Multidisciplinary team members views about MDT working:

Results from a survey commissioned by the National Cancer Action Team

Open question responses: Allied Health Professionals

November 2009

Report prepared by:
Cath Taylor, Research Manager
National Cancer Action Team MDT Development Programme

Kings College London
St Thomas' Hospital
London
SE1 7EH
020 7188 0907
cath.taylor@kcl.ac.uk

Introduction
This report provides the responses given by **allied health professionals** to the open questions within an on-line survey commissioned by the National Cancer Action Team and undertaken by Business Boffins Ltd. The survey aimed to assess multidisciplinary team (MDT) members' perceptions regarding: what parameters are essential for an effective MDT, how best to measure MDT effectiveness, and what support or tools MDTs may need to become or remain effective.

For full details regarding the methods and procedure of the survey, please see the final report issued in October 2009: http://www.ncin.org.uk/mdt

Open questions
In total, the survey contained 21 free-text (open) questions covering the following aspects of MDT working *(question shown in italics)*:

1. **Domains that are important for effective MDT working**
   What do you think constitutes an effective MDT?
   - The Team
     - o Leadership
       - *What qualities make a good MDT chair/leader?*
       - *What types of training do MDT leaders require?*
     - o Teamworking
       - *What makes an MDT work well together?*
   - Infrastructure for meetings
     - o Physical environment of the meeting venue
       - *What is the key physical barrier to an MDT working effectively?*
     - o Technology (availability and use)
       - *What impact (positive or negative) does teleconferencing/video-conferencing have on an MDT meeting?*
       - *What additional technology do you think could enhance MDT effectiveness?*
   - Meeting organisation and logistics
     - o Preparation for MDT meetings
       - *What preparation needs to take place in advance for the MDT meeting to run effectively?*
     - o Organisation/administration during MDT meetings
       - *What makes an MDT meeting run effectively?*
   - Clinical decision-making
     - o Case management and clinical decision-making process
       - *What model of decision-making could be used for patients with recurrence/advanced disease if these patients are not discussed at an MDT?*
       - *What are the main reasons for MDT treatment recommendations not being implemented?*
       - *How can we best ensure that all new cancer cases are referred to an MDT?*
       - *How should disagreements/split-decisions over treatment recommendations be recorded?*
     - o Patient-centred care/coordination of service
       - *Who is the best person to represent the patient's view at an MDT meeting?*

- *Who should be responsible for communicating the treatment recommendations to the patient?*

2. Measuring MDT effectiveness/performance
- *What other measures could be used to evaluate MDT performance?*

3. Supporting MDTs to work effectively
- *What one thing would you change to make your MDT more effective?*
- *What would help you to improve your personal contribution to the MDT?*
- *What other types of training or tools would you find useful as an individual or team to support effective MDT working?*
- *Please provide details of training courses or tools you are aware of that support MDT development.*

4. Final comments
- *Please insert any final comments or observations on the characteristics or indicators of high-performing MDTs and appropriate measures of performance.*

The responses to each question have been compiled into reports according to each discipline, as follows:

Professional Group	Discipline	Total number of respondents to survey
Doctors	Surgeons	325
	Radiologists	127
	Histo/cytopathologists	126
	Oncologists (clinical and medical)	164
	Haematologists	98
	Palliative care specialists	65
	Other doctors (e.g. physicians, GP)	188
Nurses	Clinical nurse specialists and other nurses (e.g. nurse consultants, matrons, ward nurses etc)	532
Allied Health Professionals	**Allied Health Professionals**	**85**
MDT coordinators	MDT coordinators	302
Other (admin/clerical and managerial)	Other (admin/clerical and managerial)	42
Total number of MDT members who responded to the survey		**2054**

Method

- The total number of respondents from each discipline is shown in the table above.
- The number of respondents who responded to each question is provided at the start of each question.
- All written responses are presented in an unedited form, exactly as given by respondents (including any typographic errors, spelling mistakes, use of capitalisation etc). Exceptions to this are:

a. Where respondents did not provide an answer to a question but instead used a symbol (e.g. /) to indicate that they wanted to miss out the question. Such responses have not been included.

b. Where respondents used free-text questions to simply refer to the previous (multiple choice) question (e.g. 'see above' or 'as above'). Such responses are removed due to the lack of context provided by including these in this report but a total count of such responses is provided in the summary at the start of each question.

c. Where respondents have named an organisation or Trust or potentially identified themselves. Their responses have been anonymised.

d. Where respondents used potentially offensive language. Any such words have been replaced with xxxx.

e. If respondents have given comments that are not relevant to the question. Such comments have been removed from the response.

Responses to 3 of the open questions have been fully analysed to-date and results are provided in the final report issued in October 2009. These are:

- *What do you think constitutes an effective MDT?*
- *What qualities make a good MDT chair/leader?*
- *What one thing would you change to make your MDT more effective?*

Contents

Domains that are important for effective MDT functioning

What do you think constitutes an effective MDT?
72 AHPs responded to this question.

1. willingness to listen to other MDT members, valuing their contribution,
2. view are not always taken into account and not all detail of patient available marrow trephine are but not renal or LFT that might influence dosing decisions
3. Timely, effective and concise collaberation, where input is welcomed from all members
4. The team should involve appropriate specialists e.g. Radiologists, Pathologists, Specialist Nurses and Pharmacists to allow the best diagnostic, treatment and monitoring plans to be discussed. It is important that other consultants and allied health professionals attend so differing views can be discussed.
5. The team meet weekly and as many members attend as able. Everyone's view (if put forward) is listened to and not ignored i.e. AHP views are as important to patient well-being as surgical. We also all get on well and everyone knows each others job roles.
6. the right people round a table
7. That all disciplines involved in the MDT have a voice and that the decisions are made jointly and not by a few select individuals.
8. Team working and communication
9. Strong chairman to keep agenda moving and on track. Opportunity for debate and discussion Multi-professional opinon and working to acheive holistic patient benefit
10. start and finish times adhered to nominated leader facilities to adequately display patient medical details and radiologiacal imaging
11. Shared aims and objectives Respect for the opinions of all attendees Respect for all professional groups Efficient and effective administration Clearly demonstrated patient outcomes
12. Robust communication pathways
13. Respect between members, good communication, clear pathways and working together with patients, honesty and holistic approach
14. respect and understanding of each other's roles. good communication, clear understanding of common purpose of MDT, ability to discuss differences of opinion
15. Regular meetings, respect for all members' opinions, meetings taking place on time, a dedicated co-ordinator, a chairperson
16. regular meetings, open discussion initiated by each member
17. Regular meetings woth core members.
18. Organisation Allowing all team members to voice concerns / opinions Time keeping Including all AHP / medics / nursing staff
19. Opportunity for open discussion involving all members of the MDT, good direction to ensure effective time management, good documentation to prevent misinterpretation of discussion or repeated discussions
20. One without barriers - where every member respects and values the opinions of others, and where communication is open - and not with hidden agenda. One with a common purpose and shared goals. One without 'traditional' hierarchy.
21. one that works to a shared vision
22. not just consultant led. the direct surgical choices/radiological vital, however I feel the 'person ' should be discussed, their supprt network, ability to feed, speak, other co morbidities etc
23. NON HIERARCHICAL, GOOD COMMUNINICATION, REGULAR MEETINGS, ABILITY TO CARRY OUT AGREED PLANS, GOAL SETTING
24. Needs to be well organised and well supported by all disciplines with good facilities and enough cover and protected time designated for staff to attend and participate fully in the discussion.
25. Multidisciplinary working

26. Memebers of the different diciplines being able to attend the meeting. Communication between the team members is important
27. Meeting regularly (& frequently enough) for a mixture of learning & patient discussion. Good understanding & respect for each others roles/ contributions within the team. Good leadership & time management at meetings.
28. Lines of communication; designated lead (chairperson); open discussion; minimum required attendance; environment.
29. Knowledge and understanding of each other roles; the ability to respect each other roles and any differences; the ability to listen to team members
30. Group discussion and agreement on management of the patient. Clarity on who is responsible for taking decisions forward.
31. Good representation from all core and extended members. Well resourced. Good MDT co-ordinator with knowledge of tumour site. Support from Cancer Services. Good I.T / technical support
32. Good range of relevent health professionals. Adequate leadership/chairman
33. Good communication, an understanding of everyone's roles (and their limits) and effective meetings
34. good communication on a regular basis
35. Good communication and links with the surgeon/oncologist
36. good communication
37. Good Chairperson
38. Good attendance by all members
39. Good and timely communication. Respect for each members areas of expertise
40. getting the beast treatment plans for individual patients folowing concentrated discussion and recording the agreed outcomes.
41. Everyone taking to turns to speek and listen to each other, having all the relevant professionals present.
42. Equality and respect amoung all professions, good communication, adequate time for professionals and patients
43. Ensuring representation by all therapies / professionals and regular contact
44. efficient time management & all results available
45. Effective team working - all members communicating equally. Having trust in your collegues
46. Effective discussion regarding the correct management of patient and appropriate treatment plan
47. effective comunication
48. Effective communication, clear goal setting, equal team involvement
49. Effective communication and involvment of all members of the team and appropriate recognition of input from all team members, irrelevant of their status or modality
50. Easy access, open communication, peer learning, joint working, information access
51. Core group of essential professions and quick access to others, working together effectively and timely for the patient.
52. Communication. Clear reports. Good time keeping. Listening skills.
53. COMMUNICATION, LISTENING TO EACH OTHER, JOINT DECISION MAKING.
54. Communication and preparedness
55. Communication and collaboration with each member of the team with paricular attention being paid to holistic management and quality of life issues as appropriate
56. Communication   representation and meetings Being invited and included in MDT meetings i was asked not to attend as our comments might interupt smooth running of meeting
57. Commitment by all team members. Efficient, Experts, Communication, Information, Time to commit.
58. Clearly defined roles within the MDT and effectively co-ordinated.
59. Clear Leadership, defined patient pathways, Communication
60. Clear aim objectives and outcomes

61. All relevant members involved, for instance Clinic coordinator, Consultants, Special registrars, Histology team, Nursing staff, Speech Therapist, Dietitian, Oncology radiotherapy profs, psycho-oncologists,Macmillan prof, palliative care prof. Effective communication between all members. Guidelines.

62. All memebers respecting others with good communication between themselves to ensure seamless service for patients

63. All members of team need to be valued. All members should feel able and welcomed to contribute. A team that can communicate well/easily together.Adequate time given for full discussion of cases.

64. all disciplines relevant to attend. Notes taken and actions noted, so they actually get done.

65. All core members present and qualified in the area under discussion, enough time to talk about present results for each person discussed recording o f the decisions made good referral system to other professions

66. Adequate rooms and facilities Adequate nursing cover Clear policy on which patients included MDT co-ordinator advised with sufficient time to include patient on list Opinion of all members considered and all patient needs discussed

67. Actively sharing information, respecting another professionals experience and expertise, talking to each other when problems

68. Accurate and informed presentation of cases, good decision making by the team and confidence that the decision will not be changed without further discussion at future MDT meetings.Putting personal ego to one side for the good of the patient.

69. A team where members are commited to delivering the best quality of care (based on evidence-based practice) in as co-ordinated and timely fashion as possible. An effective MDT's core members attend meetings regularly and participate fully, feeling open to share concerns, ask for clarification and offer appropriate competency-based opinions. Minutes are promptly shared amongst members to action. Good verbal and written communication is essential.

70. a meeting that: #takes place at a set time and place # one that is attended by its members #patients are appropriately discussed #actions are set in place

71. A group of professionals who work together to provide the best outcome for patients, rather than a group of individual practitioners simply presenting their own practice.

72. A comprehensive range of disciplines who are dedicated and experienced to be involved with a patient to make sure the best outcome via discussion within the MDT is obtained for the patient/family/carers etc

The team

What qualities make a good MDT chair/leader?
34 AHPs responded to this question.

1. Time-keeping, diplomacy, good communication skills
2. SOMEONE WHO VALUES ALL MEMBERS OF THE TEAM AND WHO CAN CHALLENGE AND ENSURE NO 'RAILROADING' BY CERTAIN INDIVIDUALS
3. Respected, good communicator, organised.
4. Punctuality, fair open communication, ability to refocus team, open-mindedness to new ways of working, motivated to involving all members of the MDT, ability to convey respect to all people and to be awarded respect.
5. Promote good communication, direct discussion and ensure good use of time
6. organised good communicator able to command authority gets through the agenda facilitates appropriate discussion, stops divergence from this
7. nominated so has authority at meeting impartiallity good communicator
8. listener.time management
9. knowledgeable authrisation to make decisions listens and includes
10. Knowledageble about all aspects of care
11. Invovle al team members
12. good time keeping, respect for other team roles
13. good leadership skills and experience of MDT working and acknowldedging core members roles.
14. Good facilitator who can summarise a clear plan
15. Good communicator. Easy to approach
16. good communication/ listening skills good time management skills assertiveness
17. Good communication skills. Good facilitator. Assertive
18. Good communication skills. Diplomacy. Good leadership skills.
19. Good communication skills
20. Good communication and assertiveness
21. Good active listener/ communicator (includes being able to accurately precis), good time manager, good, knowledgable team-player
22. Fairness in listening to all MDT members Good leadership skills - moves discussions along appropriately
23. Experience, clear consise delivery,control and guidence.
24. Collaborative working with clear peramiters set for inclusive working
25. clear communicator, respect and patience
26. calm efficient manner
27. Being able to control the participants and steer the discussion to a conclusion.
28. abilty to listen to discussion and have a good working knowledge of the nhs/private processes and protocols in order to prompt if required but overall to keep everyone focused on the cases.
29. ability to manage group dynamics to ensure all contribute. Keep to time, move meeting on if gets stuck on long discussion
30. Ability to involve and listen to all team members and ensure final decision is representative of the whole MDT
31. Ability to ensure effective MDT, therefore relevant details discussed by whole team not just the loudest
32. Ability to direct and summarise the decision of the meeting, preventing long and unfocussed discourse, without making their own opinion of higher relative importance
33. A person who values all of the MDT members opinions, someone who can manage and organise time.
34. A good leader Knowing what's going on and needs to be done Acknowledging the team Good time management

What types of training do MDT leaders require?

19 AHPs responded to this question.

1. Training on providing effective accurate summaries
2. observation of other meetings
3. not sure
4. not sure
5. MDT experience
6. Managing people effectivley.
7. leadership, facilitation skills
8. Leadership and communication
9. knowledge of all processes and procedures relating to the mdt. able to keep order ?assertive training
10. Information on the MDT process behind the scenes. What needs to happen before and after. role awareness of mdt coordinator etc
11. I think that much of the skill of leading a team is personality-based, but a course on strategies to keep people to task, how to facilitate involvement by all members, motivate people to attend and stay client-focused, would be helpful for those who are not sure whether to put themselves forward for the position, particularly non-medics like myself.
12. how to manage conflict/ disagreement
13. How to be a facilitator and to chair and effective meeting
14. group dynamics, effective communication,
15. Chairing of meetings, Advanced Comms, touch-typing if this method is used for recording
16. Assertiveness training!
17. Assertiveness Communication skills Facilitator skills Team building
18. advanced communication skills understanding the role of MDT co-ordinator
19. Advanced communication and team leader management

What makes an MDT work well together?

40 AHPs responded to this question.

1. understanding and organisation
2. trust in knowledge and judgment
3. time awareness; knowledge of cases; good IT
4. The people
5. team
6. shared purpose and vision good leadership good back up and organisation
7. respect the various views when different from one another
8. Respect for each others' expertise and willingness to learn and listen to each other
9. Respect
10. pt focussed and not competing for glory
11. People
12. mutual understanding of difficult diagnostic areas
13. mutual respect. professionalism, desire to do the best for the patient.
14. Mutual respect, and a shared view that the patient is more important than any member of the team.
15. mutual respect and ownership of network guidelines
16. Mutual respect and mutual objectives in the patients' best interests.
17. Mutual respect An ability to listen to each other Regualr contact outside meetings
18. mutual respect
19. mutual respect

20. MDT members getting to know each other at the meetings certainly helps
21. Like-minded groups of clinicians of all disciplines.
22. Leadership. Sense of humour.
23. Individual commitment to it, and good leadership
24. Good working relationships
25. Good team working, respect for others opinions. Shared outcome objectives
26. good relationships and respect amongst key mdt members
27. Good leadership; appropriate attendance; availability of core information and IT
28. Good leadership and shared vision.
29. good communication efficient discussion
30. good communication
31. Folk not hogging the limelight
32. Effective leader, coordination, attendence, evidence based discussions, feedback and suggestions to improve the team work
33. effective communication between members, clear lines of communication, good organisational support
34. Collaberation between colleagues
35. clinical dedication. Good IT for displaying imaging and pathology with immediate technical support and trouble shooting
36. Attentive listening Staying focussed
37. An individual's knowledge of other members' resources (personal and professional). A sense that one's opinion is valid and valued. A sense of control over one's input. Humility: to admit when other, possibilites have value. Objective if sympathetic handling of each individual case.
38. a range of personalities involved knowledge   communication
39. A mutual respect and trust for each member of the team
40. a mixture of good organisation and personalities

Infrastructure for meetings

What is the key physical barrier to an MDT working effectively?

46 AHPs responded to this question.

1. When meeting is dominated by one profession and not supported by other members of team that makes it "multi" professional meeting
2. unsuitable environment, crowded
3. unable to view radiological imaging properly room layout not able to hear what is being said
4. Unable to view diagnostics or noise.
5. too hot/too cold
6. Timing
7. theatre style seating. Consultants at front AHPs behind.
8. Temperature. Poor video conferencing facilities
9. Technology not working, concentration if meeting is too long!
10. Seating
11. Room temperature!
12. Room layout to see results and other team members on video conferencing whilst allowing good discussion within the room
13. ROOM LAYOUT
14. room layout
15. room availability, room comfort!
16. poor communication or absence
17. Poor attendance from core members
18. Poor accoustics so you are unable to clearly hear other memebrs

19. Personally parking at trust very difficult for me as coming from outside hospital.
20. Personality!
21. Not meeting regularly, distracting surroundings
22. Not having table(s) to lean on
23. not being close to a MDT site
24. Not being able to see imaging or hear presentation. Lack of communication between all disiplines.
25. Not being able to make eye contact with the chair or other members of the mdt whom you wish to address during the meeting
26. not being able to here everyone, and also several conversations going on at a time
27. Not being able to hear members when they are talking
28. noisy room, too cold or hot, not big enough
29. Meeting room is too cramped/not large enough
30. MDT chair not ensuring that the correct people are present and not always listening to oncology colleagues. Too much emphasis on diagnosis and assessment not enough on histo results, treatment, follow up.
31. Lack of space, room layout
32. lack of meeting rooms
33. KEY MATERIAL NOT AVAILABLE
34. It being an intimidating environment with all the consultants only siting round the table
35. Insufficient room,   Positioning of chairs hehind others
36. Insufficienct rooms / clinical areas
37. Inability to hear or be heard or see diagnostics clearly
38. having too little space to fit the team and necessary equipment in.
39. Having an inner and outer circle of staff with the inner circle leading and controlling the conversation,
40. equipment not working
41. Distance between attendees
42. Communication barriers e.g. members not taking on board other peoples view points Poor planning
43. Being unable to see the imaging and unable to hear the discussion
44. being on the back row where you cant be heard
45. Background noise making it difficult to hear
46. air con noise

What impact (positive or negative) does teleconferencing/video-conferencing have on an MDT meeting?

39 AHPs responded to this question.

1. You still need people to engage in meeting. teleconferencing doesn't ensure this. Clear and well projected voice so everyone can hear Clear plans Be open to questions / suggestions from people via teleconferencing
2. We have the technology but this service is yet to commence at this moment in time.
3. We have not yet begun video-conferencing (due in approx 2 to 3 months) so cannot comment on this yet.
4. We have as yet not had to use it, but trials seemed to be promising. I think that team rapport will be a little disturbed because of communication constraints when using the facility, but this may be helpful too as it will reinforce the importance of only one speaker at a time.
5. Video conferencing allows for more discussion on complex cases.
6. VERY HELPFUL WHEN MORE THAN ONE HOSPITAL/TEAM INVOLVED. cANT ALWAYS SEE ALL THE PEOPLE AT OTHER END SO DISEMBODIED VOICES.HOWEVER DOES ALLOW SOME CONSULTANTS TO WALK OUT EARLY WHEN THEIR CASES DISCUSSED AND OFF TO THEIR CLINIC!!!!
7. takes longer but worthwhile improves decisions and networking
8. Stops effective meaningful interaction of all members of MDT. Meeting has now become a surgical/oncological presentation rather than a discussion... no time now due to numbers.
9. Positive: All members can be present despite geography therefore reduceing travel to and from meeting. Disadvantage is sound quality and difficulty in having complex multi person discussions.
10. Positive
11. positive
12. Positive - save valuable time having to travel long distances Negative - not as effective communication regarding cases
13. People cannot always hear properly due to microphone positioning and person talking cannot always be seen. More difficult to control the meeting than when all members are in the same room as people have a tendency to talko ver each other
14. Our MDT format will soon change. Two MDTs will merge from across sites. This happens next month and we have been informed that the aim will be to have video conferencing, projection of radiology etc and real time access to infoflex - all essential if the MDT is to run effectively
15. not used in hospice MDT, but is available to use to link with other MDT (in small room)
16. no opinion
17. No experience
18. no experience
19. NA
20. n/a
21. It is not used in the current MDT that I am part of but has been used in the past. It helps to improve communication across site and with time management as questions can be asked directly to team members rather than having to chase them on the telephone etc.
22. It improves attendance but reduces the clarity of the decsion-making process, even leading to lasting confusion as to which patient is being discussed
23. It can be more time consuming - participants need to be skilled users for it to be really effective Can be useful for people trying to be in more than one place at the same time
24. i have no experience of this
25. I feel awkward using teleconferencing. I would rather make time to attend a

meeting.

26. Have no experience of these modalities, but would expect enhanced input for decsion-making.
27. Have no experience of it.
28. frustrating when equipment fails.
29. Essential for effective decision making
30. Ensure optimum attendance.
31. Effective communication between all members of the MDT, enables continuity of decisions made for pateints ie treatment, medications
32. difficult for joining in the conversation from the video
33. can make the meeting dis-jointed
34. Can be done to time when it may be impossible for a core member to get there due to travelling restrictions or clinical requirements.
35. always takes time to connect up
36. Allows more members to be involved without travel between centres, however, the technology is still a little slow and images don't project well, also prevents direct interaction between teams
37. Allows larger group of people to attend and contribute without travelling. More opinions can be sought. If it doesn't work it will delay meeting or stop others participating.
38. Allows for a wider discussion and decision making process. Alternative thoughts and suggestions instantly given. Prevents delays in treatment
39. Ability to speak to consultants at other hospitals in the network and discuss the best treatment plans for their patients / get MDT decision

What additional technology do you think could enhance MDT effectiveness?

23 AHPs responded to this question.

1. When possible televisions/video for educational purposes when related to the cases and discussions at the MDT
2. Voice recognition computer programs for data collection/recording of decisions?
3. Real-time recording of treatment proposals to database
4. proper radiological imaging projection
5. Not sure
6. not sure
7. not sure
8. none I can think of at the moment.
9. none
10. NA
11. more facilities in remote workplaces -e.g. XX [Hospital]
12. Joint database for note keeping A computer in the room of the MDT
13. Improved quality teleconferencing and projection of images
14. I don't know
15. having the data base present and being completed during the meeting
16. Have no knowledge of what is available.
17. Fulluy computerised patient records
18. Better imaging / easy access to PACS systems in other hospitals in the network
19. As previously mentioned we often have problems accessing our PET images - depending on the centre that has processed them
20. An extra computer to view blood results so doses of treatment can be discussed.
21. Adjuvant on-line available
22. Acess to all of the above
23. Ability to view radiology, pathology locally without transmission over video-link

Meeting organisation and logistics

What preparation needs to take place in advance for the MDT meeting to run effectively?

55 AHPs responded to this question.

1. you need to know the patient, current condition, medical plans, treatment & d/c date, home/social situation
2. Ward round Case history/summary Note reading
3. View agenda look at case histories gather relevant information as nec/relevant
4. Trial info and patient info
5. Transfer of relevant test results to main location,agenda circulated to all members of MDT, presenting surgeons/physicians should assemble all documents and be well cognisant of their patient
6. Those who need to contibute to the discussions need to be aware of who is being discussed as early as is practical.
7. The most important preparation is done by clerical and administrative staff, making sure that people are listed enabling pertinent professionals time to prepare. These staff need to ensure that all the records are available, that any discs from external trusts have been received and delivered to the pertinent member of teh MDT for discussion. I feel that they should also be responsible for inputting the data as we do not have our own dedicated inputting clerk but share with other teams in the trust and the burden of inputting has recently been with the chair of our MDT, who is an oncologist and whose skills may not be suited to the task. The key professional identified in the list then also needs to ensure that reports are up-to-date and available and spend time preparing the case for discussion. As a speech and language therapist I will only occasionally request an addition and when I do I definitely spend about an hour preparing the materials - video-footage, reports - prior to the meeting.
8. Review relevant cases and identify discussion points
9. Relevant files pulled. Agenda plus summary sheets printed out. At present I am the MDT Chair therefore management issues / email responses, occasional letters to cancer managers may be needed etc
10. Reading of cases
11. reading case if already know patient
12. read case summaries
13. RADIOLOGY REVIEW OF CASES TO BE DISCUSSED, REVIEW OF CLINIC NOTES AND TREATMETN TO DATE
14. pulling of patient records
15. pull together the right information needed on the day
16. Prior identification of information needs.
17. Prepare patient list Summarise patient information for discussion
18. Pre-warning of patients to be discussed with full notes access Full agenda and background reading where other items are timetabled for discussion
19. Personally I collect notes from private sector and take t0 trust for relevant meeting
20. Personally - need to review known patients, be aware of current progress and issues to inform the MDT discussion. Wider MDT - notes available, clinical reports ready, images accessible, appropriate (and consistent) clinical summary.
21. Patient information, notes, imaging, reports and pathology/histology should be collated and summarised by the appropriate person for clearer more concise presentation.
22. ours now moved to a centralised site and takes forever and is less efficent and less MDT like than when it was just our 2 local hospitals - paperwork is lost, it is now very consulatnt biased and there is never any feedback in written form

afterwards - all of these lements are essential to help core and non-core members get accurate information around the patient, diagnosis and prognosis and pt pathway

23. Notes pulled and read. Discussions with other mdt members. Awareness of new patients and diagnosis
24. Knowing which patients are on.
25. I am not given any notice of which patients are to be in the mdt therefore no pharmacy work can be done and our view and assistance is not available
26. Good understanding of the patients
27. Godd knowledge of the patients you are presenting Identificationof key issues/problems Formulation of draft action plans for ratification at the MDT
28. Go through notes and any concerns that need to be brought up that may effect survival/treatment tolerance
29. General - preparation of cases for presentation and accummulation of all staging results. Personally - Familiarising with cases to be discussed and identifiying an issues to be raised as part of the discussion
30. from a personal view only to check that the patients to be discussed are known to Radiotherapy
31. From a dietitians point of view knowing who is going to be discussed would be advantageous.
32. for me....pulling casenotes. Quite often I am unaware of the patient until the MDT
33. For me it is checking which patients are to be discussed and ensuring I have relevant information of my involvement/assessments with those patients
34. Familiarisation of cases seen, relevant patient history ie other medical conditions influencing the outcome, knowledge of tests peformed on the patient ie bone scan, chest x-rays prior to theatre etc. Patients comments/ wishes during consultation.
35. Every case should be adequately prepared by each department so that all paperwork etc is present at meeting. A brief summary beforehand will expedite the meeting and ensure time is spent apropriately during the meeting.
36. Ensuring you have up to date information to hand for patients being discussed
37. ensuring all tests and results are available before the mdt results in less time wasted in the meeting itself
38. Ensure upto date relevant information is obtained to share with MDT
39. Ensure full preparation by all MDT members of the patients to be discussed- including all reports and imaging.
40. Ensure all info available at meeting
41. each member to ensure they have fulfilled their input as agreed at the last MDT.
42. Distribution of MDM list and case notes
43. current caseload revue to decide if needs to discuss at MDT. if to be discussed have notes available
44. Clearly discuss SLT assessment findings
45. Case summary/list; Collection of case information
46. case notes & imaging must be available. I check ct & mr scan reports are available, and record dates of any future imaging appts.
47. case list, case summaries, treatment plans
48. Care summary and future plan to discuss with team for each new or complex patient
49. brief and relevant pt history, current results, good timekeeping by chair, focus on the most important aspects of pts case
50. As a therapist it makes sense prior to the MDT to discuss any complex cases with joint working physiotherapist. As an individual therapist to is good practice to have a summary of your intervention with each of the patients to be discussed at MDT summarised on paper or in your head to be able give a overview of my involvement with a particular patient as they are discussed within the MDT
51. All the relevant results of investigations must be available when a patient is discussed at a MDT. PACs systems allow the retrieval of a range of imaging modalities, but in breast alot of units are still on analogue systems. This requires a tremendous amount of time in chasing patients film packets
52. all results available

53. All relevant info about each individual collated and individual members to be aware of them so that they can review their notes etc.if they need to add anything at time of discussion.
54. All patient results and case notes need to be available at the meeting. Patient lists should be circulated
55. All investigation results need to be present and the relevant professional present at the meeting

What makes an MDT meeting run effectively?

49 AHPs responded to this question.

1. timely start, attendance, assertive chair position
2. Time keeping, not overbooking the list, effective summary of case and clear feedback from those involved
3. Strong leadership
4. Strong chair Discussions to be succinct and relevant - not going off at tangents Keeping to the agenda - not diverting into teaching interesting though this might be
5. stick to the subject, no rambling gossip!
6. Presenters being prepared. Working video links. Set order to meeting.
7. PRESENTATION SKILLS HELPFUL
8. Presence of core members from each location, competent pathologist and radiologist, effective chairmanship ability to hear what is said
9. preparation succint to the point meetings (sticking to agenda) clear action plans which are followed up next meeting respect
10. Participation by all members consistently.
11. Organised patient list with relevant information available
12. organisation, preparedness, people arriving on time. Video-link to other centre working. All technical equipment working well.
13. ORGANISATION!!!!!
14. Organisation!
15. Organisation and a good chair of the meeting to move the meeting on as needed.
16. Opportunity for discussion and information exchange. Clear outcome summary Timekeeping by members
17. no waffle
18. members turning up on time members using effective communication skills (including listening) Having all information available for the meeting members focussing on primary reason for MDT
19. Members respecting each other's time; keeping to the agenda, keeping comments succinct and to the point - staying focussed
20. Members arriving on time. Good pre meeeting organisation. Focus on cases being discussed.
21. leadership, organized notes, patient list
22. Keeping to time, clear summary at end of each case
23. Keeping to the agenda, addressing questions and opinions through the chair and not allowing general conversation/discussion while cases are being presented. Attention to detail.
24. Having a co-ordinator
25. Groundwork by administrative staff, commitment from team members to deliver the best quality of care, good chairing so that time is used to best effect.
26. Good time-keeping, Clear decision making, keeping people on track (not going off at a tangent). Not bringing other agenda to the meeting - leaving more political issues to outside of the meeting time. Having all information available - and fast access to imaging (and having PET scans that actually load on to our systems!)
27. Good preparation; minimum required attendance; protocols.

28. Good preparation and attendance.
29. Good preparation
30. Good organisation. Good time keeping, not presenting cases without diagnostic imaging or biopsy results. Keeping to the point of the meeting and not wasting time.
31. Good leadership at the meeting Ensuring all patient details and scans etc are on hand Relevant doctors arriving on time so cases are presented in the correct order
32. Good commication with the MDT co-ordinator
33. Good chairing; prepared clinicians
34. Good chairing
35. Good chair and good time management
36. Everyone being present, all results/ info present. Respect for all areas in the management of cancer patients sometimes not enough emphasis on oncological aspects and too much history eg screening/ surgery.
37. Ensuring that all clinician are aware of which patients are being presented. Problems can arise when for example radiology have not had a chance to review images properly before the meeting.Therefore good communication in a timely manner to all MDT contributors is key.
38. Ensuring all relevant paperwork is to hand with test results, imaging etc so patient can be discussed fully
39. enough time, appro pts ,results available eg path /radiology
40. Effective leadership, prior planning
41. effective chairing to ensure that time is given to all cases appropriately and conclusions are reached efficiently. Respect from all members for the meeting, especially for cases they are not directly involved in.
42. Effecient switch between nursing staff covering the different bays. Allowing the nursing staff to attend, thereby having good staffing on the ward to enable this. Having a set time to do MDT rather than doing it on an ad-hoc basis.
43. Control of extraneous discussion
44. Clear, concise patient history, chair and MDT co-ordinator working together to keep the meeting moving on.
45. Clear facts/ summary and outcome Good communication Good chairing
46. arrive and start on time. If someone has urgently to leave discuss their patients first. time for everyone to contribute.
47. A good Chair,a good coordinator and well prepared cases.
48. A good Chair to run the meeting.
49. A good chair as well as the other professionals knowing what is expected of them

Clinical decision-making
What model of decision-making could be used for patients with recurrence/advanced disease if these patients are not discussed at MDT?

9 AHPs responded to this question.

1. there should always be team discussion about ongoing management of pts
2. Oncology review, often sent back through MDT for discussion but ither members appear not to be interested
3. Oncologist and patient should have the discussion about treatment options.
4. If they are not discussed at MDT they will be unknown to all but those involved in their immediate care and thus lose the opportunity for extended support
5. Engagement of tumour specific team with Pall Care team for their perspective & a joint decision-making
6. don't know
7. concensus among at least 3 treating clinicians supported by the Specialist nurse
8. Case conference with family
9. Another 'mini' mdt with just core members could be held whenever needed

What are the main reasons for MDT treatment recommendations not being implemented?

19 AHPs responded to this question.

1. Work in hospice MDT so patients usually very advanced when referred, and seen by other MDTs first
2. Unsure
3. Surgeon not following MDT decision. Patient choice.
4. Specific individual consultants not implementing MDT recommendations or patient decision.
5. renal or ~LFT being abnormal and protocols having to chang
6. Rapid tumour growth. Patient declines to be admitted at a particular time
7. Rapid change in complex patient presentation
8. patients become end of life
9. Patient opting not to have treatment, or death of patient
10. Patient not wishing to accept recommnedations
11. Patient doesn't want procedure.
12. Patient declined, disease more extensive than initial diagnosis, patient did not tolerate/ cope with treatment
13. Patient choice?
14. On discussion patient may have dicided that they did not want to have the recommended treatment.
15. Don't know this should be audited and I am currently not aware this happens
16. Don't feel I know enough about this to answer
17. complicating factors eg patient non compliance due to alcohol abuse etc
18. change in patient circumstances
19. A chance of circumstance for the person with cancer, e.g. co-morbidity issues (e.g. cardiac failure), more rapid physical deterioation than expected, physical response to treatments given (severe side-effects), psycholgical burden of the cancer diagnosis leading to non-adherence to planned action, e.g. failing to attend subsequent appointments, asking for alternative treatments, seeking second opinions.

How can we best ensure that all new cancer cases are referred to an MDT?

17 AHPs responded to this question.

1. There should be a key contact who proceses the cancer patients so that they are picked up for the appropriate MDT speciality.
2. Set up a simple, clearly advertised/ accessible process + pathway
3. make it mandatory
4. Make it integral part of the process
5. Improved tracking. One named key MDT Coordinator
6. I think that very few cases are not referred nowadays and that is because people can see the benefits and importance of the MDT, so I think that it sells itself.
7. I don't know, it is not within my remit
8. Gps refer directly to specialist cancer sites
9. electronic referals with key details co-ordinator to organise meetings/cases
10. Effective pathways and protocols
11. dedicated cancer data collection point in the hospital where information is sent out to all mdt co-ordinators. All professionals to be responsible for notifying the collection point even if the information is duplictaed.
12. consultant's secs to inform
13. communication amongst MDT and referral accepted from any source
14. an effective flagging up system
15. An effective coordinator
16. All patients need to be seen by a medic/surgeon who refers to the specialist for that cancer area e.g maxfax/H&N, who then alerts the MDT if FNA/biopsies etc have been undertaken
17. All cancers should be flagged up by pathology

How should disagreements/split decisions over treatment recommendations be recorded?

19 AHPs responded to this question.

1. Set proforma - should be signed by relevant staff
2. Reasons for each option being recommended should be documented. The majority opinion should then be documented.
3. on data sheet
4. Not sure
5. minuted with the decisions/disagreements worded to show how the decisions were made and by whom and why the decisons were not agreed or split for future audit.
6. In the patient medical notes
7. In notes with brief description of outcome
8. in notes and letter form
9. In MDT minutes for that patient
10. I do not think that this has arisen - I think that a consensus always seems to be reached- but I think that it would be good to have guidance on how this could be dealt with were the issue to arise.
11. exactly as they are discussed
12. Documented in MDT outcome form.
13. Document which professionals think whatever treatment should be documented according to which proessional said it

14. correctly and truthfully with no distortion of facts
15. both decisions recorded and the chair use a casting vote
16. As treatment options for discussion with the patient
17. As standard entries on the MDT proforma
18. As differential treatment suggestions
19. All documented

Who is the best person to represent the patient's view at an MDT meeting?

47 AHPs responded to this question.

1. Whom ever feels they know ther patient best, has a good rapport etc with that patient
2. Whoever has met and holistically assessed them
3. whoever has had the most contact with the patient - eg consultant, dietician, cns, speech therapist
4. Whilst it generally is the professional who has spent the most time with the client who may be best placed to represent their views (and often this is the Clinical Nurse Specialist or the Consultant), I feel it should be a shared team experience as far as possible - if you have not seen the person then it might be seen as pure speculation to try to identify the concerns, but asking for clarification, referencing experience and the evidence-base should be encouraged so that treatment decisions are shared.
5. VARIES. COULD BE THE SPECIALIST NURSE, CONSULTANT OR ONE OF HIS TEAM OR AN AHP. IN REALITY THE 'PERSON' IS RARELY PRESENTED BUT RATHER THEIR CONDITION. OUR MDT IS VERY MEDICAL MODEL. COULD BE IMPROVED IF BIO PSTCHSOCIAL MODEL USED
6. The treating clinician
7. The person who will have the most to do with the patient and get relevant information e.g CNS, SLT, medical team.....
8. The person in the team with the most knowledge of the patient
9. The patients' key worker
10. the patient or a named family member by the patient
11. The last person they saw in clinic.
12. The keyworker
13. The identified key worker
14. The clinician/AHP who has seen them the most
15. specialist nurses
16. Specialist nurse
17. Someone who has met them and assessed them
18. Somebody who knows the patient well
19. Quite often it's the CNS or SLT at our meetings
20. Possibly someone nominated by the patient
21. Person in the team with most knowledge of the patient.
22. Normally the clinical nurse specialist
23. no-one person as decisions should be put to the patient along with a relative,companion, or guardian with a specialist nurse or similar present so that an informed choice is made (in the patients own time if necessary)
24. named nurse or key worker - could be any member of team who patient has discussed with
25. Named nurse
26. Key worker
27. key worker
28. key worker

29. it should be 2 people a clinician who has seen the patient and the breast care nurse who has seen the patient
30. GP or nurse
31. good question only the pastient but it is not always things they understand
32. consultant or specilaist nurse
33. Clinical Nurse Specialist
34. Clinical nurse specialist
35. Cancer Nurse Specialist but could be any one the patient has confided in
36. Breast care nurses
37. Breast Care nurse who is the identified key worker
38. Anyone whoi knows the patients views
39. Anyone who met the patient prior to the meeting but this is likely to be their CNS
40. Anyone who has met the pt /spent some time with the pt and has some background in their case
41. Anybody who has assessed the patient - often AHP's and Mac nurses are able to gain a better insight into patients views as patients have more of an opprtunity to speak to them on a personal level
42. Any member who has had close dealings with the patient prior to the MDT
43. A person who has met them and spent time outside of the
44. A key worker should be an allied health professional
45. A healthcare professional/ Doctor who knows the patient and is competent/confident to do so.
46. ?nurse specialist
47. (Current) primary clinician, whatever their profession

Who should be responsible for communicating the treatment recommendations to the patient?

42 AHPs responded to this question. In addition, 4 AHPs referred to the response they had provided to the previous open question [Q32].

1. Upper GI CNS
2. this should be agreed by the team - may vary from case to case
3. The surgeon and CNS
4. The primary consultant, who has made the initial diagnosis where possible as the patient will know and have met this person before
5. The patients key worker
6. the named key worker
7. The consultant
8. The clinician
9. Surgeons/Oncologists
10. Surgeon/oncologist who will carry out the treatment supported by key worker
11. Surgeon/oncologist
12. surgeon and nurse specialist
13. Oncologist or surgeon
14. medical/health teams involved
15. medical staff incase patient has more questions which need to be answered
16. Lead clinician for the patient's care/treatment supported by the keyworker if different
17. Keyworker with the lead clinician undertaking the treatment
18. Key worker/clinician
19. key worker/clinician
20. Key worker or oncologist
21. key worker

22. I thionk that it should in principle be the consultant who will be delivering the treatment, e.g. an oncologist if chemotherapy/radiotherapy, a surgeon if surgery and preferrably within a joint clinic so that the information that is shared can be recalled to the client to enable other team members to support him/her in the most effective and consistent manner. If that consultant is not known to the person with cancer, I think it is best that the consultant who already knows the person introduces the basic outline of the treatment plan, for the relevant consultant to describe in greater detail - either within the joint clinic or at a later date, the time of which is given to the client when the treatment option is chosen so that there is as seamless a package of care as possible.
23. Doctor initially, especially around treatment decisions, but realistically could be another MDT member who knows patient well
24. Consultants with the Specialist Nurse
25. Consultant with Cancer nurse specialist support
26. Consultant with above present
27. Consultant responsible and CNS
28. Consultant overseeing their care.
29. Consultant in charge of their care
30. CONSULTANT AS USUALLY MEDICAL TREATMENT
31. Consultant
32. Consultant
33. consultant
34. consultant
35. consultan and CNS
36. Clinicians
37. clinician/surgeon
38. Clinician who has had the patient referred to them.
39. clinician
40. Clinical nurse specialist
41. BREAST CARE NURSE
42. ?

Measuring MDT effectiveness/performance

What other measures could be used to evaluate MDT performance?

8 AHPs responded to this question.

1. Staff satisfaction surveys
2. Reflection, questionnaire within house
3. Peer visits as has been done previously, but also MDTs going to other trusts to see what might work better and enable improvements to be made, such visits could be done to places of similar demographic profiles as well as to centres of excellence.
4. Outcomes may not only be about survival - important to consider management of symptoms including psychological distress
5. not sure
6. No of referrals ie increase or decrease in referrals through patient choice due to good /bad reputation of the hospital for cancer treatment.
7. I don't know
8. anonymous satisfaction survey from all staff attending mdm

Supporting MDTs to work effectively

What one thing would you change to make your MDT more effective?

32 AHPs responded to this question.

1. We have no nominated chair person.
2. That all the members are present for the whole duration of the meeting
3. team valuing the ongoing care by non medics after surgery
4. stopping internecine squabbling, more respenct for all team members
5. stick to the point.
6. space and room comfort
7. smaller patient lists, more specific to pre-surgery treatment / post surgery treatment
8. seating arrangements
9. Screening and surgeons to summarise their "story" and to get to the relevant information, to be factual and concise to allow discussion of the pertinent parts
10. room layout
11. preparation
12. People's names should only be added to the list if their cases are able to be discussed - this does not happen that often, but it wastes valuable time as professionals go over the medical history and pertinent information only to then be told that the scans are not done/ histology is not ready. etc.
13. Need a dedicated MDT coordinator - currently have changing person due to staffing problems within the coordinators team.
14. More involvement of core membes other than medical/surgical staff by encouraging them to offer an opinion and listen to what they have to say
15. More frequent shorter meetings for extended team
16. Management plan documented and projected to MDT at the time of decision making
17. IT resources
18. It not being so medically led
19. Improved timely communication
20. I think the room is a bit crowded at times, can't hear so well
21. ensure relevant staff invited

22. DISCUSS THE PERSON NOT JUST THE CANCER SURGICAL/RADIOLOGICAL TREATMENT
23. decisiveness
24. De centralise!
25. Currently no MDT lead - appoint one.
26. Current MDT is Friday lunchtime/afternoon. A mini MDT midweek to discuss NCB results, would alleviate pressure on lengthy Friday meetings and allows patients to return for results within a few days having been discussed at MDT
27. better resources and more funding
28. Better documenation of decision and /or reasons for recommendations not being followed through
29. Better control
30. Better communicaiton - more inclusive of all team members
31. All members being allocated the time to attend
32. All clinicians should turn up on time Changes in treatment plans should be brought back to the MDT

What would help you to improve your personal contribution to the MDT?

24 AHPs responded to this question.

1. Training/'time out' with all members of the mdt to consolidate what we all want out of the mdt. So we can grow as a team to strive to obtain the best results for our patients
2. Protected time, better staffing generally
3. Opportunities to present to the group our role and how we impact on patient care
4. More time/staffing resources
5. More time!
6. More reliable equipment as I generally need to show video-footage when presenting a client and have had to bring a TV/VCR into the room (a long way from my clinical treatment area) as equipment has failed to work.
7. More MDT audit/ review and service development to ensure that we are giving our patients the best
8. more confidence in meeting/contribution during meeting
9. MDt group eduacetion or CPD sessions. we all learn from each other.
10. less call on my time taking me away from the MDT, even though the MDT is ringfenced time, other broader organisational priorities sometimes encroach
11. Knowing what they want from me
12. Improved training and education sessions
13. I am able to contribute as and when I wish
14. Help with audita and data collection,presentation skills training
15. Having one effective discussion. There are too many separate discussions going on at the same time.
16. give others more chance to contribute,
17. For the chair to make it clear we are all their to discuss the patient - not just the medics
18. feel able to contribute so no complaints.In the past the surgeon has dismissed comments on technical aspects which would have benefited the patient but our new surgeon is more open minded and as a result we have a better working relationship with mutual respect and good communication.
19. Easier access to video facilities
20. Confidence to express my opinioin to the relevent cases.
21. being valued and not ignored
22. being listened to!
23. being allowed to forward opinions/asked for opinion

24.   AN OPPORTUNITY TO DISCUSS THE PERSON IN EVERY CASE

What other types of training or tools would you find useful as an individual or team to support effective MDT working?

11 AHPs responded to this question

1. this has to something that we can all do in the already jammed 37.5hrs that we alkl exceed regularly
2. The peer visits mentioned above.
3. Staff to go on effective and advanced communicaiton course
4. not sure what would help!
5. Not sure
6. mentoring where appropriate eg for chair
7. I think many of the above methods would be taken up by the motivated and already 'good' members and those who the training is targeted at would not access e - training, DVD's, on line forums. It needs to be a method that is compulsary to all.
8. how to deal with difficult colleagues training how to deal with clashing egos
9. Comparison with other MDT's/ independant review
10. Communication verbally or via minutes to all members of the MDT. sometimes decisions not documented so unable to plan appropriate care
11. ? time

Please provide details of training courses or tools you are aware of that support MDT development

8 AHPs responded to this question.

1. Refer to BAPEN nutrition mdt courses
2. Not sure of any specific ones for MDT development, but I feel that clinically-relevant programmes, like attending 'Changing Faces' course might be helpful for enabling team-building as well as improving the service we provide.
3. Not aware of any
4. none
5. Nil known
6. cancer network meetings on a quarterly basis. very informative regardless of discipline.
7. can't think of any
8. Advanced communicaiton skills in cancer was excellent

Final comments

Please insert any final comments or observations on the characteristics or indicators of high-performing MDTs and appropriate measures of performance

4 AHPs responded to this question

1. The government move to centralisation of MDTs to larger network numbers has had a serious detrimental effect on our MDT - it takes longer, is very costly in numbers of attendees, is very high on time, patients are travelling longer distances,and information is poorly circulated or not at all!
2. Members of the team need to recognise that the MDT is in the interest of the patient and not in fulfilling personal ego!   I have attended many MDT's in various locations and for various cancer sites where the focus is on personality of individuals within the meeting fighting for their speciality dominates the meeting. This can be quite unpleasant for the rest of the team who witness this. I also think visiting another MDT should be encouraged to see how other teams organise thier meetings to highlight good / bad qualities.
3. I do get fed up spending >two hours per week, listening to squabbles between clinicians, and moaning about cancer wait times and the state of the NHS. I also feel I'm expected to be seen and not heard
4. doctors showing by behaviour and body language that they do value other members of staff-that is not just lip service proper protocols in all areas of clinical practice as well as for mdms