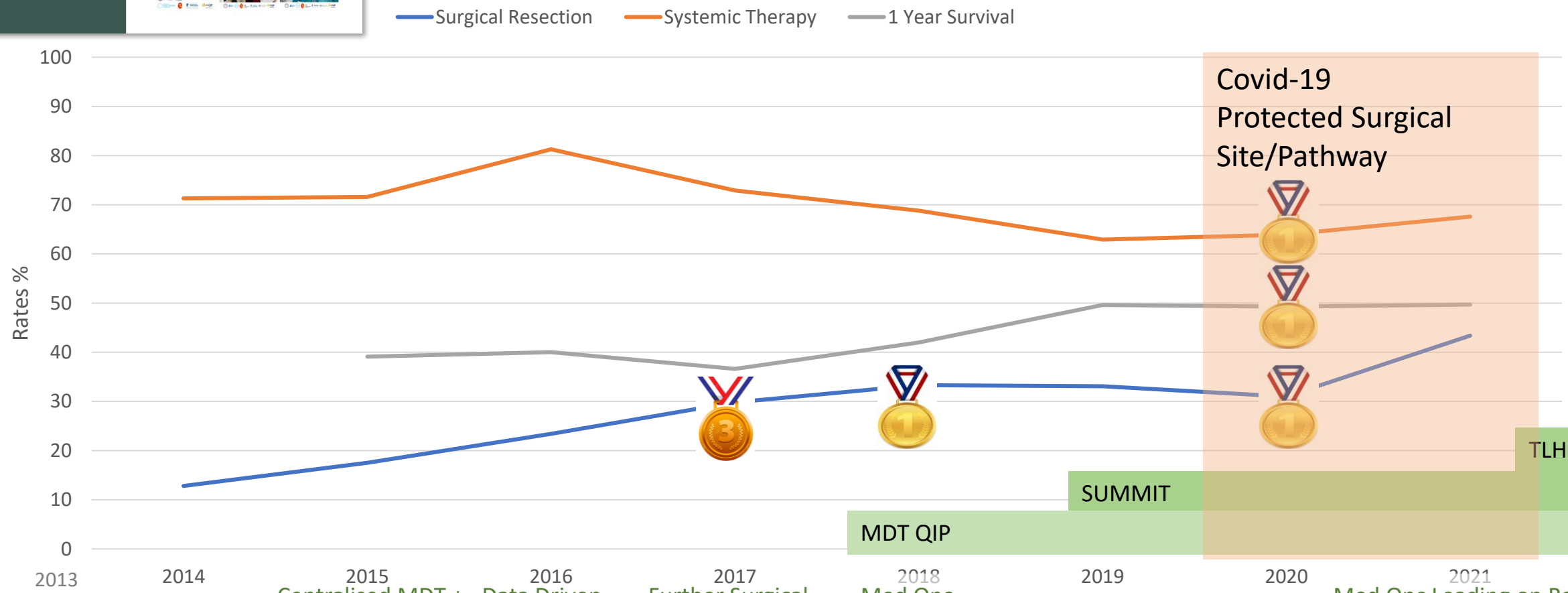
@TB_Doc

Barts Health National Lung Cancer Audit 2023

Our Improvement Journey

Barts Health NHS Trust



New Dedicated Surgeon + Clin Onc Appointed

Centralised MDT + Dedicated Chest Physician (me!)

Data Driven Improvement Pre-Hab/CPET Nav Bronch

Further Surgical Expansion RATS EBUS expansion

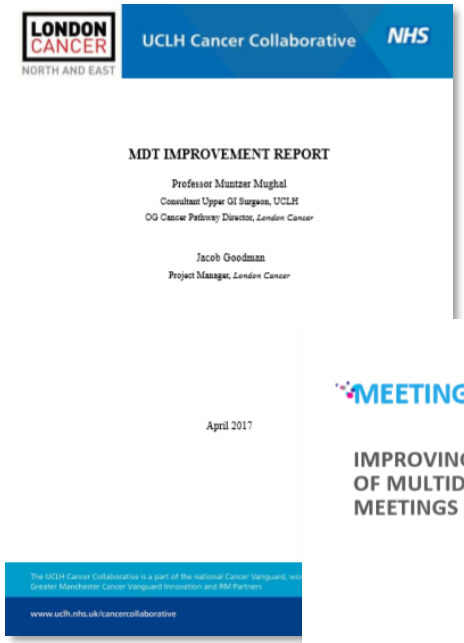
Med Onc Leading on Trials + IO

Med Onc Leading on Rapid Small Cell Pathway, Inequality and Peri-op Onc Dedicated Pre-Hab Team

Improving the MDT

Background

- Barts Heart Centre
  Respiratory Medicine
- Barts Cancer Centre
- London Cancer
- CRUK
- Learning from each other



Challenges

- Nationally:
  - Increasing patient numbers
  - NHS budget demands
  - Ensuring and *demonstrating*, safe and effective care
- Barts Health:
  - Outdated, unreliable video conferencing equipment
  - On-going review of resources (staff)
  - Large number of cancer MDTs (hub and spoke)
  - Uniquely large number of non-cancer (especially Cardiac) MDTs
  - Tertiary centre – Discuss patients never seen by BH clinician

Getting Started …

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Formation of small working group (Jan 2017)

Online questionnaire to establish current state of MDTs across BH (87 completed)

Quality Improvement Conversation (Sept 2017) (50+ attendees)

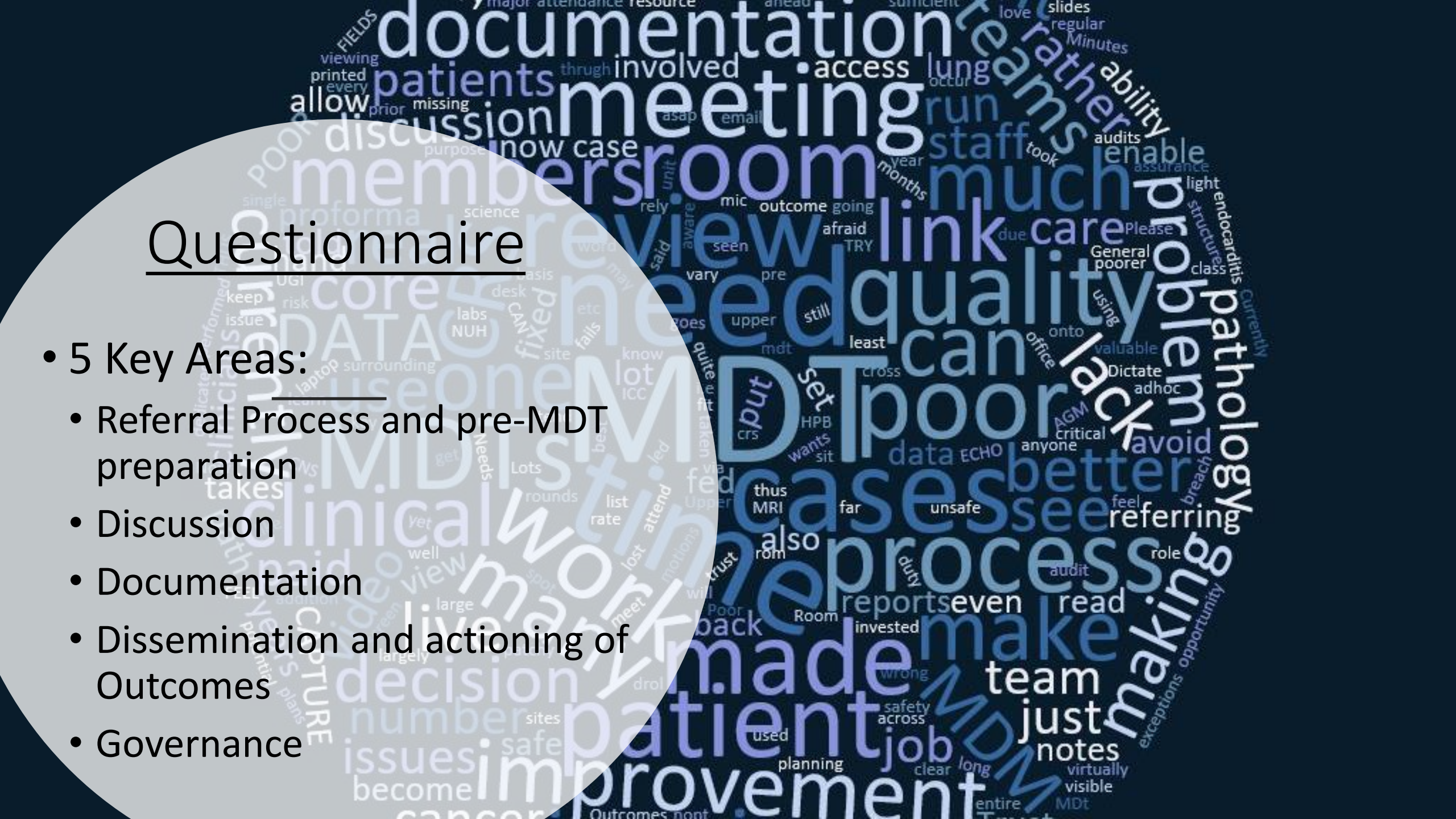
Project Summary & Recommendations document (including checklist) (Apr-May 2018)

All MDTs to read document and complete the checklist – 10 key principles/ guidelines

HMB Report June 2018

Questionnaire

- 5 Key Areas:
  - Referral Process and pre-MDT preparation
  - Discussion
  - Documentation
  - Dissemination and actioning of Outcomes
  - Governance



Quality Improvement Conversation

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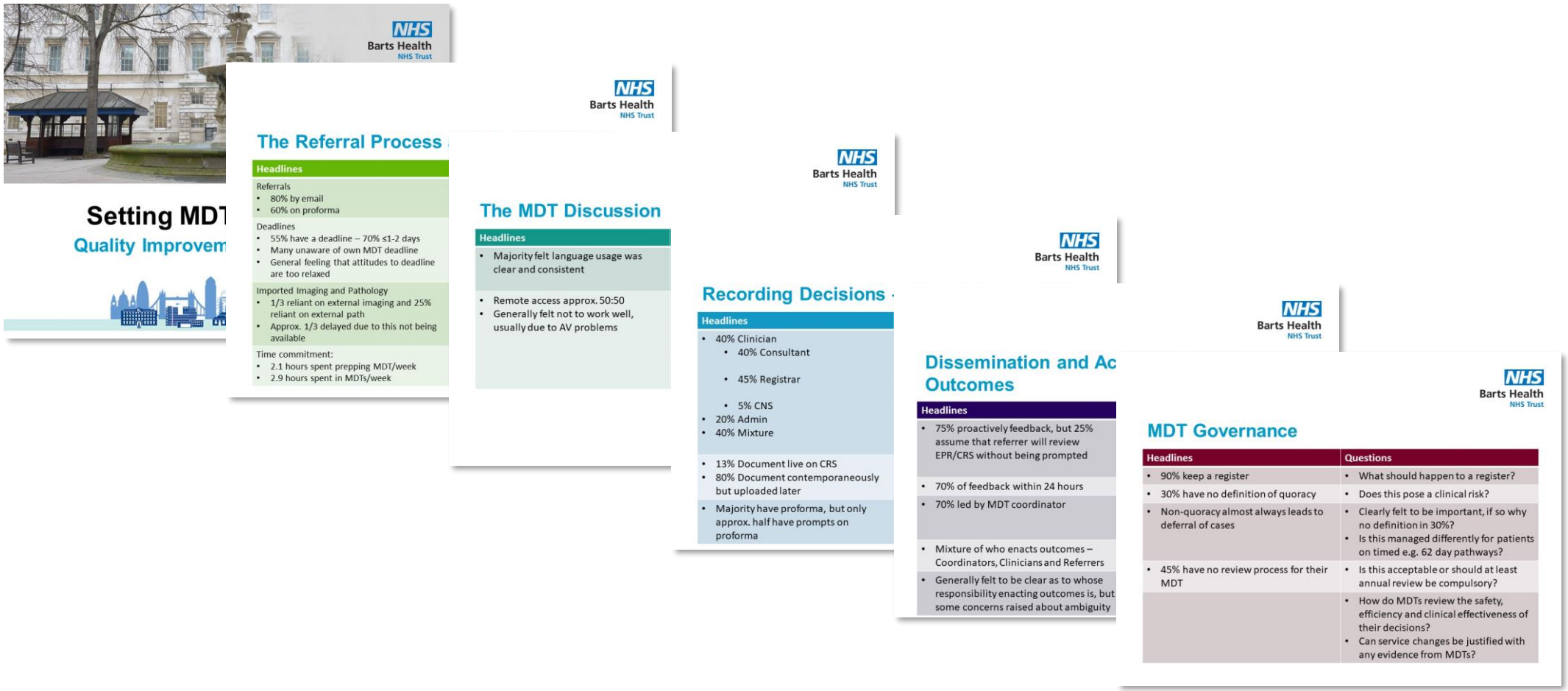

Issues Highlighted

Referral Process	• Lack of awareness of Deadlines • Time taken to prepare – Average 5 hours
MDT Discussion	• AV Equipment
Documentation	• No single system • Proforma use and design
Dissemination & Actioning Outcomes	• Potential for Ambiguity
Governance	• Definition of Quoracy • Review process

Development of 10 Key Principles

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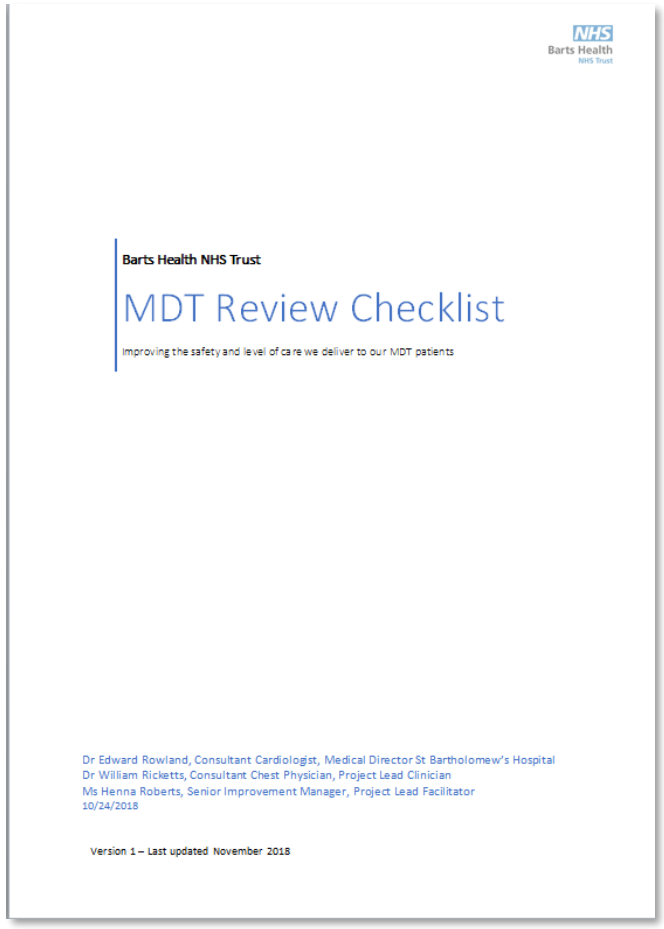
1. MDTs should have a designated Lead and Coordinator, both of whom should be job planned
2. A deadline for case submission should be set and actively enforced
3. External deadlines should be set to allow time for importing pathology and/or radiology
4. Cases should be submitted on a bespoke proforma, where discussion and outcomes should also be recorded
5. MDT agenda structured to maximise efficiency
6. MDTs should not run for longer than 2 hours, without a 15min+ break
7. Documentation should be on a proforma that encourages full discussion and data collection (audit & trials), plus patient preference
8. CRS should be used for real time documentation and have live MDT review
9. A member of the MDT must be responsible for disseminating MDT outcomes in a timely manner
10. MDTs must keep a register, have a definition of quoracy and know how to manage non-quoracy

Self Assessment



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MDT Review Checklist

Improving the safety and level of care we deliver to our MDT patients

Dr Edward Rowland, Consultant Cardiologist, Medical Director St Bartholomew's Hospital
Dr William Ricketts, Consultant Chest Physician, Project Lead Clinician
Ms Henna Roberts, Senior Improvement Manager, Project Lead Facilitator
10/24/2018

Version 1 – Last updated November 2018

MDT Review Checklist

This MDT Review Checklist is the result of a Trust improvement project to improve the safety and level of care we deliver to our MDT patients. It also aimed to share best practice across all MDT specialties (cancer and non-cancer). Out of this work came 10 MDT guidelines (see Appendix 1). This checklist will aid MDTs assess themselves against the 10 MDT guidelines. It is not intended to be [illegible]. MDTs should record any additional points they are assessing themselves ag additional sheets where needed. Where an MDT is not issue and resulting action or escalation they will be imp These actions must then be fed into the local safety an 2).

All MDTs must use the MDT Review Checklist and unde recommended) which must be minuted. The agenda fo 10 MDT guidelines as well as relevant local and nationa Completed checklists should be registered with the Tru details). Resulting actions and escalations should link t Appendix 2. Annual peer review is also recommended Surveillance process or more informally such as interna action.

Ideally this form should be completed with all MDT me guidelines and allow discussion. At a minimum it shoul Coordinator together.

Name of MDT

Clinical Lead(s)

MDT Coordinator(s)

Day and Timings of MDT

Frequency

Room/Venue

Average number of patients discussed during MDT

Is video or tele conferencing used? Yes ☐

This MDT is the Only meeting ☐ Hub ☐

If Hub, please state where the spokes are based

If Spoke, please state where the hub is based

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Date this MDT Review Checklist was completed

Date previous MDT Review Checklist was completed (if any)

Theme 1 - The referral process and pre-MDT preparation

(Please mark as appropriate)

Guideline 1	Yes	No
MDT Lead designated	☐	☐
MDT Coordinator designated	☐	☐
MDT Lead appropriately job planned	☐	☐
MDT Lead is appropriately trained	☐	☐
MDT Coordinator appropriately job planned	☐	☐
MDT Coordinator appropriately trained	☐	☐
Other MDT attendees appropriately job planned	☐	☐
Other MDT attendees appropriately and trained	☐	☐
_____	☐	☐
_____	☐	☐

Guideline 2	Yes	No
MDT case submission deadline agreed	☐	☐
MDT case submission deadline actively enforced	☐	☐
MDT deadline allows sufficient prep for relevant members (e.g. MDT Coordinator, Pathology, Imaging, etc.)	☐	☐
_____	☐	☐
_____	☐	☐

Guideline 3	Yes	No
Cases external to BH are discussed at this MDT	☐	☐
If yes, there is an earlier external case deadline	☐	☐
If yes, this actively enforced	☐	☐
_____	☐	☐
_____	☐	☐

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Guideline 4	Yes	No
Bespoke proforma created	☐	☐
Bespoke proforma always used	☐	☐
Discussion recorded on same bespoke proforma	☐	☐

_____	☐	☐

Guideline 8	Yes	No
All MDT documentation on Cerner Millennium	☐	☐
Real time documentation available to live review on large screen during MDT	☐	☐
Relevant patient information is available to live review on large screen by MDT (e.g. pathology, imaging etc.)	☐	☐
_____	☐	☐
_____	☐	☐

Theme 4 - Dissemination and actioning of MDT outcomes

(Please mark as appropriate)

Guideline 9	Yes	No
MDT member responsible for disseminating MDT outcome for patient is agreed and clear	☐	☐
MDT member responsible for disseminating MDT outcome for patient acts in a timely manner	☐	☐
Documentation is clear with what is expected of referring team	☐	☐
Responsibility for informing patient is agreed and clear	☐	☐
_____	☐	☐
_____	☐	☐

Theme 5 - MDT governance

(Please mark as appropriate)

Guideline 10	Yes	No
MDT keeps a register of attendance	☐	☐
Definition of quoracy is clear	☐	☐
Policy for non-quoracy is clear	☐	☐
Quoracy is checked each MDT	☐	☐
Non-quoracy policy is enacted when relevant	☐	☐
_____	☐	☐
_____	☐	☐

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Resulting Actions/Escalations

For responses where the MDT is not meeting some or all of a guideline, please record the issue behind this and the action or escalation the MDT will be progressing to change these to meet the guideline. See Appendix 1 for more details on the guidelines.

Issue	Action/Escalation	Owner	Review/ completion date	Monitoring Committee/ Board

Appendix 1

1. MDT Guidelines

When defining how an MDT should operate, there was an understanding during the project that, one size does not fit all. In this context the following 10 MDT guidelines have been devised which aim to be both prescriptive enough to ensure high quality governance and good patient care, but flexible enough to meet the needs of individual MDTs and their patients across Barts Health:

Theme 1 - The referral process and pre-MDT preparation

Guideline 1

All MDTs should have a designated MDT Lead/Chair[1] and Coordinator both of whom should be appropriately job planned and trained and undergo annual appraisal specific to this role. In some specialities the MDT Coordinator role will be a fulltime role and in others it may only be part time. The appointment of the MDT Lead should be via a formal process and for a fixed term. Other regular MDT attendees should be appropriately job planned.

Guideline 2

All MDTs should set a deadline for case submission which must be actively enforced with the MDT Coordinator empowered to do so with support from the MDT Lead, the only exceptions should be truly clinically urgent cases e.g. metastatic spinal cord compression or small cell lung cancer, not cases that have merely been forgotten to be added. The referral list should be real-time, and viewable by all the MDT, to allow early preparation.

Guideline 3

MDTs may choose to set an earlier deadline for external cases to ensure adequate time for imaging and/or pathology to be imported.

Guideline 4

Cases should be submitted on a bespoke proforma. Discussion and outcomes should be documented on the same proforma that the cases are submitted on. This should be on Cerner Millennium.

Theme 2 - The MDT discussion

Guideline 5

The MDT agenda should be structured in a manner to maximise efficiency e.g. by referring hospital, cancer/non-cancer, complex/simple.

Guideline 6

Two hours is the longest time possible for high quality discussion,[3] all MDTs must have a policy as to how to proceed after two hours (either taking a 15-20 minute break or deferring cases).

[1] The terms MDT Lead and MDT Chair are often used synonymously, in this document we have stuck to the word Lead as this implies the person with overall responsibility for the MDT not just chairing the meeting on the day, a role which in itself may rotate within a single meeting or even from case to case.

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Theme 3 - Documentation

Guideline 7

Documentation should be on a proforma with prompts to encourage full discussion, data collection for audit and trial recruitment. A prompt for patient preference is recommended. This should be recorded on Cerner Millennium.

Guideline 8

Cerner Millennium should be used for real time documentation and dissemination with all documentation available for live review by the MDT via a suitable screen.

Theme 4 - Dissemination and actioning of MDT outcomes

Guideline 9

A member of the MDT must be responsible for disseminating MDT outcomes in a timely manner and the documentation must make it clear as to what is expected of the referring team and what will be enacted by the MDT including responsibility for informing the patient.

Theme 5 - MDT governance

Guideline 10

All MDTs must keep a register, have a definition of quoracy and a policy for how to manage non-quoracy.

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Documentation

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Barts Thorax Centre Lung Cancer MDT Proforma

Name:		DOB:			Number:				
Consultant: CNS:		Added by:			Presenter:				
*Date for Discussion:		For Diagnostic MDT Only Cancer ☐ Non-Cancer ☐							
Breach date (to be completed by MDT Coordinator): Tuesdays = Decision to treat MDT – Cases must be submitted by 16:00 Friday Fridays = Diagnostic and General Respiratory MDT – Cases must be submitted by 13:00 Thursday It is expected that the plan will be enacted by the referring team unless specifically stated otherwise.									
***Case summary**									
****Smoking Status**		****WHO Performance Status**							
****FEV1**		****FEV1 % predicted**							
FVC		****TLCO % Predicted**							
****Relevant Social Hx Holistic Needs and Patient Preference**									
Next Follow Up		**Breach Date**							
***Question for MDT**									
* If these fields are not completed the case will not be discussed ** If these field are not completed for suspected cancer cases the case will not be discussed									
MDT Discussion:									
Staging:	**CT**	T	N	M	**Pathological**	~~pT~~	~~pN~~	Pl	R
	PET	T	N	M	**Combined**	T	N	M	
Pathology result:									
Advice/Plan:									
Plan B:									
Relevant Research Studies:									
Responsible Clinician:									

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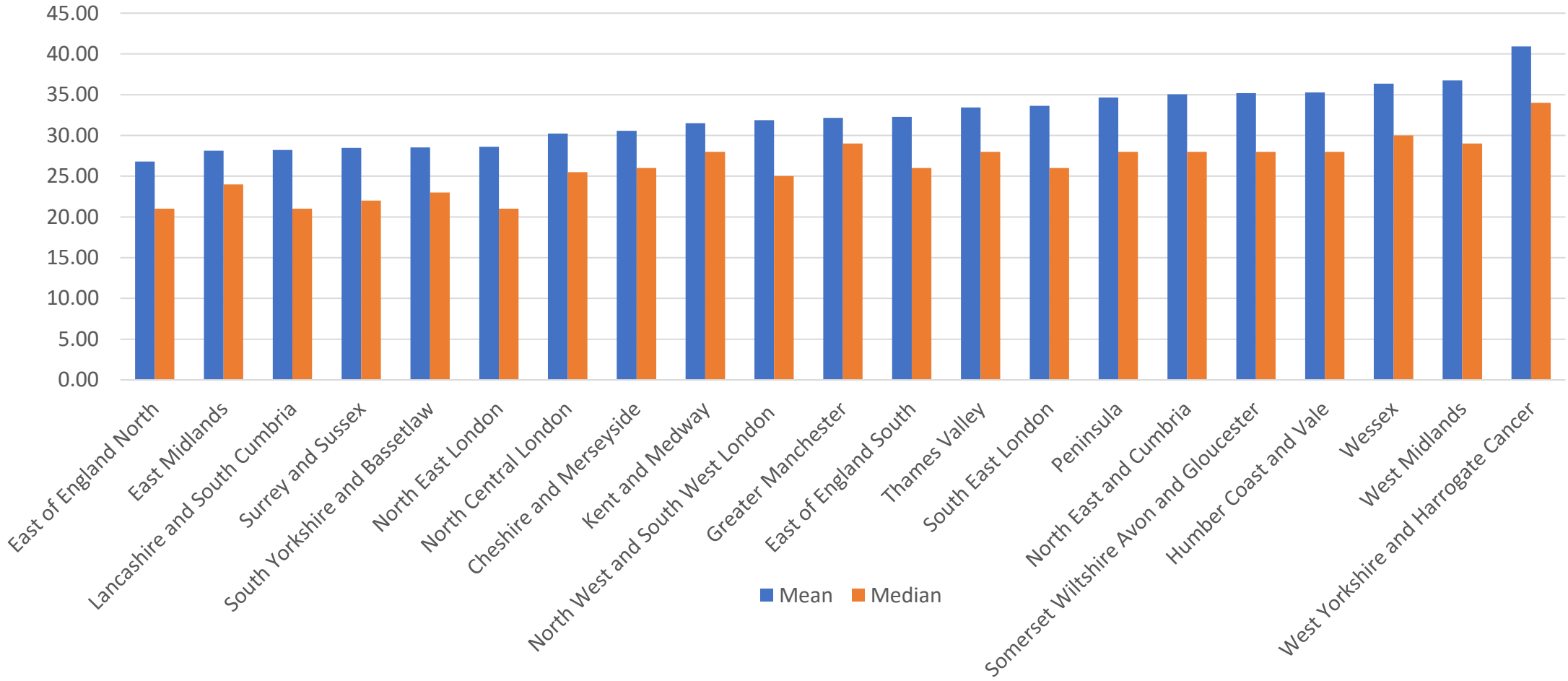
Form for repeat discussion:

Name:		Number:							
Consultant:		Added by:			Presenter:				
Date for Discussion: Date of previous discussion: Tuesdays = Decision to treat MDT – Cases must be submitted by 16:00 Friday Fridays = Diagnostic and General Respiratory MDT – Cases must be submitted by 13:00 Thursday It is expected that the plan will be enacted by the referring team unless specifically stated otherwise.									
Update since last discussion (include any incomplete mandatory fields) :									
Question for MDT (if this is not completed with a clear question the case will not be discussed):									
Next Follow Up		**Breach Date**							
MDT Discussion:									
Staging:	**CT**	T	N	M	**Pathological**	~~pT~~	~~pN~~	Pl	R
	PET	T	N	M	**Combined**	T	N	M	
Pathology result:									
Advice/Plan:									
Plan B:									
Relevant Research Studies:									
Responsible Clinician:									

Time to Treatment 2020

Mean 6th fastest, Median 3rd fastest



CWT Target			Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
BH Two Week Wait	93%	Seen	44	62	55	58	32	59	64	54	61
		Breach	4.0	4.0	4.0	17.0	5.0	15.0	13.0	9.0	7.0
		(%)	90.9%	93.5%	92.7%	70.7%	84.4%	74.6%	79.7%	83.3%	88.5%