Multidisciplinary team members views about MDT working:

Results from a survey commissioned by the National Cancer Action Team

Open question responses: Nurses

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Introduction
This report provides the responses given by **nurses** 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
     - Leadership
       - *What qualities make a good MDT chair/leader?*
       - *What types of training do MDT leaders require?*
     - Teamworking
       - *What makes an MDT work well together?*
   - Infrastructure for meetings
     - Physical environment of the meeting venue
       - *What is the key physical barrier to an MDT working effectively?*
     - 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
     - Preparation for MDT meetings
       - *What preparation needs to take place in advance for the MDT meeting to run effectively?*
     - Organisation/administration during MDT meetings
       - *What makes an MDT meeting run effectively?*
   - Clinical decision-making
     - 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?*
     - 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 Radiologists Histo/cytopathologists Oncologists (clinical and medical) Haematologists Palliative care specialists Other doctors (e.g. physicians, GP)	325 127 126 164 98 65 188
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?

420 nurses responded to this question.

1. working together as a team having a lead person
2. working as a tem and effective communication skills
3. working as a team with all staff being able to contribute to the discussion
4. whereby all core members participate FULLY to the meeting and patients are discussed as timely as possible, an mdt discussion shouldnt prevent a patient being referred from a unit to a centre clinician
5. where members, meet regularly, have an equal voice and follow agreed guidelines and protocols
6. where all members of the team are acknowledged as being as important as each other
7. When everyone knows the pupose of the meeting and feels able to input as appropriate.
8. when every one who should attends, attends. we don't always have radiology or pathology. Also need patients notes. If another team is refering they should present the patient as difficult to know the patient if you have not met them
9. Well prepared,well co-ordinated, sufficient time to discuss all patients thoroughly. MDM lead to chair and control the meeting.
10. well organised, everyone listening.
11. Well informed and dedicated team
12. video conferencing to facilitate the process good communication regular attendance respect for all members knowledge and skills
13. Up to date, expert clinicians who can communicate effectively and discuss opinions to develop a patients individual plan of treatment
14. To have all the require team to be present during the meeting
15. Timing of meeting, timing of notification Quorum of suitable folk Not too many members
16. Timely, appropriate communication regarding diagnosis treatment and follow on care with the patients interest at the core.
17. time to attend meetings time to keep abreast of current research and practice effective teamwork expert knowledge knowledge of individual patients access to resources including imaging
18. Time for full discussion of each patient with each appropriate member allowed a voice that is listened to. Resources to facilitate this.
19. Time allocation Punctuality Organisation Listening Good preparation
20. Thorough discussion of all patients at appropriate points of their pathway.
21. The personnell available to make decisions regarding patient care are present for the mdt
22. THE CORRECT CORE MEMBERS PRESENT. GOOD ORGANISATION OF MEETING IE:EFFECTIVE LEADER. ALL NOTES ETC. TO BE AVAILABLE.
23. The attendance & availability of all core members to review upto date & co-ordinated/relevant patients. To ensure treatment pathways are decided early and acted upon.
24. The appropriate people in attendence that have the time to input their expertise.
25. The admin support is vital, and that all views are respected from all team members
26. that all the core elements are in place and menbers respect each others views and opinions
27. Teamwork/Sound knowledge+evidence based practice/Strong communication/Sufficient resources+data
28. Teamwork/coordination and good communication.Systems in place to support data collection. Good IT infrastructure.
29. Teamwork and mutual respect Organisation Availability of relevant information

30. Team working. Openness. Having time to discuss difficult problems - not just being target driven!
31. Team working,equality
32. Team working, Listening skills, Always putting patient first. Environment where all team members can contribute.
33. Team working with all members playing a part
34. Team working effective communication consideration to others when presenting and an open discussion to ensure optimal patient treatment
35. Team working clinical discussion needs to be holistic planned and smooth running.
36. team work,open communication.
37. Team work, good communication, effective documentation
38. Team work, coordination, commitment, understanding of the role of the MDT & MDM
39. Team work, communication, collaboration, Agreed protocols, a common interest
40. Team work and sound leadership. Ownership of partient's and good documentation and communication.
41. Team work and good working relationship. Respect for each other contribution to the MDT
42. Team work and communication between all team members and patientwhilst acting in the best interests of the patient
43. team work and communication
44. team work across the group & recognising that despite the merger we all have a role to play in ensuring good patient care
45. Team work Organisation Knowledge of patient
46. Team work Good leadership
47. team work communication
48. Team work
49. Team work
50. Team which communicates & is accessible to each other. Information being readily available.
51. Team that interacts together efficiently
52. Strong leadership. Clear organisational policy. Valued, committed members whose priority is always best possible care for patients.
53. Strong leadership with an identifiable Lead Clinician/Chair. Valued, commited members who share the same philosophy of providing the best care for our patients. Thorough organisation and planning plus accurate data collection and audit. Responsive to new information, local and national standards and the patient voice. The MDT should have a clear operational policy which is regularly evaluated. Learning from the MDT should be disseminated down throughout the extended team.
54. strong leadership from both MDM co ordnator & clinical lead with committment to partnership working
55. Strong lead to the team with everyone understanding their roles.
56. STRONG CLINICAL LEAD, GOOD MIX OF INDIVIDUAL FIELDS OF EXPERTISE,
57. Strict guidelines, comitted members, communication
58. specific timing All core members in attendance Allpts discussed prior to being seen
59. Someone to lead it effectively. Respect for each others opinions. Willingness to listen and to focus on the case in hand, not talking about other cases privately. Punctuality. Clear decision making and effective communication of decision to MDT data collector. Not waffling.
60. someone clearly leading the meeting
61. So many factors, the main one being of all team members having a respect of each other's roles. Meeting starting on time and finishing on time and discussions not becoming political and being patient focused.
62. Smooth running, and full confirmation of the outcome at the end of the discussion

63. Slick, relevant information for professionals working cross boundary to ease the transition of care from secondary to primary care and vice versa. To ensure decisions relating to patient care are multiprofessional.
64. sharing of information treatment planning highlighting potential issues re individual patients
65. Shared goals for patient management, effective organisation and a respectful environment where all options for patient management can be discussed
66. respect for each others role good communication keep it patient focused regular introduction of improved ways of working learn from each other
67. Respect for contribution from all professionals in order to improve patient management, treatment and care plans.
68. RESPECT FOR ALL MEMBERS VIEWS. ALL VITAL DISCIPLINES REPRESENTED. WELL CHAIRED MEETINGS.
69. respect for all members of the team and adhering to mdm decision
70. Respect for all grades who attend and their opinions. People who are commited to attending on a regular basis because they care about the patients with that particular cancer
71. Respect between different professions. Good organisation. Time management
72. Representatives from each field who are expert. Access to pathology and Xray results on screen for debate etc. An orderly agenda compiled in advance. A forum where all members participate and are respected - so that best practise for the individual patient is the outcome.
73. Representatives from all disciplines involved in care, open discussion amongst members of team, respect for individual's viewpoints, taking into account patient preferences and views
74. Representation from all disciplines
75. repect for all team members and disclipline at mdt meetings, ie business only
76. regular attendence of core members
77. Regular attendence by representatives of all disciplines. A good co-ordinator Good communication between members Accepted core policies and protocols on patient pathways.
78. Regular attendance with working equiptment and representation from all teams. Time managment is also very important.
79. Regular attendance of members,all correct data to view
80. Regular attendance of core members Accurate guidance on MDT criterteria/protocols Seamless referral processes Availability of essential diagnostic results and patient details Efficient chairmanship and good team working
81. Regular attendance of all members MDT Co-ordinator
82. Regular attendance of all key professionals and timely diagnostic results.
83. Regular attendance by core members,efficient presentation and communication
84. Regular attendance by core members Good preparation of patients to be discussed Multi-disciplinary discussion Teamwork Effective co-ordination and implementation of outcomes
85. Regular attendance by all core members, with enough time allocated by team to discuss cases. Also for full cover especially by histopathology and radiology.
86. Regular attendance by all core members, good communication between MDT co-ordinator and other members and having MDT co-ordinator present at all meetings. Circulation of outcome proformas to key worker and patient's clinician after the meeting.
87. Punctuality, availability of notes xrays etc
88. Prompt and consistent attendance of core members. Teamwork and effective communication
89. PRESENCE FROM APPROPRIATE HEALTH PROFESSIONALS AND AVAILABLE WORKING EQUIPMENT. DESIGNATED CO-ORDINATOR
90. Preparation, comforable surroundings,appropriate length
91. PERPARATION MAKING A DECISION ACTIONS POST MDT
92. People working well together respecting others' views. Good communication. Good organisation.

93. People turning up on time, range of consultants, radiologists, oncologists
94. People bothering to attend as skill mix can be minimal and not of benefit to pt
95. Organised and concise Core members attendance Open forum Team working Technology Presentations contain all relevent information Minutes to be available in good time
96. organisational skills & effective communication
97. organisation, effective communication, follow up, relevant attendance
98. organisation of information
99. Operational policy with effective care pathways for the patients
100. open discussion to find best outcome for patient
101. open discussion after presentation of facts- equal weight given to all input
102. open communication, good team work, good coordinator
103. Open communication where egoes are left at the door!
104. One with core members in post. Good communicaton.
105. one which does not consist of mobile phones and bleeps going off every few minutes and numerous interuptions.
106. One where there is affective co-ordination and decision making
107. One where all memebers actively engage and contribute.
108. one that works well together to provide the best care for patients
109. One that is well co-ordinated and supported and attended by all members of the team, all of whom participate actively
110. One that deals with patient load effectively and communicating decisions swiftly.
111. One that comes to decisions, discusses relevant patients, involves appropriate people
112. ommunication.to the point not to long in time.organised.
113. Mutual respect democratic leadership style well organised taking into consideration psychosocial aspects as well as biomedical aspects of patient management more time!!!!
114. Multidisciplinary members attending on a regular basis. Clear guidelines and agreement for the MDT and patient management. A committed MDT lead & good liason with extended team members and other MDT's for joint management
115. Multidisciplinary discussion,input and accurate information.
116. multi professional with discussion of appropriate patientd
117. Multi-disciplinary decisions which are adhered to when the patient is seen, all to have equal and balanced input. Meeting should be well chaired and organised.
118. members who prioritise attendance and who contributegood IT is essential
119. Members who are motivated to providing the best for the patients. A co-ordinator who is aware of all the relevant investigations,treatments etc for patients. Adeqate period of time for the MDT meeting.
120. members to be across all disciplines -acute & community, open channels of communication
121. MDT coordinator. Wide participation from groups involved in speciality
122. MDT Co-ordinator
123. listening and respecting each member of the team.
124. Leadership and communication
125. KNOWLEDGE OF SPECIALITY, CLOSELY LINKED MEMBERS TO THEREFORE ENABLE THE BEST TREATMENT FOR PATIENTS
126. Knowledge and skill Good working relationships with all members. Value and respect for each others roles
127. Knowledge of and respect for each others roles. Effective communication. Dedication and commitment.
128. key members of the team present and effective networking within the team and between other disciplines. Appropriate resources and equipment to work effectively.
129. It relates to a professional attitude, respect and expertise.
130. It needs a core membership who are reliable.I feel the MDT coordinator needs specialist knowledge of the area/s they cover.Data collection mistakes are made due to lack of knowledge about treatment of conditions.Experience in the field in

which a coordinator works is essential.

131. Involvement of all members of the MDT. An appreciation of each others roles and responsibilities and active encouargaement from senior members to include all professionals. Approachable Consultants to enable other members of the team to ask advice to enable effective patient care to be delivered
132. Involvement and acknowledgement of all team members input. Open communication, and Consultants being approachable to ask for their advice.
133. Inter professional participation and discussion in relation to planning individual patient care.An effective Mdt Co-ordinator.
134. Input from different specialities with expertise in different areas are essential.
135. Input by all memebers of the oncology team, medical, nursing, pathology, psychology & having access to the extended AHP members who can attend/contribute to our MDT forum
136. Individual patient focussed research based treatment for each patient
137. HIGH LEVELS OF COMMUNICATION BETWEEN STAFF
138. Helps if have co-ordinator-Palliative care only just been allocated. Enough core members participating, good proforma to record information,robust method to carry out actions from MDT. It has to be meaningful in effecting patient outcomes and professional communication-not a paper excercise to tick a box. Needs to be assessed relevance of need for attendance of core members although views may be appreciated as CNS can sit through some site specific and not pick up referrals-best use of time needs consideration when could have been seeing patient
139. Having the right information, notes, scans results on each patient with the right people in the room to discuss them. Ability for all members of the group to contribute as appropriate.
140. HAVING CORE MEMBERS FROM ACROSS THE DIFFERENT SPECIALITIES. WEEKLY MEETINGS. HAVING ALL INFORMATION REQIURED READY FOR MEETING. OPEN DISCUSSION. EDUCATION AS APPROPRIATE WITHIN THE AGENDA. GOOD TIME KEEPING.
141. Having as many core members present at a meeting with sufficent clinical information for each individual discussed to formulate and progress the patient pathway
142. having allocated time
143. Having all the members of the MDM present at discussion to formulate an effective plan for each individual patient.
144. Having all the information required to make a decision, and the ability to comminucate
145. having all of the relevant specialists there to make the best possible recommendation of treatment (or no treatment)
146. Having all members available to discuss patients care and not just focusing on diagnosis
147. Having a MDT approach to patients. Patients need to be known to at least one member of the meeting
148. Have all core members present at the same time to discuss patients from a well organised itinerary
149. Group working - equal emphasis given to each member and the ability to discuss openly and with constructive criticism the rationale for treatments or their witholding
150. group of multiproffessionals that work together by effective communication both orally and written to achieve a higher standard of care for patients and cares
151. GOOO IT SYSTEMS ALL THE CORE MEMBERES NEED TO ATTEND AT LEAST 80% OF THE TIME , THERE BE A DEPUTYS FOR EACH CONSULTANT
152. good working technology efficient co-ordinators sending imaging slides etc promptly Havingthe appropriate people present
153. Good working relationships. Team committed to MDT working. Regular reviews to look at how meeting and practice could be improved
154. Good working relationships with other MDT members. Co-operation. Adequate resources in terms of facilities in which to carry out MDT meetings. Time to give each patient case the level of input it requires to make safe, evidence based

decisions regarding management. Effective communication. Enough people to cover for sickness and absence. Time for team building and training.

155. GOOD WORKING RELATIONSHIPS EFFECTIVE ADMINISTRATION DISCUSSION WHICH INVOLVES ALL MEMBERS OF THE MDT
156. good working relationship between MDT members. Knowledge of MDT members roles.
157. GOOD VENUE,ATTENDANCE,MDT CO-ORDINATOR, TIME
158. Good time management,all members being present,good preparation so all info is gathered,open communication,having an awareness of what the individual roles of people are
159. good teamwork. good communivation
160. Good teamwork, good communication between health care professionals and having the MDT co-ordinator to do just that.
161. good team, support, organisation, effective working
162. Good team working Effective leader Robust referral policy Recording of all relevant data Defined responsibilities
163. Good team work, effective communication, good timing keeping, effective leader
164. Good team work and excellent communication. Having a proactive, engaged MDT Co-ordinator can make the difference between and well run and poorly run MDT. We also need all the Clinicians to be fully engaged, which they are not!!
165. Good team players communication.
166. Good sharp and focussed leadership with good supporting structures and allocated time to meet the needs of the patients, but also develop as a team to help achieve organisational team and personalobjectives
167. good set up for meetings, being able to discuss aspects of patient care, involving all members of the team, having an effective co-ordinator to tie everything together, having set guidelines that all members adhere to
168. Good representation from all disciplines. Effective chair for good leadership. Team working and communication amongst team. Preparation prior to meeting.
169. Good quality information. Time to discuss all aspects of patient info and all relevant professionals present and committed. Information shared to be then used in the effective management of the patient
170. good preparation, effective communication and someone to lead it to keep it focused
171. Good patient case presentations Active listening whilst cases being presented Clear plan of action following discussion
172. good organization having a lead person to ensure flow of discussion
173. Good organised information and multi-professional decisions
174. Good organisation. Timely investigations and prompt results of investigations. Effective video conferencing equipment
175. good organisation, clear goals, mdt approach, data collection clear
176. Good MDT Co-ordinator Good attendence by all disciplinaries Good communication between all members
177. Good lines of communication internally, between cancer centres & with patients
178. Good liason with team members. Good availability of support from IT both for inputting and videoconferencing. Understandin of data that needs to be input.
179. Good leadership, mutual respect, adequate preparation. adequate accomodation/IT, Need it to be sessional, not an add on.
180. Good leadership, excellent administration of mdt and appropriate documentation in notes and nomination of tasks to be completed specified at MDT
181. Good leadership, and communication
182. Good leader. Good communication. The team being able to work together for the good of the patient and putting aside ego
183. good knowledge base good communication Considering each patient on an individual basis open communication with the patient / carer regular , pre arranged meetings Showing respect for each member
184. Good IT technology & support Preparation/planning to ensure concise case presentation & appopriate results available
185. Good effective systems,processes and protocols to ensure all patients who need

to be discussed are. Mutual respect. Effective leadership and chairmanship. Good communication with ALL members of the MDT and breast team; core,extended and admin staff including those not part of the MDT such as clinic clerks etc. Effective documentation of events. An environment that allows all to speak freely but in order, where a conclusion is brought together with agreed consent. A summary of the disucssion and outcome is transcribed and confirmed as correct prior to moving onto the next patient.

186. Good discussion. We do video conferenceing which is not effecctive. I would hate to think that real management decisionsare being made, based on the sound quality, picture quality, and image quality
187. Good cross speciality working and understadnign of the individuals roles within the team
188. Good communication: effective mechanisms and protocols for treating patients and for onward referrals if req'd. Good relationships between members
189. good communication/team work/ multidisciplinary approach
190. Good communication. Approachable staff, keen interest in subject.
191. Good communication, Well organised, resposibilities clearly defined
192. Good communication, team work
193. good communication, team work
194. good communication, respect & understanding of each others roles
195. Good communication, good working relationships
196. Good communication, good secretarial and co-ordinator support
197. Good communication, everyone's opinion listened to. Streamlined to prevent irrelevent discussions
198. good communication, attendance and follow up structure
199. Good communication, and the input of all memebrs
200. Good communication with all the core members and the primary care team. Good planning to ensure all the patients are discussed in a timely way. Collection of all the data to ensure 31 and 62 treatment dates are met
201. Good communication skills and a good team
202. Good communication both written and verbal, with dfined protocols for treatment and quick referral pathways.
203. Good communication between team members to ensure patients do not slip throguh the net and are discussed appropriately. Commitment to attendance at meetings and good follow-up of decision-making.
204. good communication between members. understanding of eachother's role within the MDT. patient centered.
205. Good communication between members of the team. An open and honest discussion regarding the care pathway for patients taking into account, and acting upon, patient choice.
206. Good communication between all the team,. Respect for each others professions. Encouraging all members to contribute
207. Good communication between all team members.
208. Good communication between all staff.Effective coordination of the meeting.Clear & concise meeting outcomes.IT equipment that works so that all MDT members can be present at meeting!Clear outcomes presented to patients and their GP's so that they are aware of treatment plan.
209. GOOD COMMUNICATION BETWEEN ALL MEMBERS AND THE OPPORTUNITY TO VOICE YOUR PROBELMS/OPINIONS IN A NON JUDGEMENTAL ARENA
210. good communication and team working between the members
211. Good Communication and sharing knowledge
212. Good communication and planning of patients management plan
213. good communication and organization of the meeting. Written outcomes, enthusiastic membership.Regular meetings
214. good communication and organisation
215. good communication and having an efficient MDT corodinator
216. Good communication and data collection. Good environment in which to meet

with all the team present. We meet via video link to ensure all the team is there.

217. Good communication and courtesy
218. gOOD COMMUNICATION AND ATTENDANCE AND OPEN FORUM FOR DISCUSSION
219. good communication and an effective referral system
220. Good communication and a respect for all the team members.
221. Good communication amongst an established team
222. good communication accross disciplines
223. Good communication & discussion with the team members. Designated time for MDT. All notes and mammos available for each patient
224. Good communication Good preparation Forum which encourages discussion
225. good communication good access to imaging, good attendance
226. GOOD COMMUNICATION ALL MEMBERS OF MDT TO BE PRESENT AT EACH MEETING. TEAM WORK
227. Good communication
228. good communication
229. Good co ordination of MDT with good quality patient information. This is often missing or falls to clinical nurse specialist to do in the absence of MDT co ordinator which happens on a frequent basis for our MDT it is not effective use of CNS hours. Pre reading of MDT proformas is essential and time for some memebers of team to prepare before hand ie pathology in preparing slides etc, good technology that links with each other for quality images etc.Motivated personnel and it to become a paid session for MDT memebers not just medical staff. Good will at moment ensures attendance out of hours.
230. good co-ordinator and effective team working to gether
231. Good co-ordination, willingness of disciplines to do preparatory work for MDMs, work effectively together to deliver patient centred care/treatment and respect each others roles
232. Good clear structural order of presentation, good oral and written communication. Constructive discussion backed up with rersearch/clinical evidence. Concise accurate electronic and written documents. Visual aids X-ray, tele/video conferencing. Computerised records of discussion and decision.
233. good attendance, respect, equality and active participation of members from all disciplines
234. Good attendance of core members. Regular meetings Documented outcomes
235. good attendance of all disciplines
236. Good attendance by mutidisciplinary team. eg Radiologist, pathologist etc attendanceat every meeting as much as possible. Should encorporate education for team members as well as discussing and agreeing management strategy of patients. All members views no matter how junior should contribute to management discussion if valid. Good experienced MDT co-ordinator to ensure timely referral on of patients.
237. Godd communication channels and personnel who understand their responsibilities within the MDT
238. Gaining a clear treatment plan for patients Communicating clear plan to patients Effective communication among MDT team
239. FULL MEMBERSHIP AND ATTENDANCE EFFECTIVE TERMS OF REFERENCE PARTNERSHIP APPROACH
240. FULL DISCUSSION OF ALL PATIENTS DIAGNOSED WITH A CANCER REGARDING ALL STAGING INVESTIGATIONS, CONSENSUS OF OPINION GAINED FOR A TREATMENT PLAN, POST OP PATHOLOGY REVIEW, SUBSEQUENT ABNORMAL SURVEILLANCE INVESTIGATION
241. Freedom to express opinion and to be heard in respect to a patients clinical situation
242. for MDT that have two medical specilaities teamworking is vital. also the infastructure has to be in place for an effective MDT to function in terms of its meetings,
243. For all core team members working together to ensure a co-ordinated, swift, appropriate investigation and management, providing informative support for the

patient during their cancer journey (referral to discharge)

244. Feedback/updates, post meeting
245. FACE TO FACE COMMUNICATION. ALL RELEVANT PERSONS PRESENT AND TIME TO DISCUSS. DATA COLLECTORS WOULD BE ADDITIONAL HELP
246. Exceptional communication skills, good leadership
247. excellent team working. good administrative support and cover. team members who can effectively carry out actions and outcomes from mdt.
248. Excellent interaction/communication between core members, without interruptions, enabling reasoned discussion about treatments/interventions
249. Excellent communication between all members. Clinical nurse specialist teams asked prior to meeting about case presentation instead of been given this responsibility at the last minute. All core members, especially the ones presenting case history to have prepared prior to meeting so there is no confusion Pro active MDT coordinators who can help by providing summary of case history well in advance of meeting Video conferencing with tertiary centres If core member who is responsible for case presentation unable to attend then they should be responsible for finding a deputy to present their cases for them All core members to be present Skills of all members recognised and contributions welcomed and listened to. MDT coordinators to have more knowledge and adequate training for the specialism
250. Excellent communication between all members but especially via the lead. Regular team meetings as identified in the NICE IOG are key to ensuring that staff feel valued and not only allow for service and clinical updates to take place but also the opportunity to look ahead and plan future strategies. I also feel that MDT members should be given the opportunity to understand what money is available and how it will be spent. At the moment hospital managers and budget holders meetings are kept very separate from clinical staff. Yet it is the clinical staff and MDT members who can realistically identify gaps in services and shrotfalls in patient care.
251. Everyone understanding what is expected of the MDT and understanding their own contribution and no one profession dominating it
252. Everyone being aware of their responisibilities and being given adequate time to complete all the paperwork
253. Equality of members. Open discussion. Clear expectations of members.
254. Ensuring that all relevant information is available to have an objective discussion amongst professionals on the most appropriate treatment plan for individual patients, rather than simply reviewing histology and making decisions based on national/local guidelines
255. Ensuring all core members are in attendance, appropriate time is allocated to each patient and the discussion in not purely medically focused
256. Enough time, organisation, correct equipment for viewing histology and images. Attendance of core members. Strong clinical lead.
257. enough time, good communication, an mdt coordinator to access notes
258. encouragement, respect and facilitation for all to contribute
259. efficient organisation and preparation
260. efficient management co-operative working clear decision making
261. Efficient coordinator,all members present particularly surgeon who operated on said patient. Open mind and team always willing to review protocols.
262. efficiency and excellent communication
263. EFFECTIVE TWO WAY COMMUNICATION DESIGNATED LEAD OPEN CULTURE
264. effective team work and good constructive use of the coordinators time.
265. Effective lead, robust communication channels, respect for individuals contribution, understanding of roles of MDT members, agreed protocols and guidelines, multiprofessional descission making
266. Effective discussions around the treatment options as well as any psychological issues to take in to consideration. I feel it is important to have multidisciplinary discussions rather than just consultant-led discussions, which is what happens at most MDT's that I have attended

267. effective communication. Having all results etc available. Having a structure to the Meeting making sure of effective use of the people attending.
268. effective communication, valuing of all MDT opinions
269. Effective communication, MDT co-ordinator support, effective relevant dataset
270. effective communication within department
271. Effective Communication not only between core team members but with teams involved in the referral process
272. Effective communication both verbal and written on the designated proformas. Steamlining and timliness of information between referring clinician and the relevant MDT. Good feedback of information to relevant AHP eg. Macmillan nurse. Good communication with the patient/carer re. feedback of discussion and proposals.
273. Effective Communication between all team members
274. Effective communication between all members of the MDT. In put form all members acknolaged and listened to
275. effective communication between all members
276. Effective communication and teamwork, understanding of roles and boundaries.
277. effective communication and respect for all members views
278. effective communication and commitment, patient focused
279. EFFECTIVE COMMUNICATION
280. Effective and timely communication by all health professionals producing the best individualised evidence based care for the patient and family
281. efective team working, communication skills
282. Does what it says on the tin, decisions made and acted upon in a timely manner. All individuals valued and respected for contributions.
283. Detailed agenda good chair concise case presentation full attendance of key players
284. Designated time for the MDT. All members to be present at the meetings.
285. Decicision making, acknowledgement of variation of roles, patient centered care
286. Core professionals involved in the child`s care
287. Core members who are committed to attending and are willing to share or take on knowledge about their areas of practice
288. Core members and regular attendance Leadership/chair person to keep meeting flowing. Accurate recording of outcomes
289. core members and deputies to attend in their absence to ensure all information is available
290. core members all present and opinions all voiced to be debated if neccessary. Good presentations in terms of visual and hearing. Good accurate documentation of outcomes. Specifics of outcomes i.e actual surgery stated not just 'surgery'
291. contribution from all involved
292. Contribution and commitment from all team members
293. constructive discussion and effective problem solving
294. Consistent attendance and full participation of all core members.
295. Concise, efficient multi-disciplinary review of all cancer diagnoses
296. comprehensive referral, equality across specialty, adequate key membership
297. Compliance with attendance Inclusion of all members Adherence to guidelines
298. Complete team and efficient discussion
299. COMMUNICATION. RESPECT FOR EACH PERSON'S ROLE AND APPROACHABILITY OF THAT PERSON
300. Communication,Organisation.an effective chair
301. communication, organisation, timeliness of referral and monitoring, respect, professionalism
302. Communication, effective team working. Environment that all members can voice their opinion Patient's wishes are heard
303. Communication, communication, communication
304. communication!!! organised mdt cordinator
305. communication in an honest fashion willingness to bring cases evaluation of those cases brought

306. Communication between all parties
307. communication and respect for each others opinions and views
308. Communication and organisation of members
309. Communication & respect between all members of the team
310. communication Sense of purpose Clear aims/outcomes of meetings Willingness to involve pts in the MDT
311. Communication
312. commitment to attend by core members, support from MDT coordinator and IT systems that can communicate with other cross cutting specialities
313. Commitment from the members to assess, investigate, diagnose and reach an appropriate treatment decision in a timely manner. Also to refer on efficiently to an appropriate professional if required ie alternative tumour site MDT
314. Commitment and regular attendance at MDT meetings and business meetings, together with an effective MDT lead. An organised and efficient MDT co-ordinator, who puts mechanisms in place for tracking of patients, ensure appropriate cover in absence, and efficient request of scans/pathology for review. Aboveall, respect for each other's input and excellent communication skills by all members is essential
315. commen goals team work and support of each other in the best interests of the patient
316. Collecting & co-ordinating data well
317. Collaborative working with input of all members being valued
318. Collaborative working between team members Adequate time & resources Allowing everyone to have a say 'being heard'
319. Collaboration, sharing of information and timely tracking of patient pathway.
320. Collaboration and respect
321. Collaboartive working with the patient at the centre
322. cohesive teamwork mutual respect for all members
323. Cohesive team work, to effectively deliver care, treatment to patients
324. Co-operation between members; Real support from managers.
325. Close working of MDT members Agreed clinical and manaegment guidelines. Good organisation
326. clearly outlined action plans & good communication.
327. clear presentation of patients. Adequate time for radiologist to review scans clear plan of action that everyone can follow
328. Clear outcomes enabling patients to be given results confidently
329. Clear operational policy Commitment of members Mandatory attendance of core member/ deputy Clear record of decisions and decision making process
330. Clear leadership. excellent communication skills, liason with the cns who has an overview of patients whole journey
331. clear communication with coordinator and other team members.short lists and pertinent hcp at meeting. clear outcomes guidance.
332. Broad spectrum of specialist individuals with specialist knowledge
333. Best possible communication between all members. Consistency in planning and attendance. Patient considered as paramount
334. availability of concise clinical information to maximise treatment decisions, as well as a mix of health care professionals who are able to use their expertise in their own field to ensure that the patient is treated appropriately
335. attendance, team working, contribution from each member valued,
336. Attendance, Communication,Clear presentation of cases. environmentally comfortable. courtesy when case being presented, being able/allowed to input when required
337. attendance of key members
338. Attendance from all specialities. Good communication, freedom to speak Evidence/research based treatment
339. Attendance from a wide range of core disciplines involved in the patient's care. Effective IT provision to allow VTC, viewing of images and pathology. Well co-ordinated and organised with everyone present feeling their opinion/ input is

valued and worthy.

340. As much relevant information as possible good timekeeping/punctualness- effective chair sharing of information expertise agreed outcome & plan of action feedback & outcomes annual operational review
341. Appropriate timing of patients put on MDT, with all tests completed and results present.
342. Appropriate submission of patients. Adequate information. Contribution from all team members. Clear decision making and documentation.
343. Appropriate staff attendance. willingness to get to a decision.
344. Appropriate referral, persons present who know the patient. wide range of specialists
345. appropriate patients for discussion, discussed in a timely fashion with clear cut management decisions
346. An open forum where all members are listened to and evey aspect of the patients care is looked at.
347. An MDt made up of professionals who respect each other as people aswell as respecting individuals clinical knowledge
348. An involved and active group that is led by a focused and visionary leader
349. An efficient, friendly and cohesive group without hierachy.
350. An efficient and organised MDT Co ordinator
351. An effective MDT should ensure that patients are commenced on the appropriate treatment path (if applicable)in a timely fashion.
352. An effective MDT is the core member meeting on a regular basis to discuss the pathway for patients. All members are treated respectfully and aim to provide an internationally recognised service/outcomes for patients with cancer
353. An effective leader.
354. An effective co ordinator. regular attendance and input from core members. Adequate support for local M.D.T and video conferencing M.D.T from management when C.N.S on leave, ensuring cover and function of M.D.T and decision making.
355. An atmosphere in which all members of the team feel able to contribute without feeling threatened.
356. An appropriate group of clinicians who are committed to the work of the MDT supported by the correct level of administration and data collection staff. A high level of professional respect for all MDT members is esential with each being open and honest about their work practices/opinions
357. all present and a good coodinater,
358. all patients discussed so they receive the most appropriate care. All disciplines represented
359. all patients being discussed in a timely manner and a discussion amongst specialists so that the patient is offered the optimal treatment choice
360. All patients are discussed with relevant imaging and histology on diagnosis, post operatively. on relapse ,difficult senarios for discussion and that all core members are present including AHPs
361. All mulidisplanary team working togeather,with effective communiction from everyone
362. all memebers feel they are able to contribute and have a voice
363. All members wsorking in the best interests of the patient and respect for each others opinion
364. all members understanding their role and others roles, all members taking responsibility and accountability for making the mdm effective. Having a designated lead who leads, also all other members actively contributing to the team and the MDMs.
365. All members present at meetings, Correct patient selection. Effective and quick decision making. Notes and radiology films/reports available
366. All members ofthe team meeting to discuss the patients from all aspects of their care
367. all members of the team for common purpose and with the patients best interests in mind

368. All members of the MDT working together giving the patients the same advice after discussion on treatments
369. all members having a specific role
370. All key members having an equal say in the management of a specific group of cancer patients. All patients diagnosed with a cancer are discussed at a MDT to ensure best care delivery.
371. All interested parties in a room together with all investigations available to make a joint decision about the patients care.
372. All core team members attending. Clear decisions and open discussions on treatmant plans
373. All core members present. Clear patient presentation. Summary of discussion at end of each patient. A chair for the meeting.
374. All core members contributing to discussion - all pt's newly diagnosed are discussed and treatment plans formulated
375. All core members being present at the MDT and good communication
376. Administratively well-supported. Regularly attended by core members to aid support multidisciplinary philosophy. Outcomes of MDM should be communicated to appropriate people.
377. Adequate facilities /resources. Good timekeeping. Having a lead person to direct the meeting and keep to the agenda. Having a supportive, approachable team with the same goals for improving patient care & continuity. Identifying the person who will chase reports / contact, support & inform patients / book appointments etc.
378. Active discussion about treatment decisions involving all members of the team.
379. Accurate patient information and data. Committment of all team members to attend and contribute effectively. Process is seen as effective with improved outcomes for patients/relatives and HCP's
380. A wide range of disciplines and effective communication. Also to value each members input and their views. To maintain confidentiality at all times.
381. A wide range of clinicians and AHP's meeting on a regular basis to discuss and formulate treatment plans for patients based on holistic assessment of the patients needs and on treatments that are evidence-based
382. A well coordinated and commited multi professional team that meets weekly. this team gives prompt advice and clinical management plan.
383. A timely group decision on patient cases of cancer and an action plan startedfrom that day
384. A team who work well together, who have an effective MDT lead.
385. A team who discuss honestly the patient's condition and results and ensure that a good plan of action is in place during the meeting.
386. A team who are open to everyones opinion
387. A team where everyone's contribution is valued and robust decisions are made
388. A team that respects each other and communicates effectively.
389. A TEAM THAT CAN COMMUNICATE DISCUSS AND RECORD OUTCOMES
390. A team of relevant professionals who all have input to decide optimal patient care together
391. A team of experts with upto date knowledge of specilaist area using evidenced based guidelines to inform best management for the patient's care.
392. A STRONG CHAIR. AKNOWLEDGEMENT OF ALL MEMBERS OF MDM INPUT
393. A reliable, flexible, pro- active and dynanic, good organiser and commuincator MDT co ordinator.
394. A multi-disciplinary attendance, with the views of all members taken into consideration, and good planning of action followed after MDT
395. A minimum of apparently pointless box ticking. A core membership that believes in the principals of MDT working and who respect each others view point. IT hardware & software that is fit for purpose. (simple & not too time consuming to use or pre populate)
396. A meeting with the relevant people, with good admin support, chaired effectively. Use of teleconference to reduce travel
397. A meeting with all the core members present. To discuss the pts with or potential

diagnosis of lung cancer/meso so that decisions re investigations and treatment can be made

398. A meeting of all professionals involved in planning patient care
399. A MDT which has all the appropriate core members attending, with designated cover. A MDT which adhere's to referral protocols.One which allows input from all core members.Good communication between centre and unit/locality MDT's.
400. A identifed lead of meetings either surgical or medical who is assertive without being domineering. Excellent communication skills. Availability of medical notes, radiology and pathology. Suitable enivronment and functioning technology.
401. A group of people who COMMUNICATE with each other to ensure the best care for each patient
402. A group of individuals who are knowledgeable in the specialist field who are open minded and upto date with current practices, who feel comfortable to express opinions and are acting in the patients best interest.
403. A group of health professionals with an agreed aim and purpose working with the patient's best interests in mind. Well informed and up to date individuals - all team players.
404. A good variety of members that turn up each week and contribute freely
405. a good team, reliable, who take time and do their preparation
406. A good lead clinician Teamwork Mutual respect Adequate knowledge regarding tumour type and treatment
407. a good coordinator and mdt team
408. A good chair to keep discussions direct and ensure everyone has in put. The MDT should have all members arriving at the start and not frequently attending late. Interupptions should be minimised. Images should be available electronically with a Radiologist that is prepared to review the scans (or to have reviewed them prior to the meeting) Members presenting patients should be aware of the facts around the case and present in a logical manner detailing what the 'clinical question is, or reason for discussion'
409. A FULL COMPLEMENT OF CORE MEMBERS WHO ALL RESPECT EACH OTHERS OPINION
410. A full complement of all the different disciplines involved in the patient pathway so that decisions can be made there and then
411. A forum of Health Care professionals and support team in open discussion to use best practice in determining the best treatment options available in the best interests of the patient to choose what suits him/her best.
412. a forum for an open dialogue and review of patient care requirements which may be contributed to by any professional present.
413. A dedicated co-ordinator and attendance by ALL team members on a weekly basis.
414. A concise and effect discussion of a patients relevant tests, investigations, with all HCP's involved in that patients care present.
415. A cohesive team of core members, working to agreed guidelines and protocols, with a strong lead clinician.
416. A cohesive multidisciplinary team where communication is essential and each core member is considered as equal in standing.
417. a chance for all pts on treatment and off if applicable, to be discussed to enable sharing of information between HCP to ensure patients and their family recieve the best care available to suit their needs. to share policy and proceedure news, feedback on meetings/study attended. to allow each member of MDT to feel part of a team where they are valued .
418. a balanced professional attendance to ensure the patients discussed get an equal and fair treatment plan. good information ie: patients notes to ensure the approrpiate treatment options and that the person presenting the patient has met the patient
419. 1.Frequency of meetings - need to be frequent enough to allow timely discussions of patients. 2. Each core member to have protected time to attend MDTs 3. Each member to contribute to discussion 4. Effective communication between members 5. Adequate technology if teleconferencing required. 6. Each member to be clear about their responsibilities. 7. Regular review of MDT to identify areas

for improvements and/or good practice.

420. 1. Appropriate numbers of patients for discussion in the time allocated. 2. Effective use of time 3. All results being available for MDT 4. All memebrs of the team attending 5. A lead clinician clarifying the outcomes for each patient 6. Suitable venue and equipment

The team

What qualities make a good MDT chair/leader?

266 nurses responded to this question. In addition, 5 nurses referred to the criteria in Q35 ("as above").

1. works well with coolegues having clear shred goals
2. work co-operatively and have good understanding of the MDT
3. well respected and good communicator
4. Well organised and diplomatic
5. Vision, clinical credibility, team player who values others and champions the bext car for the patient.
6. Understands the role of all members. Keeps control of the meeting ensuring all patients are given adequate discussion time. Defers items not appropriate to the clinical MDT meetings to be discussed at an apprpriate forum (Site Specific Meetings for example)
7. Understanding of the role of the mdt and ability to facilitate discussion without any one team member dominating Ability to put patient at the centre of discusssion
8. understanding of good team management and communication
9. Timely and effective management of an often noisy gruop who all have opinions!
10. time management, effective communicator,
11. think all are equally of highest importance
12. Team player Up to date knowledge Communications skills Ability to listen to all opinions
13. Team player Approachable.
14. team building, acknowleding all input creating learing environment
15. SUPPORTS THE VIEWS OF ALL TEAM MEMBERS
16. Strong transformational leadership skills
17. strong people management
18. Strong organisational character. Time management
19. Strong character Good communication skills Principled Respectful & respected
20. Speaks clearly and takes the lead
21. sound communication, ensuring a timely meeting is maintained
22. Someone with clear idea of what is to be achieved, good chair, keeps meeting ordered and moving forward.
23. someone with an air of authority, clarity of thought, no oversized ego
24. Someone who is strong enough to keep the meeting flowing without going off on tangents and wasting time.
25. Someone who has access to all information, and has good communication skills.
26. someone who ensures all members of the team are able to contribute. keeps the meeting on focus,intervens in disagreements. sets objectives at the annual review meeting which the team agree with and review regularly.
27. Someone approachable, who will listen, take objective critisism
28. some one with good communication skills, managment and leadership skills.
29. Some one who is an expert in that particular field with good communication skills.
30. Smooth running of the meeting Keeping time and allowing shared decision making Respect fromm all core members
31. Respectful/Knowledgeable/Organised/Excellent communicator,team leader,role

model.

32. Respected, able to take team with him and allow other members of the team opinions.
33. Respected by group Able to act on Decisive clear communicator
34. Respect of the MDT. Clinical credibility. Leadership qualities. An ability to challenge.
35. Respect from their peers
36. respect from other members of mdt and their knowledge. Ability to acknowledge all views and communicate effectively
37. Respect for each team member. Able to manage people.
38. respect fairness
39. regular attendance, good listener and communicator
40. punctual, respected, good communicator, efficient, reliable.
41. Pt centered and good communication skills
42. Professional, relaxed, good communication
43. Professional manner / behaviour Held in respect by members of MDT Crowd control skills! Ability to ensure meeting follows schedule Ability to negotiate disagreement
44. personable
45. Person with the best communication and leadership skills
46. person able to communicate effectively between all team members
47. Patience, organisation and ability to prioritise discussions, decision-making.
48. Patience, good communication skills, leadership qualities
49. ORGANISED/ ABLE TO 'CONTROL'SOME MDT MEMBERS AND INVOLVE OTHERS WHO ARE LESS VOCAL.
50. Organised. Good communication skills. Listens to members views. Ensures agreed clinical guidelines are followed
51. organised, well respected, clear and logical, good communicator, respects others views
52. Organised, impartial, assertive.
53. organised, calm, efficient
54. organised, approachable, knowledgeable, fair, good listening skills, passion for quality and excellent patient care
55. Organised respected by colleagues
56. organised
57. organisational skills, good communication skills, knowledge of patients diagnosis
58. organisation and ability to listen to what is being said
59. Oragnised, team player, good comunication skills, ability to delegate.
60. Open communicator Flexible, patient, open, honest and passionate. Someone who actually does what they say they are going to do
61. One who encouragees all to give their opinions, not one who dominates the discussion, or summarises for others rathe than let them speak for themselves
62. One who can keep the meeting timely and all peoples thoughts are heard especially the person acting as the patient advocate
63. one who can communicate effectively, who will listen to colleagues re decison making, one who sumarises a case so we all know what the plan is.
64. Objective, good listener and can conclude the mdt discussions, and move onto the next patient.
65. Mutually respected, good communicator, calm, able to summarise effectively and promote good decision making.
66. Must be organised and an effective communicator
67. make sure everyone is awake
68. Listens to all opinions, stops people straying from the topic
69. Listening to all views
70. Listening skills Time management skills Strength of character Personable Objective Fair Good communication skills People manageing skills
71. Listening and organisational skills. Communication

72. Learership, excellent clinical knowledge, excellent communication skills
73. Leadershp & management skills
74. leadership, good communication skills,organised,knowledge of disease and evidence base
75. leadership, advocacy, respect, communication, fair - facilitating full participation of all members, educator
76. leadership skills, good understanding of subject
77. leadership skills, good communication
78. Leadership of team, time management, communication, approachability,
79. Leadership Sound clinical knowledge clear objectives
80. knowledgeable, organsied, good with admin
81. KNOWLEDGE,LEADERSHIP
82. knowledge,good communicator,organisation and assertiveness,team player
83. Knowledge, excellent communication skills,
84. Knowledge, approachable, listener
85. Knowledge of subject and good interpersonal skills
86. Knowledge of patient and treatments
87. knowledge based and leadership skills
88. knowledge & ability
89. KNOWLEDGE COMMUNICATION SKILLS
90. Knowledgable, Good communication skills
91. knowledgable on speciality, good leader, good communicator, able to summarise
92. Knowing the team well. Understanding how your own particular system works
93. Keeps focus on patient and summarizes outcome at end for agreement
94. KEEPING THINGS CONCISE AND RELEVANT.pRIORITIZING CASES.
95. Keeping the meeting in order and running to time. Someone who does not want to impse their view on to all other members
96. Is aware of what is expected from them, stick to the agenda, had good time management skills, has clinical background and expertise to be the leader. Is clear, concise and approachable.
97. Involving all members of the team. Summarising the treatment decisons. Time management
98. Interest and knowledge
99. INCLUSIVE - ABLE TO FACILITATE A GROUP
100. I suspect medics would not accept a non medical chair. The person with the requisit skill should chair the meetings. The chair doesnt make the decisions the chair chairs!
101. GSOH, quality communication skills, empathy, sound knowledge of topic
102. Good understanding and knowldege of colorectal cancer, approachable, excellent attendence, believes in the role and value of MDT
103. Good training and preparation.
104. Good timekeeper
105. good time keeping good precis skills ability to sum all views expressed make sure coordinator knows what the decision was!
106. good management skills
107. GOOD LISTENING SKILLS WITH GOOD CLINICAL KNOWLEDGE AND HOLISTIC APPROACH
108. good listening skills and communication skills
109. Good listener, respects others opinions,good leader
110. good listener, clear communicator,able to make descisions with team and on own. high level of knowledge on tumour site and peer review
111. good leadershoip, regular attendance, experience
112. good leadership skills
113. Good leadership qualities and respect for team members
114. good leadership effective communication skills
115. good leadership and communication skills. Organisation skilss and diplomacy

116. Good knowledge of treatment available and evidence based care
117. good knowledge base, able to direct the team, able to keep team focused
118. Good evidence based decision making. Fluent and consistent. Listens to others input.
119. good communicator, team player and respects colleagues decisions
120. Good communicator, organised, approachable Knowledgeable
121. Good communicator, motivated, ensures all ontributions are listened too.
122. good communicator,
123. Good communicator and have respect for other members
124. Good communicator Acknowledges every persons contribution Ability to ensure consensus decisions are made
125. Good communicator
126. good communicator
127. good communicator
128. Good communicator - takes the lead to keep the discussion succinct and summarised for the MDT Co-ordinator.
129. Good communication/listening skills. Thorough understanding/knowledge of treatments and their management
130. Good communication/ presentation skills including listening skills to facilitate an effective discussion.
131. Good communication. Engaging.
132. good communication skills/leadership skills
133. Good communication skills. Value each member's contribution. address conflict. Organise business meetings.
134. good communication skills,diplomatic ,Focussed, priortorise, good time manager, team player,recognise importance of input all MDT members
135. Good communication skills, visionary, respect for and of others. Good timekeeping, addresses MDT issues so they are resolved
136. good communication skills, time management
137. Good communication skills, the ability to move the discussions forward and professional skill with respect for all members of the MDT.
138. good communication skills, someone who is ocused on patients, strong leadership qualities and who is able to challenge
139. Good communication skills, respect for team members, assertiveness
140. Good communication skills, able to maintain order and steer meeting to time, avoiding digression.
141. Good communication skills, able to encourage other members to participate and value opinions of others. Remains the patient advocate.
142. GOOD COMMUNICATION SKILLS,
143. Good communication skills and efficiency
144. Good communication skills and approachability
145. good communication skills and acknowledging skills of all MDT members Valuing all members
146. good communication skills good time management skills
147. Good communication skills Good leadership skills
148. Good communication skills Able to deal with others with strong views organised
149. Good communication skills
150. Good communication skills
151. good communication skills
152. Good communication and leadership
153. GOOD COMMUNICATION
154. Good communication
155. good communication
156. good communication
157. Good communiaction skills. Effective leadership skills.
158. good chairing skills. expert knowledge
159. Focused, good working relations with all, values opinions of all members, can

bring meeting to order quickly.

160. focused time manager
161. focused , pt centred approach
162. Focus, time managment, assertiveness
163. focus on time constraints and curtail members going off on tangents with unrelated topics.all comments form members should be treated equally
164. Firm but Fair
165. fairness respect
166. Fair, respected for their clinical skills. Clear thinking and able to see the trees not the woods.
167. Fair, non judgemental,
168. Experience, knowledge and knowing when to politely move on
169. Experience within the specialty .Professional respect from all MDT members Common sense approach. The ability to listen and apprecaite others point of view Organisation
170. experience and respect of other members
171. experience and knowledge
172. experience / good communicator
173. Excellent communicator. Good time management and leadership skills. A thick skin.
174. Excellent communication skills, respected by rest of team, approachable
175. Excellent communication skills, consistency, value all team members contribution, commitmnet to the role
176. Excellent communication skills, calm approach, tenacity, sense of humour, assertiveness, organisational ability, clarity of thought, reliability
177. Excellent communication and interpersonal skills, Values skills and attributes of all members
178. Enthusiastic, knowledgeable, good communicator,
179. ensuring everyones opinion is heard
180. Ensure team keept to time, keep to topic and ensure mutual respect
181. Ensure good flow of meeting All members views are heard Promotes effective discussions
182. encouraging all core members to participate and value all contributions
183. effective communicator approachable keep meeting to time
184. Effective communicator
185. Effective communication skills Can lead discussions Supprt speakers and efficiently run the meetings in a timely fahion
186. Effective communication skills
187. effect communication skills experience
188. effecient, listen to everybody but also able to move the team on to the next case to get through the workload.
189. Direction and time management Plus should as non medical staff if there is anything additional that needs to be covered
190. Diplomacy,assertiveness,effective communication and knowledge
191. Diplomacy
192. democratic leadership style non-threatening polite respectful
193. Decisiveness; knowledge & experience;people management skills; openess, diplomacy. honesty, confidence, Must have the professional respect of the team and their support within the role. Must demonstrate strong leadership without being dictorial or altocratic.
194. constructive feedback
195. confident, non confrontational, good communication skils
196. Confidence,eloquence,assertiveness,likeability,shares teams objectives
197. Confidence, organisational skills,
198. communicative skills strong leadership
199. communication, coordination, leadrership and taking control of meeting
200. communication skills, knowledge and experience dynamic leader

201. Communication skills and subject knowledge.
202. communication and time management
203. communication and organisational skills
204. Communication ,time management,interpersonal skills
205. Communication
206. committed, respected, supportive
207. Commitment, responsibility organisational skills. Assertiveness to move the meeting along if deviating. Delegation of duties.
208. commitment, enthusiasm, drive
209. Commitment to the role
210. Coherent, concise
211. Clinical experience, respect for other professions, good communicator
212. clinical experience and expertise. confident in controlling group
213. clear direction, following shared decision making
214. Clear consise presentation/communication skills. Ability to ensure order within a room.
215. Clear concise communicator who is focused and able to chair the MDT to allow appropriate discussion enabling informed outcomes. in which all members are able to contribute.
216. Clear and succinct Disciplinarian Promotes fairness in allowing all to communicate
217. Clear and relevant presentation of patient. Good time and case management skills. Articulate and encouraging participation].
218. Clear / Consice / Good time keeper / Values contributions of team members
219. Clear objectives adherence to time. Allow all team members to take part and have equal value.
220. Clarity of vision Awareness of the MDT purpose
221. Charismatic, able to engage team members. Able to steer meeting to achieve objectives
222. calm, good organiser, timekeeper, respected,
223. calm, assertive,
224. bringing team together
225. Authority, experience, patience direction
226. Assertive, fair, good communicator
227. ASSERTIVE CLEAR DIRECTIONS INCLUDE ALL MEMBERS LISTENING SKILLS
228. Assertive and fair
229. Assertive and decisive
230. articulate/good communicator knowledgeable in the subject and the other member's roles
231. Articulate Focused Concise objectives Good time keeping Good communicaton skills Efficiency in reporting outcomes Good leader in discussions Diplomacy skills Ability to speak clearly and guide members opinions to assist decision making Ability to summarise and confirm treatment plans
232. approachable,good communicator, assertive
233. approachable, precise
234. Approachable, open to opinions from all professional groups, focussed, experienced in their field of care provision
235. Approachable, fair. Sound, up to date knowledge which reflects evidence base. Dynamic. Committed to the highest quality patient care.
236. Approachable, democratic, tactful, good desicion maker
237. Approachable Interpersonal skills Good communicator Listener
238. Approacable, fair. Good communication skills. Able to ensure smooth running of MDT. Good time-keeper. Listens to all sides of a discussion.
239. Appreciation for others, thinking about and checking if they are happy with the meetings outcomes
240. Alows debate,a nd includes all members. Stops arguments effectively.

241. Allows equal voice from each MDT member, ability to precis discussion in order to ensure clear mgt decision
242. acknowledge contributions from all. ensure actual decision is specific and documented. establish how this will get to the patient
243. Accessable. Organised, can hold a team together. Encourages team participation. Always has patient interest. Timely.
244. able to steer the group so that it doesn't veer off at a tangent
245. Able to manage personalities within the mdt
246. Able to maintain order and ensure each member is listened to. Good timekeeping and that decisions are made in the best interest of the patient
247. able to listen, summerise views expressed and move meeting on if needed
248. Able to ensure that the meting runs smoothly and moves it along to ensure that each patients case is discussed fairly.
249. Ability to move through cases thoroughly and ensure full discussion without digression.
250. Ability to listen to all contributions and summarise decisions.
251. Ability to keep the meeting relevant. Summarise decisions & ensure the appropriate personeel know what their role is
252. Ability to keep others focused
253. ability to involve team members and recognise contributions, assertiveness
254. Ability to focus members and keep discussion to the point.
255. Ability to ensure cases are discussed in clear, concise way. Able to move meeting on appropriately
256. ability to encourage all members to be respected and views acknowledged
257. Ability to control a meeting and those involved, plus to ensure everyone is allowed to have an opinion and feels valued.
258. A willingness to be objective and consider alternative views of the patient and MDT members
259. A willingness and ability to ensure smooth,effective running of the MDT.
260. A team player who is also confident in their leadership role
261. a respectful individual who is objective and yet assertive if required
262. A respected health care professional with good communication skills who is well organised and encourages input from all other members of the meeting.
263. A leader needs to be firm but fair, and able to challege negativity. They need to be respected by their colleagues.
264. A good team player who values its members equally. Needs to be respected by other team members. Has natural authority whilst remaining approachable. Has a good knowledge base of the subject and requirements needed by an MDT on a national, local and patient centered level. Needs to be a decisive, clear communicator and patient all at the same time.
265. a good secretary! availabilty, time assigned for the role good communication skills
266. 1. Effective communicator 2. Knowledge, patience and focus 3. Well orgainised

What types of training do MDT leaders require?

206 nurses responded to this question.

1. Workshops, leadership courses.
2. Use of technology, communication skills.
3. Unsure
4. unsure
5. treatment updates
6. Training with regard to chairing a multiprofessional meeting.
7. TRAINING TO FULLY UNDERSTAND THE ROLE AND THE OBJECTIVES OF MDT
8. training re peer review expectations for the chair
9. Training in leadership skills
10. Training in charing meetings; training in people management skills; traing in organisational skills; training in report writing.
11. To ensure we are all working to a national standard. Some negotiating skills as there will be occasions when people dont agreee.
12. time management, preparation of mdt
13. They need to know the value of an MDT meeting. Have a better knowledge of why patients are discussed at the meetings. Be trained to be more pro active within the meetings.
14. Team Leadership
15. Team building, how to get people on board and participate and take responsiblity for MDT activity. Influencing and assertive skills for above plus to aid service development. Time management as this is a very time consuming (if done correctly) activity that is added to the work load that exisited prior to MDT's existing. Service development or networking opportunities; how do others do things, what can can I learn from others?
16. specific as above [referring to Q35]
17. Probably to stay focused and achieve results in an efficient but effective manner.
18. Prior experience of chairing meetings and a good sound knowledge base of the diseases that are being discussed.
19. Practical and accademic skills
20. People skills and how to chair a meeting.
21. people managing, mdt working
22. our whole MDT core members have attended 3 x2day courses together. 1 on decision making as a team 1 on clinical trials and 1 on TEMS for rectal cancer
23. OUR MDT LEAD HAS RECEIVED NO TRAINING RE THIS
24. organisational
25. Not sure.
26. Not sure that they do need training
27. not sure of this
28. NOT SURE
29. Not sure
30. Not sure
31. not sure
32. not sure
33. None if clinically and medically competent/ vocalising opinions
34. None
35. None
36. most have required skills without additional training
37. Meeting Management. Communication skills Some IT skills are desirable. Good people skills though this is hard to train for.
38. medical/nurse training advanced communication skills IT
39. Medical

40. Managing themselves / managing a meeting / Team building
41. Managing people and performance
42. Management/leadership programmes
43. management, communication,
44. management training, communication training
45. Management training including, effective decision making and advanced communication skills
46. Man management skills Organisation & timekeeping
47. Ledership and communication skills
48. Leadership. Improving outcomes update
49. Leadership.
50. Leadership.
51. Leadership, listening skills and effective communication
52. Leadership, communication, using electronic records!
53. leadership, communication and management training
54. Leadership, assertiveness training
55. Leadership skills. Meeting skills.
56. Leadership skills. Chairing a meeting.
57. leadership skills, meeting skills
58. Leadership skills
59. leadership skills
60. leadership in chairing meetings and keeping order whilst allowing others to contrbute
61. leadership and meeting skills
62. leadership and communication skills
63. leadership and communication skills
64. leadership and communication skills
65. Leadership and communication
66. leadership , communication skills
67. Leadership Communication
68. Leadership
69. knowledge of CWT
70. its not rockett science -its just common scence-all shuld know-we all are adult and have expertise-some one have t chair to manage the time-we have fantastic chair and he didnt had any training as such-
71. IT. Assertiveness training, communication training. chairing a meeting training
72. is there any?
73. Interpersonal skills training, leadership skills. Time management.
74. Interpersonal and communication skills training management and leadership training Conflict resolution training
75. I think it it is a skill aquired through practice.
76. I have done the 3 day Advanced Communication Skills Training and found it invaluable. They would greatly benefit from an enforced attandance!
77. I feel they need to be able to communicate and have experience in their field.
78. I don't know but they need some!
79. How to take control and formulate outcome in clear manner
80. how to remain focused, witness other mdts and recieve feedback on theirs
81. how to lead a meeting How to value each member and demonstrate this within the MDT setting How to resolve conflicts within meetings
82. How to control disruptive members of the team. Timekeeping skills to ensure smooth running of meeting and no over running of meeting.
83. How to chair groups
84. How to chair a meeting, advanced communication skills
85. How to chair a meeting and handle surgeons' training.
86. How to chair a meeting Communication skills
87. How to chair

88. How ot communicate in difficutl circumstance and crowd control! Ensure all members stay on task and do not get distracted by irrelevant information
89. Have clinical training. Communication skills. Training on management and leadership.
90. guidelines, current up to date info, changes in protocols, trial info
91. Group working Advanced communication skills
92. Good Presentation & communication skills Ability to stay focused on the intention to offer the best possible care
93. good management skills
94. good communicator, leader
95. Fully aware of disease area / guidelines. Management skills
96. Effective communication skills. Thorough understanding of the cancer targets etc.
97. Effective Communication
98. don't know what is available
99. don't know either they got what it takes or not to be a good leader.
100. Don't know
101. Don't know
102. Don't know
103. Do you mean co-ordinators. They need to understand basic medical terms and have the confidence to ask if they do not understand.
104. database
105. communications training 'chairing a group' training
106. communications skills
107. Communications
108. Communication/diplomacy skills Chairmanship training Team management skills Recording/summarising training Knowledge of Cancer Plan and Tracking Liaising/meeting with all core members
109. Communication/ leadership
110. Communication. Team Management. Knowledge of the pt journey pathway. Knowledge of the wider MDT process-ie booking of imaging requests.
111. communication, need to be clinicians to lead MDT
112. Communication, leadership.
113. communication, leadership, decision making skills
114. Communication, leadership
115. communication, indepth knowledge of subject
116. Communication, conflict resolution, diplomacy, time management, team leading, roles of MDT memebers and needs with regards to MDT
117. Communication, audit, leadership, organisational and time management.
118. Communication,
119. Communication training. Managing People training.
120. communication training
121. Communication training 'Chairing / organisational' skills
122. Communication skills. Leadership
123. Communication skills. Conflict management
124. communication skills,organisation skills,time management and assertiveness training.
125. communication skills,management skills
126. communication skills,assertiveness
127. communication skills, upto date knowledge re: treatments/options for patients
128. Communication skills, team building, peer review system
129. communication skills, management skills, meeting chairing skills, knowledge of Peer Review cancer standards
130. Communication Skills, leadership and management
131. Communication skills, how to chair a meeting, leadership skills
132. Communication skills, clinical decision making skills, conflict management awareness and skills, knowledge of organisational 'things' which have a bearing

on the clinical management of patients. People skills
133. Communication skills, although not ours!
134. Communication skills training MDT training programme
135. Communication skills training
136. Communication skills training
137. communication skills training
138. communication skills time management etc
139. COMMUNICATION SKILLS MOST IMPORTANT
140. Communication skills including listening leadership skills
141. Communication skills Use of equipment e.g video- conferencing, PACS
142. communication skills teamwork skills
143. Communication skills Peer supervision Regular updates re: latest body of evidence
144. Communication skills Organisational skills Interpersonal skills
145. communication skills Managing meetings Effective time management
146. Communication skills Leadership skills Team working skills
147. Communication skills Leadership skills
148. Communication skills Conflict resolution!
149. communication skills chairing tuition leadership advice
150. Communication skills
151. Communication skills
152. Communication skills
153. Communication skills
154. Communication skills
155. Communication skills
156. communication skills
157. communication skills
158. communication skills
159. communication and leadership skills
160. communication and informed consent of the patient
161. Communication and facilitation training.
162. communication and diplomacy as well as assertiveness
163. communication managing the process
164. Communication Leadership
165. communication and facilitating skills
166. Communication
167. Communication
168. communication
169. communication
170. communicaition skills Interpersonal skills time management skills
171. commmunication
172. commincation, time managment
173. chairperson skills are important
174. Chairing meetings Leadership
175. chairing meetings
176. chair training
177. basic leadership skills
178. Assertiveness training
179. Assertiveness skills!
180. assertiveness and people management skills
181. Ascertiveness
182. As it would need to be a senior clinician, should have well developed leadership skills already
183. AS above [Q35]
184. Are leaders born or made? Awareness of responsibilities, leadership skills training

185. already trained to lead this type of meeting
186. advanced skills in managing meetings
187. Advanced communications and specialise in key area
188. advanced communication, LEO course
189. advanced communication training may be an advantage
190. Advanced communication training
191. advanced communication skills, time mangement.
192. Advanced communication skills training
193. Advanced communication skills training
194. advanced communication skills training
195. advanced communication skills !
196. Advanced communiation skills
197. admin training, medical knowledge
198. a knowledge of the MDt proforma, expectaions of them
199. 1. Communication skills training
200. ?SPECIFIC TRAINING REQUIRED, A KNOWLEDGE OF WHAT IS REQUIRED AT A MDT
201. ?communication
202. ?assertiveness training in some cases communication skills training if necessary
203. ?? what is available
204. ?
205. ?
206. ?

What makes an MDT work well together?

262 nurses responded to this question.

1. Working towards the same goal Shared perspective, efficient communication
2. working towards common guidelines, good relationships between members
3. Working together, and sharing views. Making sure the patient's needs come first.
4. working together with same agenda for the well being of the patient
5. Working on the same site
6. working as a team with a patient centered focus
7. when members opinions are equally valued
8. When all members are prepared to listen and to be constructive when there is conflict.
9. well prepared ,well attended by core members Time for discussion
10. Well balanced team dynamics
11. views of all members valued and acknowledged
12. very repetetive question,sorry
13. Varied experience and listening to each other.
14. valuing each contributer to patient care
15. valuing all core members and including them this is particularly aimed at consultants who sometimes manage the mdt on their ego alone
16. Value each other, expert knowledge/opinions
17. understanding of roles, attendance good communication skills
18. understanding and professional respect for each others roles
19. Trust in each other Allowing people to have an opinion Listening to each other
20. Trust between members.
21. Trust Knowledge of patients
22. Tolerance and putting patient centred care first
23. Time/knowledge/communication
24. The willingness of the team to look on and reflect, what is going well, what is'nt working.

25. the team working together
26. The respect of all the members of the team for each one's role in the patients treatment, an openness that questioning is fine, that it is a learning environment and their will be indivuals who need support
27. the members of the team recognising the value of the contribution of others
28. the co-ordination of decisions from that meeting
29. That there is interprofessional respect with regard to the valuable input to the decision making, & clearly defined roles
30. that the pt is at the centre of everything and every one feels the same
31. that all members put the patient first and respect the patients wishes, often this is overlooked
32. Teamwork and communication
33. Team working
34. Team work, team players
35. Team work and communication and respect
36. Team work and all helping in obtaining information & tests together
37. team spirit and beeing nice to each other
38. Strong leadership.
39. Strong leadership who promotes effective communication between members. A clear operational policy which has been constructed with involvement from core members, agreed upon by members and regularly reviewed thus promoting shared common goals and working practices. Discussion of all patients to foster an environment of transparency which supports clinical supervision and governance. Active educational framework which values contributions from members and promotes professional development.
40. Stong leadership. Respect amongst members for each other. A feeling that your input is valued. Common goals and objectives focused on clear quality outcomes.
41. Sharing a common goal Good communication Regular business meetings Educational programmes
42. Shares common views and perspectives
43. Shared sense of purpose
44. Shared opjectives Good chairmanship Good multi-disciplinarary team working
45. Shared interest and safe enviroment
46. Shared goals and objectives
47. Shared goals Patient centred care
48. Shared goals A desire to provide the best possible paitent care
49. same as previously stated good co ordinator is essential
50. rspecting others opinions
51. Respecting each others input
52. Respect. Caring about team & patients. Sharing information. Ongoing study / education of team members
53. respect, listening, speaking clearly, acknowledgement of people's views, friendly, calm,
54. respect, cooperation and give each time member acknowledgement for input
55. respect of team members for one another
56. Respect of others views. Pt care!!!!!
57. Respect of all members
58. respect of all individuals
59. respect for views. having agreed protocols re: patient management
60. Respect for views and knowledge of each other
61. respect for others roles and views, good communication between members
62. respect for others opinions. listening skills
63. Respect for others opinions, grades, abilities
64. respect for one another. listening to one another. having the patients best interest as the main focus
65. Respect for one another. All taking responsibility for their patients
66. Respect for one another and for other views and opinions.

67. Respect for individual members.
68. Respect for individual member's views
69. RESPECT FOR EVERYONES ROLE WITHIN THE TEAM
70. respect for eachother and the patients
71. respect for each others views, remember the patient is the priority
72. Respect for each others specialities / experience and opinions.
73. Respect for each others roles,knowledge and opinions
74. Respect for each others opinions, good communication
75. Respect for each other and a common goal
76. respect for each other organisation preparation
77. RESPECT FOR EACH OTHER
78. Respect for each other
79. Respect for each other
80. respect for each other
81. respect for each members contribution, knowledge and experience, communication, acknowledgement.
82. Respect for each member. Effective communiation.
83. Respect for each individuals role and contribution. OPen discussion.
84. Respect for colleagues and the ability to voice oppinion.
85. RESPECT FOR COLLEAGUES VALUING OTHERS VIEWS
86. respect for clinical decision making, communication and having all the relevant information available
87. Respect for another's opinion even though you may not totally agree. Open communication.
88. Respect for all team members regardless of position All aware of roles Clear vision for the purpose of the MDT
89. respect for all opinions from the team members
90. Respect for ALL members and their opinions
91. Respect for all members Communication Patient comes first
92. respect and team players
93. Respect and communication
94. respect and communication
95. Respect .Communication in an open and honest way. Familiarity with one anothers working practices
96. respect organisation
97. respect clear set objectives
98. Respect
99. Respect
100. respect
101. respect
102. RESPECT - INCLUSIVENESS
103. Regular attendance by all members the chance for all members to be involved in the decision making process
104. Recognising, acknowledging and respecting one anothers contribution
105. Recognising all core members
106. putting personalities out of the way and considering what is best for patient care, good communication
107. Putting personal disagreements aside & working professionally in the interests of patients. Valuing others' contributions to care plans.
108. Professionalism. Respect for each others knowledge and skills.
109. Professional team, good support network, effective communication and respect for each other.
110. professional respect for others and their contribution. Knowledge of the speciality.
111. Professional equality. Effective chair.
112. People are valued and their opinions taken seriously and considered. The Chair should endeavour to control controversy between members, if necessary speak to

the individuals and try and resolve problems occuring at the MDT. Socialising with team members so you know them on a personal level.

113. Organisation by MDT co-ordinator is essential along with good chairperson
114. Mutual respect; professionalism; open and effective communication pathways. a relaxed environment rather than a fractious one!
115. Mutual respect. Good listening skills and clear, sharded objectives.
116. Mutual respect. Understanding of your own and each others roles and boudaries. Agreed MDT ground rules. Good communication, chairing, leadership, management.
117. mutual respect, common aim of doing your best for an individual patient
118. Mutual respect of all members Appropriate praise and criticism
119. mutual respect for each individual members contribution to the decision making
120. Mutual respect and shared goals Good communication
121. mutual respect and consideration
122. mutual respect and agreement on treatment protocols
123. mutual respect and acknowledgement of individuals learning needs and limitations
124. Mutual respect
125. Mutual respect
126. mutual respect
127. Mutual professional respect
128. Mutual goals, patient centred care, valued prescence, non-dismissive with views & opinions.
129. mutal respect from all individuals discussing patient pathways
130. mentioned already
131. Listening to and respecting other people's opinions
132. Listening to all opinions, good communication
133. Listening skills, respect, good organisation.
134. listening and valuing each individual
135. listening respect good communication clear and detailed information regarding each patient
136. knowledge and respect for each individual role
137. Informed communication effective presentation of patients
138. head and neck is unique in that it consists of many distinct and separate specialities, each one of which wants to safeguard their own individual fields. Some specialty members have had their own "MINI MDT" before attending the MDT meeting and often have already booked a date for the patient to have a certain treatment carried out. This makes a mockery of the whole system. Also some specialities have a historical clash and I feel some patients would be better of being operated on by a more experienced surgeon from another speciality. Although no breech is being carried out, I know that for example, a better cosmetic result would be acheived from say an experienced plastic surgeon rather than a new maxillo facial surgeon. These factors are never taken into consideration and there are no support mechanisms in place for newly qualified consultants.
139. Having an agreement on the objectives of the MDT and agreed managment algorithims for patients as guidance
140. having a common goal, accepting personality traits
141. Having a clear goal of making the right decision for every patient Good working environment Excellent admin support
142. good working relationships, clear, concise decision making between members and respect for anothers professional opinion & specialist interests.
143. Good working relationships and a common goal - wanting what is best for the patient and family
144. Good working relation
145. good working partnership within the team/every1 working together
146. Good working environment and treating everyones opionions the same
147. Good tema work and respect
148. Good teamwork, effective leadership and members that get along with each other!

149. Good team working, respect for each other
150. Good team working and especially having respectful and curtious relationships + agreed and (seen to be) fair division of work and responsibilites between team members and hospital sites
151. Good team work Evidence based practice correct info and equipment available
152. Good skill mix and widespread experiential learning. Good communication with other members, ability to take on board other oppinions
153. good relationshipbetween teams
154. good range of people & experience & knowledge
155. good listening, well coordianted meeting
156. Good leadership. Desire to work effectively
157. Good leadership,good communication and respect for everyone's contribution, having clerical support-co-ordinator,good time management
158. Good leadership, mutual respect, common working values, flexible working, commitment and support
159. good leadership willingness of all core members to participate
160. Good leadership
161. Good knowledge base, good skill mix, good communication and respect for colleagues
162. Good interpersonal working i.e. respect for each others viewpoint
163. Good interpersonal communication skills. Respect and value for each others roles, and professional contribution. A good sense of humour.
164. Good guidelines to adhere to, good leader, effective meeting planning
165. good coordination, good preparation. Good attenance by all core members.Ability to communicate effectively Respecting each others roles and contribution. Meeting courtesy.
166. good communications and a willingness to work together to help speed up the patient pathway
167. GOOD COMMUNICATION. RESPECT FOR OTHERS AND THEIR INPUT TO PATIENT CARE. PHYSICAL LAYOUT OF MDT AT THE MEETINGS SO EVERYONE CAN SEE EACH OTHER THERBY IMPROVING INTERACTION.
168. Good communication. Respect of each others contributions.
169. good communication, respect of all members,time
170. Good communication, designated responsibilities, timescales
171. Good communication, caring for the patient and a sense of humour
172. GOOD COMMUNICATION SKILLS, ENSURING AND ACKNOWLEDGING ALL MEMBERS OF THE TEAM HAVE INPUT IN MEETING
173. good communication skills and respect for other people's roles.
174. Good communication regarding all aspects of the patient pathway and treatment decisions
175. good communication chance for everyone to speak each mdt member should feel valued
176. Good communication between team members. Respect for each member and their role and value.
177. good communication between team members, all notes and results are readily available, everybody is on time
178. Good communication between core members Good time keeping good attendance of core members
179. Good communication betweeen members
180. good communication and to value opinions of all team members
181. good communication and team work
182. Good communication and systems that are followed
183. good communication and suport from team members
184. GOOD COMMUNICATION AND RESPECT FOR ROLES.
185. good communication and mutual respect for each others roles
186. Good communication and documentation
187. Good communication and collaborative working.

188. good communication amongst team members
189. good communication good involvement of everyone evryones opinions valued good peer support
190. GOOD COMMUNICATION
191. Good communication
192. Good communication
193. Good communication
194. good communication
195. good communication
196. good communication
197. Good close knit team who acknowledges each person for their own skills and input
198. general respect for eachothers views
199. feeling involved and valued
200. fair accepting work ethos
201. Everyone being patient focused. acceptance of personalities
202. established team members with good communication channels
203. Effective leadership, protocols and shared beliefs.
204. Effective communication. Clear and precised decision re. treatment pathways. Understanding of each person's role within the MDT.
205. Effective communication, teamwork
206. Effective communication between team members. Regular meetings. recognising the contribution of each professional equally.
207. effective communication
208. Doctors being managed properly outside of the meetings
209. Discussion and understanding of others needs
210. development of good working relationships and knowledge of role.
211. cooperation with team members, respect views and acknowledge that others have different views, working in pts best interests
212. Coomon understanding and goals
213. Consultation
214. COMMUNICATIONS RESPECT
215. Communication, respect for each discipline.
216. Communication, respect each other whether nurse, doctor or co-ordinator, ask for each others views.
217. Communication, preparation, all information/imaging/histology available,
218. Communication with each other, respect for each others views
219. communication and attendence
220. Communication & peer support
221. COMMUNICATION
222. COMMUNICATION
223. Communication
224. communication
225. communication
226. Common goals, good leadership, valuing all members.
227. common goals, agreed protocols, unified IT support and access. Strong MDT chair, good MDT co-ordination, full attendance.
228. common goals clear communication documented outcomes
229. common goal and clear perimeters
230. Common goal
231. common aim, democratic working with good knowledge base of the illness being treated for the patient.
232. committment to patient care
233. Collective objectives, respect for all team members, strong leadership
234. Cohesion+teamwork/respect for others/sound knowledge base(s).Effective Leadership.

235. Cohesion and support for each other, offering to help where and if necessary
236. co hesive team
237. clearly observed ground rules
238. Clear objectives. Operational policy / Team work Available IT
239. Clear objectives, effective co-ordination
240. Clear common goals, professional respect,
241. Being willing to listen and being receptive to challenge
242. being respectful of the knowledge other disciplines bring to the meeting
243. being open to change listen to other people's opinions
244. Being comfortable with each other Willingness to listen to others' views Good communication A clear understqanding of each others role within the team
245. availability of case information, respect and aknowledgement of the contribution all members, occasional humour! food!
246. Areed goals ie patient centred care, respect for patients ,respect for each persons contribution good record keeping ,knowing who is responsible for what
247. an appreciation of each others knowledge and experience and opinion
248. all working towards the same goal, best practice.
249. All members of the team to be respected and be respectable of each other. Members to feel able to speak up and feel they are being acknowledged and listened to
250. All levels of professionals able to listen to each other and communicate effectively
251. all input from all levels is welcomed and contribution comes not just from the consultants but all members - an atmosphere of "your views are important" makes for an interactive mdt
252. agreement on standards of care, MDT process and workiong to protocol
253. acknowlegment that each member of the MDt has a valuable contribution to make.
254. Acknowledging each persons contribution and skills.
255. Accurate perceptions of the importance and benefit of the process. Respect and willingness to go the extra mile when needed
256. A professional approach and good leadership.
257. A good chair.
258. A good chair to allow everybody time and can manage difficult or forceful personalities
259. A good chair and a mutial respect for each others opinions
260. a good chair
261. A common purpose. Respect for each others roles.
262. 1. Shared goals and outcomes 2. Tolerance/ respect for each other

Infrastructure for meetings

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

344 nurses responded to this question.

1. When you are not seen and people therefore do not know that you are in attendance.
2. When videoconferencing is tried, it does not work well - reg's from RMH give up. Need uninterrupted space and time
3. when the chair feels that their opinion is the only one
4. when technology fails. this occurs rarely
5. when people cannot see or hear each other, poor teleconferencing equipment.
6. when one person has already decided on the treatment before discussing the case and chooses not to listen to others opinions
7. when electronic failure of equipment for ct scans and data on computers
8. When diagnostics viewing is limited due to technical break downs
9. When communicating via video conference it is essential that people listen and do not talk amongst themselves
10. VTC not available faulty technology room space poor sound behaviour of some members
11. Video link up problems
12. video link between sites not working well
13. video conferencng that doesn't work
14. Video conferencing. You cant alway here what is being said, important comments are often missed
15. Video conferencing with a Centre. It is difficult to see and hear what is being said
16. Video conferencing whihc does not always work therfore making meetings disjointed. Ideally MDT members should be in the same room to make discussion more cohesive as there is a few seconds delay in transmitting voices across video link, which means individuals may talk over each other
17. VIDEO CONFERENCING
18. Venue Timekeeping Aloted time
19. Unwilling members
20. Unplanned. Not conducive to team involvment/ discussion.
21. uncomfortable heat
22. unavailable data/ records poor attendance of core members
23. unable to view reportss radiological/histological
24. unable to hear or see info
25. unable to hear everyone
26. un protected time for members to attend
27. Too small a room
28. too much irrelevant information, idle chit chat
29. Too may people speaking at once. Some personalities being too forceful
30. too many attendees, poor room layout
31. Too large a room or equally too small so that not everyone can fit in.
32. Tiredness/comfort of chairs
33. Timing , location of meeting, ack of attendance and poor prep
34. timing
35. Time keeping, some team members arrive late regularly. Missing notes, mammos and most importantly histology
36. Time constraints of Consultants and C.N.S, clinic commitments, often clinics start half way through designating meeting time. Late arrival and disruption to meeting, requiring back tracking of patients already discussed.
37. time & space
38. Time

39. Time
40. Time
41. time - racing against it
42. Those presenting do not always speak loudly/clearly and consicely enough
43. Theatre style arrangement. Discussion not encouraged.
44. the willingness of key members attendance and the inability of the leader to make decisions
45. The room not having enough chairs. People arriving late and disrupting the meeting. The room temperature being too hot or too cold.
46. THAT everyone can see/hear the case being discuused ie.radiology/histo.good air conditioning
47. Temperature. Inability to see IT screens. Face to face with each when speaking
48. Temperature and noise
49. TEMPERATURE
50. temperature
51. Telecommunication can reduce communication and effect decision making
52. Tele-conferencing. You can't hear what is being said, the picture is distorted. It doesn't always help team building
53. Technology not working.
54. Technology malfunction.
55. technology :not being able to see radiology or have links to pathology not hearing what is being discussed
56. technical problems,delay of reports,abscence of radiologist and tretment doctors,late comers
57. technical problems with video link,
58. talking amongst themselves,no organisation no order
59. talking amongst members when someone is presenting
60. Staff not understanding how eqipment works
61. Space and technology
62. Space
63. space
64. Sound
65. Small room, but we dont have this problem
66. small room large group of attendees,heat
67. sittings in rows Not helpful speaking to the backs of peoples heads !
68. senior mdt members around table, other members at back of the room
69. Seating and space
70. Scans on encrypted CD ROMS, lack of dedicated time for the consultants to attend, unmotivated MDT co-ordinator. Having a PACS system that is not compatible with our cancer centres and referring trusts causes delays and increases costs through having to copy onto CD ROMS (which can then not be opened!)
71. Sadly my expereince is that of medical collegues with an agenda taking over the discussion with no oppurtunity for other members of the MDT to contribute.
72. RUSHED SURGEON INBETWEEN THEATRE CASES
73. room too small, heating hot/cold
74. room too small for numbers of people (including trainees)
75. ROOM TOO SMALL
76. room to small
77. Room Temp,
78. room not big enough not enough chairs
79. room layout, poor resources
80. Room layout which prevents everyone from sseing screens and particioate in discussion
81. room layout & interruptions
82. room layout

83. Room being too warm!
84. room availibility and enough time for discussion
85. Presence of core members adnbeing able to see each others faces
86. poorly functioning equipment
87. poor visibility of pathology and record keeping
88. poor view of screen
89. poor video connections/technology
90. Poor video conferencing. Noise. Talking between parties. Conversation outside the realms of the meeting
91. poor technology over multiple sites,
92. Poor technology
93. poor technology - availabilty of notes
94. poor technical support
95. Poor seating disruption in video confrencing technology resulting in poor picture and sound quality
96. Poor room layout/ IT problems
97. Poor quality IT access.
98. Poor preparation. Poor IT equipment hindering the review of imaging and pathology. Poor communication between team members.
99. Poor preparation. Equipment not working. Core members not available. Poor teamwork
100. Poor preparation. Poor chairmanship. Poor team work. Lack of mutual respect or an atmosphere of fear preventing people from speaking or challenging. Poor organisation such as lack of protocol, systems and processes.
101. Poor or late attendance, poor seating layout to room
102. Poor light and poor vision of screen presented information (pathology and radiology) Poor video conferencing equipment
103. poor layout
104. Poor IT and microphones.NOT Enough patient lists to go round .mobile phones going off
105. Poor facilities where scans etc cannot be seen by the whole team, poor preparation
106. Poor communication due to room layout/seating
107. Poor Communication between members. members workload
108. Poor communication Lack of planning Feeling unable to speak/give opinion
109. Poor communication
110. Poor communication
111. poor communication
112. poor communication
113. Poor co-ordination of meetings, so that relevant radiology, pathology, medical notes, results are not easy to hand to make an effective discussion.
114. Poor chairmanship, distractions, inappropriate conversations. lack of preparation by clinicians. Absence of summaries for reason for discussion
115. Poor attendance. Not being able to see the faces of other attendees
116. poor attendance, inability for all players to feel able to participate
117. Poor attendance by mix of core members
118. poor attendance
119. Poor accoustics in the venue Poor room layout
120. Personalities and dominant characters
121. People with their backs to each other - as when seated in rows. Constant interruptions or people holding private conversations during meeting.
122. people who think their own agenda is very important, or view the exercise as a social gathering
123. people talking when others are very distracting need good chairman
124. People not turning up, people bringing late additions, private patient discussions that last longer than NHS pts!
125. people having their back to you and you can't hear what's been said

126. People being given seats where they can't see or interact effectively, or seats which could be deemed less important.
127. patient medical notes, noise/disturbance and team not workingtogether
128. Pagers, bleeps, disruption of the meeting, forced attenance and lack of interest in other than their own patients
129. Pacs not being available
130. Overcrowding in the room; ineffective air conditioning...sleep snacks are taken...!The absence and lack of appropriate cover in key members e.g. histology, radiology or consultants whose patients are put on for discussion not being present.
131. outside noise and interruptions
132. ours are working effectively
133. Our MDT is tele-linked across two sites and the sound is very poor so when other site are discussing their patients we cannpot hear them, we then have to wait until tey are finished and often have to fit in 10 mins however many patients we have. Also member obstructiveness ie. certain members will cut short discussion when they do not perceive relevant. Also problem with notes going off site for clinical coding and therefore not being available.
134. ONE IS THE ENVIRONMENT, IF YOU ARE NOT ABLE TO VIEW HISTOLOGY SLIDES, AND RADIOLOGY.
135. Numbers of spectators who need not be there. Effective teleconferencing Having no chair
136. Notes not available, images and histology not available
137. not listening to each other, not having all the appropriate infromation available. MDt coordiantor beign absent and having alternative MSDT co ordinator
138. Not having enough information about the case discussed. Not having effective working diagnostics or if the video conferencing link fails.
139. Not having a dedicated room. (i.e. using the school room, so they have to close during this period.)
140. not everyone being there at the same time.
141. not enought space or not able to see scans displayed
142. not enough room and cramped conditions
143. Not being run smoothly, and not always being able to hear everyone talking (video link)
144. not being able tohear properly
145. Not being able to view x-ray images or mdt typing
146. not being able to view radiology images
147. Not being able to see view box from seating, or face or chair or presenter. Mobile phones not switched off.
148. not being able to see the screens clearly
149. not being able to see the results,pictures imaging etc
150. not being able to see people who are talking as this often means they are not listened to
151. Not being able to see or hear other sites easily; 1 person dominating the meeting
152. Not being able to see or hear fellow MDT members.
153. not being able to see and hear
154. Not being able to see . Temperature
155. not being able to hear. sitting at the back if you are a core member. Not feeling able to contribute due to being heckled.
156. not being able to hear the histopathologist/presenting doctor/other because the room is so large and no-one keeping on top of chatter going on around the room during MDT discussion, or the annoying crunching on food and rattling of crisp packets-again lunch meetings are not appropriate
157. Not being able to hear or see properly due to chairs being in rows.
158. not being able to hear everybody clearly poor video quality
159. Not being able to hear contributions.
160. not being able to hear an individual when they speak
161. not being able to see the visuals

162. Not been able to face to face communicate with members or hear them in discussions
163. not all relevant information being available so a decision cannot be made.
164. Not all core members bing present Notes and reports not ready Computers and other equipment not working or having full access
165. Not all core members attending
166. Non engagement of members present, this leads to mini discussions taking place rather than a co-ordinated meeting
167. Non attendance of members
168. Non attendance by a core member or person left presenting patient does not know the patient well enough and decisions about treatment are made purely on stage and type of cancer without considering patient wishes or performance status.
169. Non-functioning equipment
170. noisy environment, so unable to hear speaker
171. noisy environment,
172. Noise interuptions
173. Noise from neighbouring rooms & non-core members discussing other cases at back of room
174. noise and lack of privacy
175. Noise
176. No common interest/ poor communication, lack of preparation
177. no comminication, no one coordinating meeting, no notes or photographs available, no prior agenda set
178. no allocated room availability
179. NO ACCESS TO SCANS/ PATHOLOGY. POOR LAYOUT OF MDT MEMBERS LEADS TO POOR INTERACTION. A GREAT DEAL IS NON VERBAL COMMUNICATION
180. multipul teleconferencing ie more than 3 way.
181. Mobile Phones
182. Miscommunication, lack of communication one upmanship between team members
183. members who do not arrive, poor quality video conferencing, people leaving once they have presented
184. members not listening to others when presenting patients.
185. Members NOT being able to see relevant materials
186. Members may feel that if they are sat at the back of a room that their contribution is not valid.
187. members in the way of viewing patient imaging/pathology individuals discussing issues
188. Member chatting amongst themselves instead of concentrating on the job in hand!
189. MDT which are medically focussed and does not utilise the key skills and expertise of the other professional groups involved.
190. MDT members sitting away from table, therefore not making eye contact with other MDT members
191. Malfunctioning videoconferencing
192. logistics meaning that voice projection is inhibited, so junior members cannot hear clearly what is being said
193. Linking to other units
194. Limited space & lack of furniture
195. lecture style seating, not equal
196. Layout which makes communication awkward ie unable to see each other comfortably
197. Layout
198. lay out, none attendence, people discussing other cases when some one is presenting
199. Late attendance by key member and early departure
200. late arrival of key personnel
201. lack of view of daignositics

202. lack of video conf equipment for linking with members who cannot physically be in the room
203. lack of ventilation, poor seating.
204. lack of time and attendance
205. lack of technology and patient info
206. lack of technology (i.e. imaging)
207. Lack of technological support
208. Lack of tables or chairs, problems with room temperature
209. lack of systems to view results.
210. Lack of space. Lack of time. Interruptions.
211. lack of space, poor i.t
212. Lack of space, either too hot or too cold.Uncomfortable seats. Not being able to make eye contact with other MDT members.
213. Lack of space and access to viewing equipment
214. Lack of space
215. lack of respect for the other participants interuptions
216. lack of protected time
217. lack of preparation poor facilities lack of respect for each other
218. Lack of preparation & co-ordination
219. lack of preparation
220. Lack of leadership during MDT case discussions, non attendence of core members, lack of prep
221. lack of leadership
222. lack of information key members not being present
223. lack of eye contact
224. LACK OF EQUIPMENT
225. lack of efficient IT facilities
226. Lack of drink facilities
227. LACK OF COMMUNICATION BETWEEN SPECIALIST TEAMS.
228. lack of communication /restistance to change.
229. lack of communication
230. lack of committment by clinicians
231. lack of commitment, not IT sytem that works between specialities, time
232. Lack of commitment re attendance from members. Information requested, not being available ie results
233. Lack of casenotes, information. Proper results not available. People arriving late
234. Lack of available patient information.
235. Lack of attendance by key members
236. Lack of attendance and committment from core members
237. lack of attendance poor prep
238. Lack of a designated room with technical /audio equipment Enough chairs and tables
239. Lack of appropriate room and dedicated time
240. Key personnel missing
241. Key members not being present eg Radiology
242. Juniors presenting their pts should feel supported by Core members.
243. ITC PROBLEMS FOR VIEWING IMIGINE
244. IT malfunction .
245. IT issues
246. IT equipment not working
247. interruptions
248. insufficient seating, hot room, inability to hear whole discussion
249. Ineffient equipment.
250. Ineffective video conferencing equipment
251. Ineffective tele conferencing with the cancer centre, too much noise, inappropriate

conversations on the side.

252. individual clinicians emphasis on what is important to them
253. Inappropriate environement - too small and too hot. All members of the team do not feel that they can then contribute
254. Inadequate ventilation Not enough space No fluids (sometimes the meetings go on for more than 2 hours)
255. Inability to hear/see what is happening
256. Inability to hear case presentation due to room arrangement or presenter's voice
257. In our case poor IT & Video conferencing links.
258. in accurate or incomplete information being presented due to a lack of time preparing
259. In a previous role, the MDT was carries out in a room with very noisy air conditioning, which made it difficult to participate as we couldn't hear much of what was happening!
260. ill equipped venue
261. If you have team members not on board with the process (not applicable in our case by the way)
262. if the computers are down or one aspect unavailable, ie radiography
263. If the chair does not speak clearly or summarise cases well. Poor technology where all members are unable to see history or radiology
264. If notes are difficult to obtain or lack of information
265. If individuals are unable to access notes from where they are sitting and cannot see scans on screen
266. if core members are not available for the meeting
267. I think it is easier to interact when face top face and build working relationships, but then I am a nurse.Quality on video confrencing is poor to say the leaset
268. hierarchy no group interaction
269. Heirarchy! Juniors may not feel able to voice their opinions with some consultants
270. Heirarchy
271. having to have our MDT in our lunch hour at another hospital site, we are under great pressure to attend on time and return in time for our afternoon clinic
272. having the meetings before working day, at lunch time is not conducive to unresentful attendance and execution
273. Have a comfort break if more tha 2 hours
274. Hard seats and limited access to IT
275. Gossip
276. Functioning IT.
277. For us, whether the teleconferencing is working well, and that all core members are available.
278. Faulty equipment and missing core members
279. faulty equipment
280. failure of video confernceing equiptment
281. Extraneous noise/ distractions Mobile phones/bleeps
282. Exhaustion and rushing from clinic to squeese everything in.
283. Excess noise. Interruptions and interjections from members talking over others
284. everyone talking at once, room environment, equipment not working properly, core people or deputy not attending.
285. Everyone's attnedance & being aware of patients being discussed especially if you are the key consultant.
286. Equipment that doesn't work, noisy room
287. Equipment not working in order to view eg scan results.
288. equipment not working
289. equipment not working
290. electronic systems not working or being slow - eg radiology from other sites running slowly
291. ego's
292. effective environment

293. disturbance. lack of space.no computer
294. Distractions Outside pressure not related to mdt clinical need
295. Disorganisation.
296. Disharmony amongst members
297. Difficulties arise when equipment does not function properly e.g video conference.
298. Difficult to video conferance. Always feels like the team video linking are outsiders.
299. Definitely need co-ordinator otherwise paper work falls on others
300. Dedicated facilities in an appropriately equiped room
301. cross site working - video conferencing not working
302. Cramped venues
303. Cramped room with limited seating and visibility
304. cramped environment
305. Core team not attending or leaving . Poor communication within the team To many pts within limited time span
306. Core members not turning up
307. core members not being present/represented
308. core members not at the meeting as this can stop decisions being made and can delay patients pathway
309. consultants not listening to others, cns build up a good rapport with patients and very often their advocate. mdt needs to be non threatening and friendly
310. Constant interuptions
311. Computers not working!!!!
312. Computer networks
313. communicating with people not in your eye view
314. COLD ROOM
315. Co-operation of the team and its ability to work together harmoniously.
316. Classroom style setting - hierarchical arramngement - i.e. consultants at front - often contributes to talking amongst themselves - physically limits all attendees hearing discussion
317. clashing personalities
318. clashing of the different personalities. Insifficent information
319. Chairs in rows promotes hierachy
320. Chairs in Rows
321. Chair person
322. Broken equipment.
323. Breakdown of video conferencing facility
324. breakdown in technology
325. Being valued as a core member. Being listend to and comments taken on board.
326. Being unable to hear/see what is being discussed
327. Being unable to hear all members due to seating arrangements
328. being allowed to speak up
329. Background noise and people moving around unnecessarily in each venue.
330. Any core member not present eg radiologist or consultant
331. An unsuitable venue
332. an unsuitable room, toohot/cold, crowded
333. Although video conferencing is good, it does actually inhibit effective discussion.
334. All team members skills, attributes and contributions valued and listened to
335. all facing forwards, so hard to see each other to speak.
336. ALL DISCIPLINARIES ATTENDING AT THE SAME TIME
337. access to suitable room
338. Absence or lateness of core members. I T isnt functioning.
339. Absence of meeting room/and or equipment/ or reporting clinicians
340. Absence of core members
341. A NON COMMITMENT OF CORE MEMBERS TO BE CONSISTENT IN THEIR ATTENDANCE

342. a discipline not being able to attend. A lack of attendance fro all discipines
343. 1. Space 2. Not being able to visulaise other members or equipment
344. ?

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

279 nurses responded to this question.

1. Works well usually, but can fragment a meeting when going to various sites
2. WHEN WORKING A POSITIVE IMPACT
3. When there is a geographically divided team it is essential.
4. when there are problems with the connection this can be time consuming on a positive side liaison with colleagues within the network enhances the decision making process
5. When it works it incorporates better decision making as it involves a cross section of specialists from around the network
6. Weekly teleconferencin ensures rapid discussion of surgically resectable , staged patients with specialist centre and allocation of appointments and further staging requests.
7. We hope to have video conferencing in the near future to allow us to maximise the level of expertise across the network
8. We haven't started yet but will be this month. I feel that it will give a broader view to everyone of latest treatments available across the Network
9. we have the teleconferencing facility but have yet to use it so I am unable to comment
10. we dont need to use it
11. We don't need to use it but others do and find that the images do not project well enough to make a meaningful discussion possible
12. We don't have this facility
13. We don't have the above available at the moment but I would think it would give better communication between hospital staff, which should ensure the best treatment for patients.
14. We do not use this facility
15. visability of members creates a better communicative enviroment, sometimes dial up connection fails which can cause delays and frustration.
16. Video conferencing is positive, however the technology does not always work. At times, the sound may not be working or the projection may not work. Also there may be a time delay and time can be wasted whilst waiting to hear the discussion from the other team.
17. Video conferencing is not appropriate for brain and CNS tumours due to the intricate nature of scan reviewing and would have to include multiple sites which would make managing the process difficult.
18. Video conferencing has a positive impact on MDT meeting. You need someone to manage the equipment whilst taking part in the discussion. Doctors and nurses cannot be expected to do both as it breaks their concentration.
19. video conferencing allows clinicians off site to join in discussions but does not allow them to actually see and talk to the patients or perform a full skin check
20. Video coferencing is available to use but we haven't need to so far
21. videa conferencing not yet available here but is going to be soon. We have never used teleconferencing as a means of communication between MDT core members.
22. Very positive, means that we can discuss cases with our Cancer Centre on a regular basis, showing images, and pathology
23. Very positive and effective - this promotes effective dialogue and visual communication.
24. very positive

25. very importand in decision making as all the experts can give their opinion
26. valuable input by core members if it is working effectively when there are technology breakdowns this delays the meeting videoconferencing facilities are not always available
27. useful with remote members e.g. plastic surgery or referral centres
28. unreliable technology
29. unknown
30. Under development
31. unable to comment
32. Travelling members do not have to travel. Saves time
33. too many patients,poor auditory quality, no real knowledge of the patients
34. timely manner,cirsulate the list prior to meeting,appropriate prioritisation,abscence should be notified
35. Time saving with busy core members and timetabling Difficulties sometimes hearing when people sit close to speakers and have conversations or fiddle with papers
36. Those who don't attend in person never chair the meeting or lead it, they also opt-in for their pts only then sign out reducing expert opinion for remaining pts whilst thier pts have the benefit of input from all. Time delay, audibility and cost all have impact.
37. There is a slight delay, but once you get used to this system it is excellent, and encourages all to attend
38. THE MAIN CENTRE FORGETS THE REST OF MDT ON VIDEO CONFERENCING POOR QUALITY OF SOUND AND IMAGES SOMETIMES DON'T FEEL PART OF THE MDT MISS THE FACE TO FACE TALKING AND BANTER
39. the frustration it creastes when it does not work
40. the equipment fails regularly
41. The difficulties we have had in getting the technology to work has been extremely frustrating at times
42. teleconferencing..never had postive experience. it is sometimes the "soft" communication between MDt memebers which is important not just the "hard" clinical facts
43. Teleconferencing with large numbers of attendees is chaotic Video-conferencing is excellent if the equipment works!
44. teleconferencing enables all members to take part in the MDT but quality of the interaction is dictated by the quality of the teleconferencing equipment at both ends.sound quality can be poor and MDT members who do not have english as their first langauge can find it difficult to interact successfully with the rest of the MDT
45. tele-conferencing can be dominated by certain individuals - intonation can be misinterpretted. All participants cannot see what is being discussed or recorded so cannot carrect errors real time. Video-conferencing allows people from dofferent locations to get together avoiding the delay of travelling. Can see real time images and discussion more meaningful.
46. Technology may not work. Images may not be good. It does mean that we can get some of the other network members to discuss their patients in the MDT. Saves people's time if not on site of MDT.
47. Takes a long time and the connection is often poor.
48. surgical input not otherwise available
49. Speeds up referral to speciality in another hospital
50. sound is not always good, depending on where microphone is placed therefore creating a lot of noise from page turning or not hearing what someone is saying if they turn another way. Seem to waste time clarifying what has been said several times until we are all agreed. Different accents dont help either. However it stops travelling from one hospital to another and enables quicker referrals times as we are able to organise the pt journey quicker and without too many problems.
51. Sometimes time consuming Mis use of tele conferencing deviates from MDT discussion & decision making

52. sometimes does not work properly
53. some times sounds and picture distortion can be a problem
54. some mdts link up to other hospitals but has not been used in ours
55. so you can get access to specialists from other hospitals.compare cases with other tems in different hospital when you cannot physically travel +to save time
56. slows things down - difficult to see the images clearly - some problems with hearing one another. Saves travel time and cost. Allows patients to be discussed who would not otherwise be.
57. Sleep induced
58. Saves valuable time and allows specialist review on a more immediate basis Saves patients having to attends several clinics
59. saves travel time and allows members to be present when based at different sites so that appropriate decisions can be made
60. Saves time when MDT is on two sites (ours are 30 miles apart)
61. Saves people time travelling Initially have to get used to doing it.
62. Resolves travel difficulties. Enables staff to remian on site. Prone to technology failures.
63. Remote users only join in for their patients (which is good) but then are not part of whole network pt discussions (which goes against idea of MDT)
64. Reduces time taken by clinicians to travel. Sometimes there can be a delay when one person os speaking. Images can be seen well enough to be assessed by the party dialing in.
65. Reduces time spent travelling to specialist MDT meetings. Uses clinician and other members time more effectively
66. Reduces the need for clinicains to travel.
67. Radiotherapy is on another site so the beginning of our meeting is linked to another haospital so all rectal and anal pts are discussed approprately for their treatment decisions to be made
68. quite difficult as both sides have a tendancy to start discussing amongst themselves
69. quality of the system, time delay when talking, other noises being picked up - doors opening
70. Quality of the links can be a barrier to discussion
71. providing the quality is good then can be very effective, is now improving
72. presently do not use video conferencing. Plans in the future to use this with the Gynae cancer center in XX [area]
73. positiveimpact, allows many professionals to discuss the most appropriate treatment for a patient
74. Positive:Real time discussions, true MDT decisions made Negatives: poor sound sometimes, members can speak too quietly or papers rattling in background
75. Positive: effective communication with local hospitals. Negative: frustrating when not working properly and delays meeting
76. positive: able to have mdt across the network negative, lack of opportunity to network and interact
77. Positive. collective decision making, review of images and pathology for all to see. Very good for teaching.
78. positive interaction from all.
79. Positive impact but can be time consuming if problems with technology.
80. Positive if the equipment works. As we do not have a ny surgeon on site it proves very useful
81. Positive aspects out weigh the disadvantages
82. Positive as it allows everyone to participate.
83. positive more co operation less time committment
84. Positive
85. positive
86. Positive -it is time saving instead of traveling to another hospital site. Neg- if the teleconeference not working properly it is difficult to view other team on the screen,

87. Positive - larger MDT, reduces delays. Negatives - Poor image projection, poor sound quality, organising call in timings, costs
88. positive - it is a better use of peoples time if do not have to spend time travelling to meeitngs. Negative - failure of technology can be an issue, people tend to sit facing screen so cannot see each other in the room, unable to view hard copies of notes as relying on colleague to give accurate account of patients condition.
89. Poor technology.
90. Poor quality of projection
91. poor i.t facilities/support can be frustrating and time consuming
92. poor equipment means not everyone can hear, no eye contact, delay in replies, abrupt speaking causing frustration or mis interpretation.
93. poor electronics / technology can detract from meeting. saves travel time .
94. poor communication, difficult to hear
95. Personally I do not like teleconferenceing. I do not think the discussion is ever as effective. I think a face to face meeting is by far the superior and therefore should always be the option of choice unless there is no alternative.
96. Permits MDT members on other hospital sites/networks to participate fully in the MDT.
97. Often doen't connect or have difficulty hearing from the main meeting can cause frustrations
98. Occasionally difficult to hear on another, technology lets us down some times.
99. NOT YET USING IT
100. not yet connected
101. Not used in my trust
102. not used in my experience
103. not used currently
104. Not used before
105. Not used
106. Not used
107. Not the same as face to face but a good second best
108. Not sure as due to commence April 09
109. Not sure
110. not sure
111. not required in my area of work (palliative care)
112. Not experienced
113. Not enough experience of these to comment
114. not currently using video conf.
115. not available at my trust I have to travel to associate hospital at insistance of my consultant . complete waste of resources for me !!
116. not attended one yet
117. Not applicable
118. Not always real time so communication difficult.
119. Not always able to hear. Makes discussions disjointed
120. No need for long travel time for members All members attending
121. no experience of this although now have technology and would be useful to link in with specialist centre- hoping to try in future
122. No experience
123. NK
124. never witnessed use of this
125. NEVER USED THIS YET
126. Never used it
127. never used it
128. never used it
129. never taken part so I don't know.
130. negative. delays time
131. Negative impact

132. Negative
133. Negative
134. negative- delayed commication takes more time have to listen to someone liking their own voice, not being equal partners
135. Needs to be state of the art technology to be effective
136. NA
137. n/a to our team
138. N/A
139. N/A
140. N/A
141. N/a
142. n/a
143. Much prefer face to face
144. members v/c are not present for whole MDT, often concentrate on own patients only
145. members on other sites can be part of the meeting with out having to travel
146. Members needing to travel from a far can be present
147. MDT members unable to attend in person can still have their views taken into account when planning treatment.
148. may impact on time used for debate. may lead to clinicians not using mdt for educational needs. is good for having expertise as required
149. May exclude junior or non core members from case discussion.
150. Makes for a very poor MDT -cant hear the other end discsussion as system picks up every small rustle of paper etc. We have to do it in two halves and therefore there is not good cross communication. The plus side is that it saves travelleing to one site (over 45mins journey)
151. Makes discussion difficult sometimes when everybody speaks at once
152. Less travelling time for more remote members of the team. Lack of personal contact. Personally, use the opportunity to visit our patients who are inpatients at tertiary centre
153. Its very disruptive when it doesn't work properly
154. It will never be face to face, therefore the dynamic can't be the same. It could still work but requires concerted attention from all parties
155. It saves time from travelling between areas and allows discussion between relevant professionals. It can sometimes be impersonal, but as the main aim is to discuss a plan for the patient, the impersonal element should not restrict the discussion and outcome.
156. It saves time (i.e. two hospitals within the same trust have access to the same meeting saving time by not having two meetings and travelling time to one venue). Facilitates core member attendance. It can however delay matters if the equipment breaks down or sound/ view is of poor quality. Limiting at present as only two sites available (three way coming imminently)
157. it never works!!!
158. it means we don't have to have two different meetings per week
159. It is unreliable - hence not always available
160. It is our link with the Oncologist, but as our meetings are held over lunch time this can be a problem for all team memebers, for different reasons. When the system fails it is a nightmare as I then have to speak to the oncologist on the phone and relay the treament trajectory plans back to the individual consultants later and the MDT letters will require altering again
161. It is essential when having joint MDT but it does not woek properly
162. it is advantage for the MDT teams for all to attends
163. It ensures that all core members can be involved in the meeting and provide a valuable and important contribution which would not be otherwise possible especialy when core members are working across many different Hospital areas
164. It ensures all core members can be present
165. It enables productive discussion between larger groups with the patients recommended treatment being a result of a whole host of specialists.

166. It enables all personnel to attend without travelling. Works well providing all team members know each other. Enables supraregional meetings to take place. Its hopeless when technology is poor.
167. it enables all members of the team attend the meeting but it restricts discussion
168. It can be impersonal and depending on number of people present then can be difficult to be heard and to hear what discussions are taking place. Quality of technology may not be very good.
169. It allows access to the necessary expertise in order to make decisions about patient care. It saves time
170. Involvement of absent colleagues this has a definite positive impact on decision making
171. invariably the equipment is faulty and is hard to hear other members of team, despite asking to have equipment fixed, this does not happen! makes for poor conferncing and potential to miss important information
172. individuals have caseloads and work at different sites if MDM tele-conferenced would all who should attend
173. Increases debate among members
174. includes members based off site
175. In this MDT we have needed the use of video-conferencing as all core members are always present
176. Improves networking and relationships with other Trusts. Negative when technology doesn't work!
177. Impacts negatively on easy communication and increases the possibility of errors
178. If scheduled correctly so the meeting is not suddenly disturbed, video-conferencing allows clinical experts in other settings to be involved in case discussions thus promoting timely, cost effective treatment decisions.Our MDT video-conferencing is well supported by a technological advisor who is present to deal with any issues relating to images and sound. This is essential to avoid problems which delay discussion and render the conferencing useless.
179. I WOULD SAY A POSITIVE, IT ASSIST DECISION MAKING
180. I have not used this facility so cannot comment. Have trained in its use but al members attend so not required as yet.
181. I have not experienced it
182. I have no experience of teleconferencing /video-conferencing
183. I feel it makes the MDT disjointed as a negative positive is that more people can attend and it reduces travelling time between sites
184. I don't have access to this facility for the mdt i attend.
185. I do not think it is as effective as it was sold as.
186. I cannot answer this as I have no experienc of it.
187. I am CNS but ?helps medical decision making on management. Educational for all members. enables better attendance but there can be functional issues
188. I agre with th epotential of video coferencing but the very poor quality of this facility strongly mitigates any potential this system has.
189. Hugely positive to speak directly in real time
190. HAVING NEVER HAD THIS I CAN'T REALLY COMMENT. POTENTIALLY IT WIL MEAN SOME MDT MEMBERS WON'T HAVE TO WASTE TIME TRAVELLING AND THE COMMUNICATION WOULD BE FAR MORE INTERACTIVE AT THE TIME OF THE MDT RATHER THAN BY E-MAIL /LETTER AFTER THE MEETING
191. havent ever used it but may be useful for those who cant attend
192. HAVE NOT USED TELECONFERENCING
193. Have not experienced this lately
194. have not been involved in video conferencing
195. Have never used it
196. Half the time it never works or the people you try to connect with are not there and miss the discussion. When they are there we have to re discuss case.
197. Had minmal experience but what i have seen was a technological disaster.
198. Greater involvement form more team members.
199. Great as long as it works. Only have facility for 2 way confernencing and need 3

to 4 so that all hospitals can join

200. Good when it works,delays if equipment fails
201. good when equipment is working,then members leave before completion of MDT
202. Good if we can hear properly
203. good
204. gives the consultant the chance to discuss their patient.However they are not aware of conversations between consultants at meeting
205. Frequently problems which actually make the meeting unsafe.
206. focuses discussion
207. Expert opinion for the patient incuding a second opinion. Allows communication face to face with team. Allows more attendees. If equipment fails can be frustrating and cause delays in the meetings.
208. equipment does not always work
209. Ensures that potentially the maximum number of MDT members can attend
210. Ensures good time management of busy staff so they are more likely to attend the meetings
211. Ensures everyone can give their opinion
212. ensures all members are available. Debate is possible but can be difficult with time delays etc.
213. ENHANCES CROSS TRUST COMMUNICATION AND ATTENDENCE
214. Enables us to ahave a surgical opinion each week. Our surgeon alternates between us and another trust.
215. Enables two sites to have conference without travelling to different sites
216. enables teams from outside county to be present without wasting time travelling
217. Enables all members to take part
218. enables all core members to be present despite very busy workloads. Difficult when it breaks down
219. enable to groups of clinicians to jouin in
220. efficient use of time when members geographically separated.
221. Efficient exchange of patient information/diagnostic results Live decision making with appropriate surgeons in attendance Enforced availability of clinicians at specific time/date aimed at patient benefit/outcome Can be time wasting if equipment fails or surgeon DNA's meeting Ps (Our Network videolink conferencing takes place 1 day after our local MDT)
222. Due to the specialist nature of our anal MDT it is not possible for all key members to be present. Video - conferencing allows a weekly MDT to take place which promotes effective treatment planning, allows good clinical discussion and avoids delays in patient care.Video - conferencing needs to take place at a scheduled time on the agenda to prevent the usual flow of the rest of the meeting from being disturbed. Technological support, present at each meeting is vital to avoid problems with equipment.
223. drs can access mdt from other hospitals
224. Don't think that there is sufficient interaction
225. Don't know never used it
226. Don't know because as yet this is not available in my Trust
227. does not permit educational discussion due to time constraints
228. does not always work
229. does not always promote discussion - disadvantage. Can't hear well or see preson speaking.
230. do not know as we have never participated in one
231. do not have this facility
232. do not have the facility in place currently
233. discussion of case,timeliness of decisions,no need to send histology scans etc to another MDT
234. difficulty in concentrating. communication not effective enough and better to actually attend the meeting to properly debate complex cases.
235. difficulties sometimes with direct communication cant beat face-to-face contact

236. Difficult with time lapse sometimes, team members can end up talking over one another. Sometimes it is difficult to hear due to back ground noise.
237. Difficult to conduct a meeting with a projected image. Does not have the same impact as face to face meeting.
238. Difficult to co ordinate and manage extra pressur on chairman not always good images
239. Delay in discussion causes increase in length of MDT. Connection not consistently reliable.Unable to pick up non verbal cues from team members. Avoids lengthy travel for some members of MDT. Avoids notes being taken outside of Trust
240. Decisions to treat early
241. Decisions from specialists ie liver surgeons etc. Timely.
242. concise information for clinical decisions
243. collective decisions from all members of the Cancer centre involving those from the cancer centre unit - definative decisions being made
244. Can slow meeting down/ is difficult when not working properly
245. Can see what other members have jouined the discussion, gives a much wider forum for debate. Reassuring for the patient that a consensus has been reached.
246. Can reduce communication due to poor quality
247. Can make it difficult if people have conversations within the team at their end. Videoconferencing does allow for better communication than teleconferencing.
248. Can make disjointed meetings if doesn't work properly Not able to view radiology images correctly
249. Can make communication awkward but outweighed by usefulness of having maximum numbers present
250. Can help those patients that travel off site for treatment and familiarise the team with patient details prior to consultation
251. can get views but limits discussion
252. Can create barriers due to time lapse, individual using it cannot necessarily see imaging or pathology screen
253. Can be time consuming as equipment often doesnt work.
254. Can be negative
255. Can be long winded sometimes and inappropriate patients discussed
256. CAN BE DIFFICULT TO ACHIEVE UNITY OF GROUP - ON CORE MEMBERS CAN BECOME DISTRACTED - POSITIVELY ALLOWS REGULAR COMMUNICATION BETWEEN DISTANT SITES
257. can alter order of discussion, can help focus discussion,
258. Can't comment never been involved with this.
259. Can't comment as we don't use it.....yet
260. Better attendance
261. At present it is not used in our MDT,but because of demand from consultants at other teriery centres. It is now coming into use. I feel it must have a positive impact as consultants that can not make the meeting from other centres can still be involved.
262. As mentioned previously video conferencing inhibits communication.
263. Always us to attend and not have to travel about 1-2 hrs to get there
264. Always a time delay & does not provoke good discussion as not everyone can talk at once & therfore the point is lost!
265. allows people to attend mdt's however somethimes problems with connectiveity
266. ALLOWS OTHER MEMBERS OF THE MDT WHO WORK IN DIFFERENT HOSPITALS TO PARTICIPATE
267. allows more peole to attend
268. allows me to be involved in a meeting that i would not be able to attend physically without a huge loss of time in my day
269. Allows greater involvement and teaching to all members
270. Allows full evolvement of the team in the MDT -positive Not always easy to track the conversation via teleconferencing - negative
271. Allows Clinical Oncologist to be present as they work at a different DGH
272. allows better input across awider geographical area

273. Allows better attendance at meetings particularly for specialists who would otherwise have to travel between MDT's. Allows the opportunity for advice and opinion from colleagues which otherwise may not be obtained. Often felt as time wasted for those clinicians not involved in the care of patients at other sites.
274. Allows all members to be able to attent and to acquire 2nd opinions
275. All members can be present. Immediate advice/decisions can be reached with cancer centre
276. A negative would have to be when it breaks down and you are unable to attend the MDT. A positive is that enables more members to attend at their place of work.
277. +ve - less wasted time travelling -ve - images slow & get blurred
278. + all can attend - equipment malfunctions
279. ? HAVE FACILITIES

What additional technology do you think could enhance MDT effectiveness?

157 nurses responded to this question.

1. Written treatment proposals are then stored electronically, real time would be safer and more accesible to all
2. Would like a patient database to record outcomes.
3. we use an electronic database that can be projected and has all letters previously written about the patient, and can project blood results also
4. We join with a hospital close by. Would help if our imaging was accesable at the other hospital. Having to take cd's of images is ok but problematic at times.
5. We have the technology, but have had a lot of problems getting it to work at all.Its also getting the other sites into being able to use it effectively when it does work.
6. we currently have the appropriate equipment to effectively mee tht needs of the MDT
7. We are in the process of acquiring a database with MDT facilities for real time entry
8. Voice recognition software
9. Viewing the real time documentation at all sites involved in the meeting. A way to avoid delays, at our MDT a decsion can be discussed and made but a referral letter is still required - a way for immediate referral would be of benefit
10. Viewing pathology. MDT's are very intensive and I believe being able to visualise as much as possible helps with understanding/education and interest and therefore aids concetration and attention span.
11. Video conferencing!! Radiology, although it is rarley relevant ot the skin MDT. PACS would automatially be availaable if we did have radiology.
12. video conferencing is excellent - if it works!
13. Video & teleconferencing.
14. Video-recording meetings may also help in improving MDM efficiency (i.e. as training aid)
15. Video-conferencing available at all times in all rooms allocated for MDT
16. Unsure
17. unsure
18. The ability to enter MDT outcomes directly into a database.
19. The ability to book inverstigations from the MDT room directly to radiology. For referals to be sent directly from the MDT to the oncologist as opposed to dictating a letter when returning to the office
20. TELE CONFERENCING
21. Technology that worked would be a huge start.
22. technology support we are healthcare workers not technology experts
23. Space in room

24. Sometimes when more than one hospital joins the meeting it can slow the technology down or even crash it
25. Reliable and faster transmission of radiology, pathology and voices
26. relable electronic systems
27. referral letter facilities straight from MDT
28. recording treatment proposals and projection of those decisions
29. recording the information put to the MDT in which the decision is based
30. recording of treatmentsproposalto database
31. Real time recording of treatment proposals
32. REAL TIME DECISION RECORDING
33. Quicker sound and imaging projections. All specialist units beuing on pacs so imaging can be wired through.
34. Projection of treatment decisions. Improved video conferencing facilities
35. projection of pathology slides connection to other services, eg XX [area] imaging centre
36. PROJECTION OF FINDINGS AT ALL TIMES
37. Projection of decision.
38. Possibly videoconferencing so that individuals do not have to travel to attend meetings.
39. Patient notes, results, etc available
40. only seen it one teleconferencing, it was difficult to hear what was being said and see images
41. Not sure, we would embrace guaranteed effective working of what we have!
42. Not sure, just more reliable of what already exists
43. Not sure
44. Not sure
45. not sure
46. not sure
47. not sure
48. Not sure - don't know what is available
49. not aware of others
50. none, just availability of working existing technology
51. None at present, the system we have works well.
52. None at present
53. None at present
54. None
55. None
56. none
57. none
58. none
59. need to be able to see other MDTs radiology and histology- current videoconfrencing equipment not perfect
60. National NHS system for blood results/ images etc. Our network centre currently has a different system to the centres for accessing blood results. It would be easier if this was the same and members could access all systems within their network.
61. N/A
62. n/a
63. More admin support and better video-conferencing facilities
64. MICROPHONE SFOR KEY SPEAKERS, CORE MDT
65. microphone for presentef of cases. spot lights for reading if big light off to see Pacs
66. MDT Co-ordinator
67. LIVE RECORD OF OUTCOMES AND MORE VERSATILITY OF FREE TEXT IN INFOFLEX SCREENS
68. Linking into off site pathology and radiology

69. laptops to recored data direct on to database
70. LAPTOP IN THE MEETING TO MAKE DECISIONS MORE TIMELY
71. Knowing when patient is attending clinic would be useful to know sometimes (for timing of planned interventions), therefore access to hospital patient information system
72. It's probably more technology training that is needed.
73. Interative PACS systems. We would benefit from a national IT template for electonically recording decisions
74. in our mdt technology us fine
75. Improvement in video-conferencing equipment Ability to connect PACS to video-conferencing equipment
76. if the scan results could be accessed across site on a system like PACs and not have to sepnd time uploading discs during meeting time
77. identical format for all tumour sites, effective records, useful info being transferred to sheet such as next opa, or scan dates
78. I dont feel we lack anything.
79. Hand held patients records were outcomes could be recoreded
80. halo conferencing
81. Good sound system, microphones so that we can all hear presentation of cases, imaging and pathology
82. good quality imaging, via videoconference link if needed.
83. fully functioning VTC in all trusts . tumour groups sticking to time slots
84. for all equipment to work on a regular basis as we experiance delays each week
85. equipment to allow MDT decision to be documented at the meeting.
86. equipment between different sites connecting effectively
87. Electronic MDT system for recording all patients details in one accessible place.
88. Electronic database connectivity for real time references and additions and uploading to DAHNO
89. electronic data base instead of paper
90. EFFECTIVE DATABASE TO RECORD DECISON MAKING ETC WHICH IS ABLE TO 'TALK' TO OTHER RELEVANT DATABASES IF/WHEN REQUIRED
91. EACH CORE MEMBER SHOULD BE CONNECTED TO A RADIO MICROPHONE
92. E-mdt
93. Double projection screen
94. Dont know enough about htis field to comment
95. dont know
96. dont always think is necesary
97. don,t know
98. DON'T KNOW
99. Don't know
100. Don't know
101. Don't know
102. don't know
103. don't know
104. Direct recording of decision onto electronic database
105. direct access to make appointments at MDT, ie PET scans,CT scans, MR scans, and any other invest required this should include OPD appointments, rather than having to wait until later, can miss some if rushed
106. Direct access to G.P screen to type update from M.D.T to provide instant access and information for G.P's undertaking M.D.T patient review.
107. Dedicated MDT room with perenant IT access (the repeated pulling in and out of plugs can cause damage to the syatem) + it needs soemone to know how to connect correctly. Repeated setting up puting away is very tiem consuming and wasteful.
108. dedicated cover for the MDT facilitator when she is off
109. Data collection during the meeting by data collection person

110. data clerk collecting realtime data
111. Computer to put things on the system straight away.
112. Clearer link ups so you can hear/see better
113. CAN'T THINK OF ANY OTHER?
114. better vtc
115. Better video links.
116. better sound and picture quality. viewing slides at tele conferencing can be non productive in that by the time the picture settles our end the pathologist has moved the slide to next point.
117. better sound and picture quality
118. better projection of pacs images
119. better picture. it is sometimes very scratchy and slow
120. better microphones coffee machine
121. Better microphones and camera. Access to all software on computers
122. Better microphones
123. Better communication channels, more on limiting case numbers for discussion Tea and coffee refreshmnets for all the team More Nurses and AHP attending this great learning environment
124. Better acoustic, microphones. Not all members can hear the discussion
125. Been able to look at other X rays from different sites
126. Be able to view mdt decisions at the mdt, ie real-time recording
127. awaitng the real-time recording of treatment- a prposal for the near future
128. availibility of electronic database at all meetings
129. an IT person available
130. an IT person
131. Amplifying discussion as air conditioning is rather noisy.
132. Althoug we have facilities for PACs it is incredubly unreliable as to whether it is working correctly or not, adn we cannot always access the images we need
133. All the information on one system
134. All the hospitals, using the same equipment and therefore the sound and picture projection being the same.
135. Addition technology facility to link with a fifth network site (for video linking) Facility for projection of treatment decisions to all MDT members
136. Access to video conferencing when our MDT expands the area it covers to include Northampton and Kettering patients
137. Access to tertiary PACS or similar
138. Access to slides/cytology/pathology results for some relevant patients, but not for all.
139. Access to Network imaging, pathology and data collection
140. Access to instant recording
141. Access to data base for real time documentation
142. access to computers to record outcomes and to look at our isoft system ie appointments, outcomes from previous consultations
143. access to cancer databases after meeting
144. access to bronchoscopy database and images
145. Ability to view more than two screens at a time
146. Ability to uplaod onto national databases (lucada) at the same time
147. ability to collect real time data
148. A working consistent video conferencing facility
149. A video conferencing that is clear in picture and speech. The reception and picture can be at most times poor.
150. a technician in room as I struggle with remote controls
151. a national system to look at imaging done elsewhere in the country. a decent coffee machine as our mdt is out of hours with no facilities to encompass decent refreshments
152. a lap top for recording decisions

153. A designated room properly equipped and more time to allow for teaching and better discussion.
154. A dedicated technician to facilitate the equipment
155. A database for effective data collection.
156. ??
157. ? video conferencing

Meeting organisation and logistics

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

370 nurses responded to this question. In addition, 18 nurses referred to the criteria presented in Q13 answering “as above” or similar response.

1. working with co ordiantor to ensure all patients for discussion are on list well in advance of MDT co ordiantion of clinic appointments as clinic in place after MDT.
2. Whoever presents the case knows all the events. Radiology and pathology information available. Case notes present.
3. Which ever firm is presenting the patients case, needs to know the patient's case well.
4. We are not able to have patient notes but I have to often assist the MDt co-ordinator with clinical decisions about the importance of obtaining scans, liaising with the referring clinician (we are a intra-network centre) to ensure we manage the case effeceintly
5. Updating about patients in screening and folow up for trials
6. update patients records, check agenda, note any specific patient wishes etc. check investigations and results available.
7. Up to date list Correct patient information available Ensuring all relevant imaging & pathology is available
8. Up to date informaton
9. up to date information needs accessing. Discussion led by key worker or team member that is fully informed
10. up to date information
11. understanding of case to be discussed Proformas prepared lists for relevant AHP in prep. for meeting Electronic patient information of blood test etc.
12. to have knowledge of patients being presented
13. To have all the necessary results and the referral team to be there to present the case
14. to ensure all patients discussed are presented by their team, as they should know the patient.
15. timing of tests, collation of results and data
16. Timely placement on patients on lists, request for all relevant radiology, pathology to be undertaken, ensuring all notes, relvant results are available for the meeting. A deadline for requests. Circulation of lists pre-meeting
17. Timely and complete referral forms need to be submitted before deadline to allow detailed agenda to be distributed in advance. This helps to ensure that case notes, radiological images, histopathology reports and relevent experts can gather the required information in readiness for the meeting to make the discussion worthwhile. Further preparation may involve briefing team members who are representing cases on a core member's behalf and familiarising oneself with your own cases for discussion.
18. Time for members to look at agenda and prepare for discussion if relevant to them, ie gain access to notes if necessary
19. Time and preparation. This is not available to all the core memebers of the team
20. The patient list should be put together, with correct details and reason for

discussion, and sent out in timely manner. Case notes should be available prior to the day. MDT sheets should be completed with case summary.

21. the one i attend is only a small group. we do need lists of relevant patients.
22. The main preparation should be done by those presenting patients, including histopathologists and radiologists.
23. The full case history needs to be availabe along with relevent investigations results. This will then allow the rest of the MDT to be fully aware of all the facts prior to making a desicion. As a CNS I ensure that I am aware of the follow arangements of the patient aswell as share their concerns with the rest of the MDT.
24. The coordinator needs to collate all patients to be discussed and ensure that all notes and images are available and produce a written list for team members to use.
25. The coordinator checks has corect patients on thelist and able to obtain all the notes. The room set up and video working (if applicable)he radiographer should chelck the scans are uploaded on the system to be able to discuss them at meeting. If core members not available then their seconder (if one) should be aware of meeting and relevent preperations made
26. The clinicians should prepare the summaries and the other core members should have access prior to the meetings. The mdt co -or d should ensure that all the scans etc are available.
27. The above and from my perspective reviewing case notes and summarising ready for presentation
28. That the lists are circulated in time,all available radiology/histo/lung functions reports available
29. Test results are present. Notes and knoledge of pts
30. Taking ownership of patients to be discussed at my request. Refamiliarising myself with PMH, history to date, reason for discussion, patient fitness etc
31. Summary of treatment, referral source, breach date, reason for discussion
32. Summary of previous treatments & tests, staging, prognostic index, co-morbidities. Patients psychological/social condition Availability of current test reports.
33. summary of clinical case clarity of patient list
34. summaries, case notes, getting x-rays and results (these are done by Drs and MDT co-ordinators), I need to make sure that the psycho-social side is taken into account, the speech and swallowing and dietetic information is also provided for nutritional support
35. staging results, contacting other hospitals etc for these. ensuring pathway being followed
36. Run through list, pull files for patients already known to team or make up a new file for those first presenting. Ensure info packs are available and contact cards.
37. REVIEWING THE PATIENT PATHWAY RE INVESTIGATIONS / TREATMENT AND PLACING ON LIST
38. Review the case notes, plan how to present the clinical question
39. Review of records & path results.
40. review of poatioent, investigations, advocacy
41. Review of patient history to see if potientially eligible for a clinical trail.
42. Review of patient case notes/ results/imaging etc Production of a case summary prior to presenting patients.
43. review of patient case
44. Review of pathology & radiology tests, what needs to be available at meeting. All relevant patients added to list.
45. review of notes making sure all diagnostic tests results are available
46. Review of histology/ radiology. Communication between team and MDT coordinator about events that need to be discussed
47. Resume of each patient which is concise and timely. Ensure clinical case notes, test results are available.
48. results, knowledge re pt and pt wishes should direct the outcome from the mdt. ie if pt does not want further investigaions- it would be a waste of time , resources and would put burden on the patient to book further investigations without

knowledge of their preferences.

49. results finding
50. results are available, who and ipr scores. cycles of treament received
51. Relevant test results to be present. Clear outline as to why they are being discussed.
52. reflection on the patients symptoms, investigations thorough examination of relevant investigations/concerns
53. Referrals need to be sent in a timely way with all data presented. Results need to be collated so they are readily available. Agenda needs to be distributed so all members can prepare their relevent part.
54. Referral proformas need completion. MDT meeting outcome forms attached to all notes. List compiled & split into Level 1 and Level 2 cases. Identification of source of patient & imaging / histology to be discussed - formatting of images prior to meeting - discussion of histology prior to meeting across sites
55. Record of all patients to be discussed needs to be up to date. We currently do not have the patients notes available for the MDT meeting but we do document in minutes. Because our MDT is not really a decision on treatment, their is a slightly different focus and aim of the meeting
56. Reading notes for full clinical history, availablity of all investigation reports
57. reading information, investigating any missing information
58. ratified listing, relevant history, imaging and other results, social issues/pt preferences that may affect pt choice summarised & noted, technology check, list circulation,
59. Pulling the list together for the coordinator - ensuring all patients are added for completeness. Checkig with radiology and oncology
60. Pulling of notes, slides and histology reports. Compiling patient list. Completing patient demographic details on outcome proforma sheets. Circulating agenda to all MDT members.
61. pt results, sometimes notes, MDT outcomes from previous week.phone calls to families or regional unit for update
62. PT NOTES AND ALL CURRENT RESULTS. PT HAVING BEEN SEEN BY A CLINICIAN FOR ASSESSMENT FOR SUITABILITY FOR RX OPTIONS
63. Proforma basic details, checking results available, getting notes, putting together patient list, checking equipment
64. preperation of performa for each individual patient with ps,lung function tests results,cxr fidings,ct findings,histology findings ,al other test reults appropriately,presenting symptoms,patients choice if known etc
65. Preparing of patients notes
66. Preparing nursing recors cards and reading through these
67. Preparing notes, paperwork and summaries
68. preparing notes, , chasing up investingations and transfering onto disc to be accessed in another trust as systems not compatable
69. preparing a summary of the patient history so far
70. prepare new patient presentation slips, information prepared around what complex symptoms you whant mdt advise on.
71. preparation ofnecesary imaging and pathology samples to be viewed
72. preparation of xrays, histology reports,patient histories,casenotes,room-refreshments,equipment,lighting&heating,chairs etc.All staff to have list of patients to be discussed.Computer available & working to record outcomes.Paper copies of patient list to be available
73. Preparation of notes, images and slides. Clear presentation guidelines
74. Preparation of letters and summaries to GP's. Preparation of slides. Lists to be circulated
75. Preparation of ensuring results of investigations are avalable, getting notes and results across site to mdt meeting room
76. Preparation of agenda.Summary of clinical imformation re patient. Radiology review.Request for histology.Reminding Dr's.of MDT
77. prep of the list of pts needing to be discussed, enduring tests have been done and results available

78. Personally, I prepare the proformas and forward them to the MDT coordinator at the tertiary referral centre where our MDT is held. I also ensure that all histopathology and imaging is available prior to the meeting for review by the relevant specialists.
79. Personally, I need to be sure I am up to date with available clinical trials. It is nopt necessary to spend a lot of time preparing. I believe it is the trackers and co-ordinator who need to spend the most time and their organisation is invaluable
80. personally write the list of patients who may be applicable to me. I dont have preparation responsibilities other than informing the MDT coordinator if i have a patient to add to the agenda.
81. person adding name to list needs to plan presentation of patient - not read through last clinic letter at point of meeting
82. patients notes and diagnostic tests need to be completed, and appointment to see patient needs to be made.
83. patients casenotes with the results
84. patient summary with relavent information to permit the decision making process
85. Patient summary Notes, histology and radiology available
86. PATIENT LIST/ PATIENTS OPA DATE, NOTES
87. Patient list, availabilty of all investgations and results, availability of clinic dates, treat by dates, etc. Gathering of notes
88. Patient information and history summarised. Ensuring that histology and diagnostic images are available. Preparing patient for possible outcomes of MDT. Arranging timely appointments for patient following MDT, to include OPA and/or surgery. Identification of patient that require video linking for review by specialist elsewhere.
89. Patient info - results,social history,etc. Availability of appropriate treatments & knowledge of referral pathways. Members to be punctual.
90. Patient case history, staging and patient views.
91. Path info so notes can be made up for those with a cancer. Ready for bcn to write in as no time after when staff are part time. Packs made up for clinic of pos pts. Mammos are collected ready for meeting.
92. pateint case notes/summaries/diagnotic results/treatment already planned
93. Palliative care patients clinical presentation can change rapidly need to update and report back to mdt. For site specific see who on list and ensure can report update if already known to team
94. Outline proforma completed before MDT with relevant detainls lifted from notes and checked 'live' at the MDT.
95. organising investigations,collaberating results, ensuring investigations have been done prior to mdt, case summaries and proformas
96. Orderly case notes - with page marked/highlighted with most recent patient correspondence/clinical notes available. Imaging accessible/available. Pathology reports available. Refreshments!
97. obtaining of results and images, the collection of all patients case notes
98. Obtaining ,results, histology, CT's gen info regarding fitness for surgery
99. notification of all patients to be included in MDT collation of patient notes /records
100. Notes, x-ray preparation
101. notes, imaging & pathology must be made available ro MDM co ordinator, advanced list to radiologist and pathologist in order to faciliate review of results/ reports and summary preparation prior to meeting.Completed list of patienst to be discussed should be circulated 24 hours in advance
102. Notes, case history, data collection
103. Notes, all patient information collected (as not always in notes).
104. notes to be available x rays to be reported along with pathology
105. notes need to be collated, histology results need to be available if not in notes, MDT list circulated to members and also histology, agenda for meeting to be done
106. Notes need to be available with all results. A list of all patients to be discussed along with a brief outline of the patients history in order that the notes need only be referred to if necessary
107. Notes collated, proforma to summarise the case prepared, ensure results are

available

108. Notes available and relevant scans histology IT up and runningcomplete team to make multidisplinary descison
109. notes and scan availability, CNS or other key worker to give background re patient and any co-morbidities, and social background - i.e are they are carer for ill relative, does that impact on their care/plans/wishes re treatment that we discuss at MDT
110. Notes and investigation results available
111. notes and all reports need to be collected patient needs to be seen and appointments made to discuss results all clinicains ned to be informed of patient list
112. Notes access to x ray system. Good presentation of patient. Distribution of list
113. Note collection, speaking to other hospitals to obtain images, collation of names
114. note collection, radiologist/pathologist need to review scans/path., presenting member to know patient & history
115. None, from a palliative care CNS point of view. The presenting consultants obviously need to be very familiar with the cases they present and be able to field questions or suggestions from the MDT members.
116. Need to read through the cases and familiarise self with each paitent and what stage they are at in their management. In reality I seldom have time to do this.
117. Need to know the issues that are required for discussion and all test results available with appropriate medication. Also any co-morbidites and if possible the patient choice and patient condition.
118. need to be able to assess patients for clinical trials
119. my preparation is ensuring cases i present have all the information available including relevant PMH. each member should take responsibility for presenting their cases and the radiographers, histopathologists, nuclear med consultants need time to examine relevant images, slides etc
120. Most important factor is that someone is present who knows the patient and has provided the info for the question about them to be asked and answered.
121. meeting with the patient to assess medical status and specific choices list of patients to be discussed at least 24-48 in advance of the meeting OPA to be on the same day as MDT
122. meeting with co-ordinator, preparing proforma, list,
123. MDT list does not always have all clinical details I have to go through patient info to collect it and prepare notes for the MDT clinic.
124. MDT facilitator should ensure a copy of patient lists forwarded to all members of MDT - notes, images etc all available to ook at before meeting
125. MDT coordinater spends a long time preparing all the info and relevant notes/reports Histo path prepares slides As a CNS I see who is on list add people to list prepare any relevant info i have. take things patient wants me to take to meeting, ie info patients want me to pass on
126. MDT co-ordinator side needs doing obviously but also prep by clinicians if they refer a case for discussion, ensure results etc available for meeting
127. making sure investigatio reports are ready, notes are available, clinic appointments available
128. Making sure everything needed is in the notes and patient on the list. If MDT coordinator not about this seems to fall to the CNS. Checking people on the list should be there.
129. LOOKING UP SCAN/HISTOLOGY REPORTS
130. Location of notes
131. locate patients medical notes, have results available for all investigations, prepare mdt referral form
132. Live and accurate information needs to be captured on each patient. This should be as holistic as possibe
133. Lists, Notes, xrays, histology
134. List of patients and all appropriate investigations to be collated and circulated to relevant personel who need to scrutinise scans etc. medical records collected, proformas completed and attached to medical records. Room prepared. Agenda

circulated to all MDT members in advance.

135. List of new patients faxed to co-ordinator 2 days before MDT. Includes all patients seen in the past week, any ongoing patients with problems or need to share information and deaths.
136. Liasing with the head a nd neck cancer secretary at our cancer centre in XX [area], to ensure that all the scans and biopsy results, demographic data and clinical information are sent to the hub at XX [area]. Ensuring that they also receive the information from XX [area] too. It is very important that the scans are put on PAC at the Hub ready for the SMDTM otherwise this results in a delayed outcome.
137. Liaise with the MDT coordinator. Within our specialist area, pull the nurse specialists notes and summarise all case histories for presentation
138. Knowing the patient, ensuring tests are completed prior to the meeting, follow up OPAs are ready
139. knowing patients cases, relevant history, performance status and patients preference of treatment,
140. know patient history, preparaton of imaging
141. It preparation to recall patients being discussed and list of patients to be discussed
142. It is all done by lead clinician and MDT co-ordinator
143. investigations to be discussed and any discrepencies discussed with appropriate core members
144. information collection-notes,scans,histology,
145. information collated by mdt co-ordinators and forwarded to appropriate persons, booking of location with no overlap of other mdt meetings.
146. info re; patients such as case notes/images/reports etc should be available
147. info available on patient
148. In my role I will review case notes which are available electronically.
149. Images need to be available current notes etc to ensure all appropriate info is available so delays do not occur or care cannot be properly planned
150. if you are the presenting clinician, full history, clear why here at MDT, what questions/decisions need to be asked and why, all relevant results/imaging to hand, coordination with patient post MDT to communicate and involve in decisions/questions
151. If you are presenting the patient, clear knowledge of the patient, to be able to give an account of the salient points. The notes to be available to refer to.
152. if presenting a patient, know your patient's case.
153. If I had patient list i would check to see my patients and check what was happening with them rather than just going on memory
154. identifying patients for discussion, tracing and collectionof medical notes, compiling and sending out agenda, data collection and input on database, Cancer wait times, apologies, ensuring technology works ie computer, projector etc.
155. I think the peiple presenting the case should have all the necessary facts ready and have looked at them prior to meeting. A minimum data set should help this.
156. I review the patients past treatments if they have had any. New patients I check the mode of referral
157. I prepare and collate my own records, check what test results are available etc
158. I need to re-brief myself on patients known to me schedule for MDT review. To do that I need advance notice - which I don't get.
159. I need to have an understanding of patient hopes and expectations and performance status to aid discussion of suitable treatment
160. i NEED TO HAVE A CLEAR KNOWLEDGE OF MY PATIENTS WHO ARE TO BE DUSCUSSED
161. I like to read the comprehensive letter I wrote on the patient when I last saw him.
162. i keep track of all imaging requests that come through the MDT meetings and make sure they go back on the list when done.
163. I have to let the MDT co-ordinater have the patients names. I fax the patients names to the pathology department, prior to the meeting. I input all the patient clinical data onto the patient register.
164. I have to collate all the individual patient's history - details of presenting complaint,

PMH, details of investigations so far, dates of forthcoming investigations. contact GP if necessary for further deatils. establish patient's views on treatment options if appropriate to relay to MDT.

165. i feel that if the notes are reviewed and a summary prepared prior to the meeting it works much better.Unfortunately in my trust i am having problems getting a list of pts and notes prior to the MDT.This is down to the coordinator.I have a session dedicated to preparation (at my request) which i am unable to utilise.
166. I act as MDT coordinator and colorectal CNS
167. History summarised to MDT proforma, Data collection for audit
168. having knowledge of the patients discussed, so discussion can be concise and relevant
169. Have your p/w for each patient with you
170. getting notes, pathology, trial protocol
171. gathering of all info including scans and histology slides
172. Gathering all info including notes and all results
173. Full knowledge of patients case. Comprehensive completion of proformas
174. fROM A cns VIEW POINT IT IS GETTING OUR CASE NOTES READY AND REVIEWING WHERE PT IS ON PATHWAY AND IN SOME CASES CHASING REPORTS OF TESTS ETC OR REVCIWEING IN PTS BEIING DISCUSSED.
175. From a CNS point of view to have good knowledge about the patient i am intending to present.
176. for network mdt info slides and xray reports need to be sent before the deadline
177. For me it is checking against trial entry criteria to screen potential subjects
178. for me I like to be up to dat ere the patients I know so I can efectively contribute to decision making process/discussion
179. For MDT Coordinator needs to collect all necessary patients notes/imaging/inform Pathology etc. For me, check my own patient records/admission details, scans due to see who needs adding to meeting.
180. for case notes, histology and radiology to be available orhganising of notes to have results/history at hand. Completion of MDT proforma
181. feedback from oncology centres (PTC). Good communications from all involved.
182. FAMILIARISATION WITH YOUR PATIENTS
183. Everybody must have the correct information so that time is spent preparing the cases to ensure smooth running of the meeting so each patient is discussed and a treatment plan m,ade
184. Ensuring timely listing of patients on mdt is communicated to all attenders in order to ensure adequate preparation and collation of relevant clinical detail and images for discussion
185. Ensuring the right patients are discussed at the right point in the pathway to avoid duplication of discussion. Ensuring the team have advance notice of patients for discussion.
186. Ensuring the one core meber knows the patient who is being discussed and making sure all test results are available
187. Ensuring that case notes and correct imaging and histology reports are availible on all patients.MDT co ordinaters have more knowledge about the cases that are going to be discussed and have an awareness of the value of the MDt meeting and it s importance within patients care outcomes.
188. ensuring that all the relevant information is available for discussion
189. ensuring test results are availalble to faciliate swift diagnosis and action
190. ensuring results are available, recent letters if applicable
191. Ensuring patients with non-cancer diagnosis are not included Case summaries should be prepared
192. Ensuring patients who need to be discussed are put on the agenda and that pathology/imaging/ etc are available. Also that patients being discussed have an appropriate follow-up appointment to discuss MDT treatment plan or other plan. It is also important to consider any social/psychological needs eg carer or lives alone and these need to be highlighted to team members.
193. Ensuring patient's case is ready for discussion Communication of patient information Own personal information to take to mdt. Time management

194. ensuring case notes and relevant results are available
195. Ensuring appropriate patients are listed for discussion. radiology and pathology reviewed prior to meeting. A representative who knows the patient is attending
196. Ensuring all results for histology, scan etc are available so discussion can take place. As a nurse i ensure i know where patients are in the cancer pathway and their opinion/feelings and fitness to undergo other treatments, this information is then fed into the discussion at mdt.
197. Ensuring all reports are available on the day and that all members have a period of time prior to the Mdt to review the content for discussion.
198. Ensuring all relevant information and imaging is available
199. ENSURE THE MDT LIST IS CICULATED TO ALL CORE MEMBERS, RELEVANT PATIENT HISTORY BIOGRAPHACIAL DETAILS SHOULD BE ENTERED, ALL RADIOLOGY AND HISTOLOGY SHOULD BE CUT AND PACE ON THE MDT PROFORMER. ALL DATES OF SCAN BOOK, ALSO THERE SHOULD BE AN ACTION LIST FROM THE PREVIOUS , OF PATIENTS WHO HAVE BEEN PREVIOULSY DISCUSSED, BUT NEED FURTHER INVESTIGATIONS, OR NEED TO BE DISCUSS AT ANOTHER TUMOURE SITE BEFOR DECISIONS CAN BE MADE.
200. Ensure that correct information is recorded on summary sheet. Include any discussion with patient regarding their own choice of treatment. Copy of photo available when discussing lesions (helps with teaching as well as identifying lesion position)
201. ENSURE THAT ALL SPECIALITIES ARE AWARE OF PT ON AGENDA AND REASON WHY. ENSURE RESULTS OF INVESTIGATIONS ARE READY. ENSURE MEDICAL NOTES ARE AVAILABLE. ENSURE THAT CHAIR IS ATTENDING, IF NOT A DEPUTY IS NOMINATED. ENSURE APPROPRIATE PTS ARE ON AGENDA.
202. ensure patient names submitted to the coordinator in good time. Check names on the pre- sent list,
203. Ensure notes and films are available. List of patients for discussion circulated to team members. Note preparation on day of meeting
204. Ensure indvidual responsibility in presenting the case MDT co-ordinator to circulate list Path and histopathology available
205. ensure histopathologist and radiologist able to attend
206. Ensure diary allows attendance Print/ read circulated lists
207. Ensure core members will be present.Agenda drawn up and sent out to team in timely fashion.All patients requiring discussion are on the agenda providing work up is complete
208. ensure any investigations or results are in place.technical equipment are in order,appropriate members are present.
209. Ensure all notes and tests need to be available, good summaries of each case prepared. Pathology and radiology preparation. Preparation of decision sheets
210. Ensure all data is collected and present at meeting (all areas in question 13 should be undertaken)
211. Effective MDT co-ordination i.e case notes available,summaries of diagnoses,results of diagnostics etc./patient advocacy+up-to-date info with relevant caseloads.
212. Effective communicaton from clinicians with names of patients to be added to MDT so that radiologist, histopathologist,co-ordinator have the time to get relevant slides, notes, pacs ready for the meeting.
213. Documenattaion in order - notes/files etc Video/computers working
214. detailed proforma preparation with all results available for the meeting, patient notes available, histopathology slide review prior to Live Link MDT with cancer centre. technology working for Live Link meeting to be effective
215. depends who by
216. depends on how many patients are known to me who are on the meeting
217. Data manager needs time for preparation to collect all information-mammogram/ultrasound films copies of histology reports etc. Radilolgists and pathologists need time to prepare for presentation of films/slides

218. Criteria of cases for MDT, creation of case list and circulation with reports available prior to MDT meeting
219. correct patients on list. room available members informed of cases to be discussed
220. correct patient information/results (up to date pathway)
221. correct assessment of who needs to be referred, good preparation of case notes
222. coordination with MDT clerk.
223. concise pt records need to be available, technology and IT support must be accessible and working efficiently, key personnel must be available such as histologists and radiologists, minimum dataset for each pt completed, current notes/letters
224. Completion of the MDT proforma to give full history of patients care
225. COMPLETION OF MDT PROFORMAS FOR PATIENTS CNS WANTS DISCUSSED. CNS PATIENT INFORMATION COLLATED
226. Complete documentation and submit to co-ordinator to ensure appropriate investigation results are requested and available for review in time.
227. compiling a list of patients completion of pro-forma for each patient
228. Compile patient list & send out. Order notes Upload patient information / reults of bloods/scans etc onto electronic records for each weeks discussion Chase procedures i.e CT scans / biopsies
229. communication with MDT Co ordinator after clinics Checking of lists with MDT Co ordinator
230. Collection of staging results and ensure filed correctly in notes. Only listing adequately staged patients. Complete M.D.T list with concise patient history and co morbidity to ensure fitness considered in appropriate management plan. Check clinic availibility for patient review post M.D.T decision, contact patient pre M.D.T to ensure they are aware of dates and rationale behind meetings. Liase with radiology and histology to ensure they are aware of listed patients to enable availibility of histo and authorised staging C.T's and input from radiologists at M.D.T. Prepare G.P proformas on M.D.T patients, completing demographics so that they can be faxed post M.D.T decision to maintain P.C.T update.
231. COLLECTION OF PTS NOTES. KNOWING SOCIAL INFO
232. Collection of patient names/reason for MDT inclusion/name of referrer+ named consultant/histology/radiology results/MDT list including circulation/room preparation + equipment/record of attendees/stationery etc
233. Collection of notes. Checking of proformas. Collecting results. Setting up the room
234. collection of notes,pathology & radiology results sould always be available. A full detailed anitation.
235. Collection of notes, all available histology, staging results and other necessary patient information. Preparation of MDT proforma to facilitate presentation at meeting Pathologist and radiologist to have information at least 48 hrs before meeting for review
236. Collection of notes with relevant letters/ reports. Distribution of lists and patient plans
237. COLLECTION OF MEDICAL NOTES PREPARATION OF CASE LIST/AGENDA CHECK OF EQUIPMENT
238. collection of individual specialist notes and availability of scan reports
239. collection of histologies, preparation of draught copy of mdt list, plist pt's etc
240. Collection of data - patients records, electronic lists set up, preparation of pathoplogy slides and radiology records. Review of slides and scan etc by members
241. Collection of any details I have about the patient. If I have not heard of the patient investigation in to the reason why
242. collection of all relevant information and representation of all disciplines
243. collection of all appropriate information and dissemination of patients on meeting to all members of team
244. collection and organization of patient details, notes. Summary of patient history,palliative treatments, interventions, advanced care planning decisions (if already discussed with patient/ family) MDT information sheet

245. Collection and corrolation of clinical radiological and pathological details
246. Collecting notes, ensuring all patients are on the MDT list
247. Collecting notes and results. Check everything has been sent from unit to centre. check follow up, breach dates, completing paperwork
248. collation of results
249. collation of patients to be presented. Notification to co-ordinator, histopath, imaging etc consultants to preview the results. Collation of notes. Venue should be pre-booked yearly and any changes of venue notified ASAP
250. collation of patients for discussion, patient history, availability of investigation/diagnostic reports
251. COLLATION OF PATIENT LIST PATIENT INVESTIGATION RESULTS NOTES PROFORMAS TARGET DATES
252. collation of notes, selection of suitable patients, summaries, ensure all tests available
253. Collation of medical notes, results, histology and imaging outcomes ready for discussion. Co ordination of MDT members, if the histologist is absent the MDT is cancelled locally and outcomes may be postphoned if this happens at the centre MDT.
254. Collation of information Formation of adgenda Venue arrangements Time for clinicians to prepare
255. Collating the MDT paper work, reviewing test results to ensure correct timing of presentation at MDT
256. collating notes. written info on patients. ensuring someone at the meeting knows the patient if possible and presents pt.
257. collating notes, list etc
258. collating notes of pt so prepared alerting individuals of what to be disc
259. Collate notes, write proformas, write overheads, discuss each case with presenting Dr. Ensure histology ready and Scans reviewed and available.
260. Collasion of history, agenda with relevant information,ensuring tests results are available
261. Colation of reports, biopsy results, Immaging.Notes and relevent information. Email the cancer team, consultant pathologist and consultant radiologist the patient list for discussion. All information entered into upper GI cancer database. Appointments for patients to get results and treatment plan post MDT meeting.
262. co-ordination of all group members to ensure an accurate list is composed, and gathering of relevant information.
263. CNS ensures that all appropriate patients are listed
264. Clinicians prepare their summary to avoid rifling through notes and delays and 'waffling!' CNSs up-to date re condition af patient - psychologically and physically. Radiology and Pathology prepared for presentation
265. Clinical review to enable accurate summaries. Thought given to planning the agenda especially when issues around service provision are likely to arise from clinical issues. To plan for the inclusion of audit, servcie review and clinical governance within the MDT's Preparation of notes, results, proforma documents. Preparation of IT equipment.
266. clinical details to hand. completing proformas. know which patients need to be discussed - case management
267. clear medical history, with all investination dates and results if available
268. clear instructions to co-ordinator. All tests should be complete brfore discussion of plan
269. Circulation of patient list. Notes available at the venue so that decisions can be documented. A good comprehensive summary of each patient to be discussed to ensure that the meeting runs smoothly and that time is not wasted.
270. circulation of lists checking that all requested investigations are available patient notes available knowledge of patients to be discussed prompt start availability of core members
271. Circulation of list, Patient names & details for co-ordinator during the week prior to next meting.
272. Checking patients for discussion have been added to list. Liaising with MDT co-

ordinator.

273. Check up on current information and liaise with colleagues
274. Check that data base up to the minute.
275. Check that all Results available including pathology/histology/radiology. Aware of dates for futher tests investigation and OPA
276. check staging dates are meeting targets (do not want to request review of some imaging if other imaging is imminent, liase with the relevant consultant re appropriateness,
277. Check results are available, when patient has OPA. presenter of patient needs good knowledge of patient
278. Check pt results. Ready the post meeting paperwork
279. Check patients known to me for discussion. Update myself on status of patients
280. check patient eligibility for studies, check test and histology results, double check eligibility criteria
281. Check clinic lists to ensure what patients are needed for discussion. Ensure all test results etc. are available for discussion.Obtain a past history of patient.
282. Check all tests, results and appointments prior to meetings.
283. CHASING EUS AND PET REPORTS,BIOPSIES AND CT REPORTS, ENSURING BLOOD RESULTS ARE AVAILABLE, BE AWARE OF THE PATIENTS RECENT SYMPTOMS, PMH, PREPARATION OF ELECTRONIC PROFORMA'S
284. chase results, ensure nursing contribution documentation available
285. Chase reports for investigations. Summarise patient pathway. Does patient still need to be on MDM?
286. case summary preparation
287. case summaries need to be accurate, including relavent medical history
288. Case summaries by MDT co-ordinater and making sure that scans etc are available. The Consultant radiograher needs to R/V the imaging prior to meeting
289. Case notes, treatmen options available
290. Case notes, reports, investigations to be prepared. patient appointments arranged to ensure good flow of journey timings/treatments. Ensure that there is going to be attendance of relevant members, and cover at holidays is organised.
291. Briefing information, lists of patients and gathering all the relevant investigations, such as imaging, blood results etc.
292. Being aware of the stage of the patient pathway/results of invetsigations/physical ability of patient
293. background knowledge of patient, history of presentation record of their wishes in decision making decisions made in other MDTS
294. Awarness of who is on agenda and summary of care from CNS perspective, awarness of patient key concerns
295. Awareness of pts investigations,when and what and plan of care to date and future plans
296. Awareness of patient's wishes All scans/biopises are ready for patient to be discussed properly
297. aware of patient and need for discussion - awareness of patient OPD or ward attendance for discussion of plan
298. Availablility and reporting of all scans and blood tests. All clinicians involved in their care present
299. availabilty of all clinical information pre planning
300. availability of imaging and pathology.awareness of patients performance status inorder to assess fitness and approriateness for treatment. availability of information re patients diagnostic pathway if they have attended any other hospital.
301. Availability of healthcare records, history, results of tests already carried out, dates for any tests planned for future, patient understanding & information given so far
302. Availability of all scans etc and review by radiologist. All histology to be available. Blood results to be available. medical background to be known.
303. Availability of all notes and case summary so all members can concentrate on cases being presented

304. At our meetings the CNS does the preparatory work and presents the majority of cases as she is the key worker. There is little preparation by anyone else.
305. At least one member of the MDT needs to have seen and fully assessed the patient
306. Assess pt list and the contribution I might make. MDT co-ordinator prep is vast. Sufficient information needs to be at the meeting. Access to images, pathology. Clinical test results etc.
307. Assembly of appropriate patients ,and reason for discussion.Collection/retreival of notes,imaging ,histopathology.Preparation of short case history either to be deliverd verbally or presented via electronic system and projected.Ensure all IT systems are running effectively
308. As we write our own outcomes all assessment forms for patients being discussed are brought to m.d.m by us and kept in our own files [B.C.NS]
309. as we do not have an mdt co-ordinator I have to check what appointments pts have and look at the histology reports to see if further action is required eg wide local excision. I also have to ring GPs up if they have removed a skin cancer in primary care etc
310. As the CNS, I assess the physical /mental capacity of the in- patients & their wishes which empowers me to act as their advocate in deciding their treatment pathway at the MDT discussion
311. as the CNS sound knowledge of the pts performance status,quality of life and their wishes should be known to the MDT
312. As long as you have an MDT co-ordinator to orangise this I do not think that I need to do anything in preparation as I will do paperwork as the meeting happens
313. As CNS I might put a patient on for discussion through the co-ordinator. I also compile a list of patients who are currently in-patients on the surgical ward so their ongoing clinical management can be verified through the MDT. This also allows other specialists to be aware of where patients are on their clinical pathways.
314. As CNS I like to ensure I know about the patient prior to the meeting and that it is appropriate to discuss the patient at MDT
315. As CNS 's we do not require any preparation time pre, do not consider it our role to prepare MDT's as affects time spent with our patients although when crisis hits within this trust it always falls on the nurse specialist irrelevant how busy we are.
316. eg sending out cases for discussions etc
317. As a CNS we take all the relevant information on patients to be discussed e.g. their preparedness for bad news, for various treatments and patients feelings about them, functional status etc.
318. As a CNS OFTEN WE HAVE MET THE PATIENT BEFORE SO BRING IN A HOLISTIC ELEMENT FOR CARE.
319. As a breast care nurse we have little preparation to undertake prior to the MDT meeting.
320. appropriate timming of patient to be on MDT, investigations/pathology reported in time for MDT, spread sheet prepared for MDT, e-mailed prior to MDT to all members, collection of patients notes, room prepared.
321. Appropriate selection of patients for Specialist or Local discussion. A comprehensive case summary with clear reason why the discussion is taking place. (What is the question about this case?) Notes fully available. No temporary casenotes. Access to Pathology and radiology. Sufficient time to discuss and document each case.
322. Appropriate patients must be added to meeting and lists prepared and distributed by MDT co-ordinator. Hard copy of MDT lists to be prepaerd so available for MDT members to follow meeting (these include a patient clinical summary). MDT Co-ordinator checks theatre lists to ensure all patients operated on are included. Images required for meeting must be collected and collated. Pathology required collected and collated. BCN checks MDT patient list so is aware of what to expect to add patient views/feelings, question outcomes, cross check choices availble to patient. Research to be aware of patients in advance to ensure appropriate trials are suggested. The more prepared you are the better the discussion and so the better the outcome or offers best choice/options. Less thinking time on your feet and more considered discussions. Quicker the more prepared you are.

323. Appropriate paperwork completed. Enough core members to attend however due to other commitments this is not always feasible. I think the amount of time that is taken up in the preperation, attendance and completion of paper work involved in MDT's has been completley underestimated
324. Any patients possibly suitable for trial need to be identified and tracked as to the most siutable time for when they should be approached re trial and by whom.
325. An effective MDT co-ordinator should ensure all relevent information has been collected prior to the meeting
326. all up to date staging, histology, scans, relevant notes, patient opinion if possible
327. All the patients test results should be availableand easily accessable. All core members should be present or have a stand in. iy should be clearly stated who will act upon the MDT outcome.
328. All the above [Q13] plus ensure one is able to attend the meetings
329. All scans/ histopathology and patients social history
330. All reports/ images / results need to be available MDT co-ordinator supported in doing this. Any reports need to be available to appropriate clinicians e.g. Radiologist / Histopathologist
331. All relevant information to be to hand
332. All relevant information gathererd and all MDT members informed. Annual leave needs to be covered.
333. all relevant documentation up to date, blood and bone marrow etc results available, MDT coordinator has details of those being presented
334. all relevant clinical information needs to be available
335. All radiological investigations regarding patients should be uploaded into PACS system or a CD scans sent for uploading. The histopathologist/Radiologist should have prior notice/list of patients being discussed. A list should be circulated to core members days before the meeting.
336. All preparation work is done by the mdt co-oedinator. But most patients are known to the members before discussion
337. All pending/ relevant results and investigations are available. Ensure any planned follow up arrangements are known and documented on the case summaries as well as dates pending for any future investigations/ surgery/ biopsies. A comprehensive patient history including referral dates, breach dates. Knowledge of the specialised guidelines.
338. All patients to be discussed have an allocated person who know their case to present them. Ensuring all imaging and histopathology is available for the meeting. Circulation of MDT list at least 48 hrs in advance of meeting.
339. All of the above [Q13] as well as there being a clear understanding of who is presenting the patient - the patient needs to be presented by someone who has met them and can make a judgement on things like performance status and patient wishes
340. All of Q13 plus attendance from core members
341. ALL NOTES ARE AVAILABLE AND RESULTS, PATHOLOGY/RESECTIONS ETC. DATES FOR AVAILABLE SURGICAL PROCEDURES. PATIENT PRIOR COMMITMENTS TAKEN INTO ACCOUNT.
342. All notes and imaging available complete with test results. Knowledge of the patients being discussed.
343. All notes and images need to be available, doctors presenting cases should have a clear idea of the question they are asking.
344. all notes investigations and mdt team to be present
345. All necessary paper work / films available and ready for commencement of meeting
346. All members to be present Case notes ready Diagnostic results available
347. ALL MEMBERS REPRESENTED HAVE APPROPRIATE INFO AVAILABLE
348. All medical notes, pathology slides and results, scan results and films collected and checked. Video conferencing equipment set up. Agenda sent out two days prior to meeting.
349. All medical notes available Summaries of patients on system
350. All investigations available, Notes available, List of patients, up to date and given

earlier if aplicable

351. all information required to assist in treatment planning should be readily available,every aspect of each individual case should be prepared and be available ie; blood results, Ct reports, PET reports etc.
352. All information needs to be available at the meeting.
353. All images need to be available - performance status and general fitness info available. All pt information available
354. All correct details of patients. All imaging and pathology
355. ALL Case notes/investigation results etc should be available prior to the meeting otherwise the patient has to be re-discussed.
356. All case notes, images and reports should be available.I review the interventions I have had with the patients and their family/carer prior to the meeting so that I can ensure that my knowledge is up to date for presentation. I undertake to take my casenotes to the MDT.
357. All available information to get an all round picture of what's going on with the patient
358. all above [Q13] as well as pathology information
359. Agenda, notification of to colleagues of imaging and histo needed. Notes need collecting ensuring all relevant information in them.
360. agenda, notes, results, radiology available, case preparation, documention
361. agenda being circulated to all members histology available
362. Agenda and patient list compilation, medical notes and results availability. Up to date tracking.
363. Agenda and agreed cut off time for non urgent cases. MDT 'packs' to consultants and agenda sent to all attendees. Lengthy preparation by Radiologist
364. Admin to ensure all information and results are available. Time for clinician presenting patient to prepare proforma so they know patient to be discussed. Time for radiologists and histopathologist to review test results. Time for CNS to review patient list so she can contribute to the meeting.
365. accurate information re patient diagnosis, treatment, options available, choices patient may have already made, who is involved, patient details
366. access to medical/nursing notes, imaging, histo/cyto and CNS aware of patient
367. A MDT co-ordinator must be available to prepare chosen patients, all relevant information must be collated and made available. A statiac venue must be arranged.
368. A full history of the patient, co-ordination of all investigations and reviews of path and radiology. Appointments for patients need also to be co-ordinated with the MDT so that definitive treatment plans can be arranged and organised appropriately and efficiently
369. a clinical update on the patient and results
370. 1. Patient list devised and circulated in advance 2. Results checked to ensure they are available 3. Check to ensure all necassary patients are on the list for discussion 4. Ensuring all patients for discussion have F/U appts if necessary 5. Tracking & obtaining patient notes

What makes an MDT meeting run effectively?

340 nurses responded to this question. In addition, 9 nurses referred to answers they have given to previous questions, and 3 stated “all of the above”, referring to Q16.

1. when preparation has been carried out effectively before the meeting particularly for those presenting the patients
2. Wel co-ordinated, MDM lead
3. We now have a dedicated session for MDT and so there isnt the same restrictions.It was harder when we did it over a lunch hour.
4. varied amount of pateitns are discussed at the joined meeting and then another meeting is held to discuss 'not so urgent' cases in all takes 2.5 hours
5. Utilising time appropriately, being prepared for each case discussion, and relevant documentation to be completed at the time of MDT.
6. uNDERSTANDING OUTCOMES NEEDED FOR EVERYONE
7. timing. I hate lunch meetings, some people only attend for a free feed, not for the benefit of patients, so no lunch and strict time keeping and keeping people on track and not allowing tittle-tattle helps effective running
8. timely management of meetings can often be difficult due to complex cases.
9. Timely arrival & start of meeting. Discussions not relevant to MDT are discouraged. Chair summarises action plan for each patient discussed, to aid role of co-ordinator in accurately& briefly recording minutes.
10. timeliness, good preparation, well presented cases, good leadership
11. Timeliness - no discussion of any non related issues. all information available equality constructive discussion orderliness
12. Time, preparation, equipment and staff working together.
13. time prioritisation, punctuality of team, organisation, effective use of the time, preparation
14. Time management,Good leadership and management from the Chair and MDT Co-ordinator.
15. time management, people arriving on time for start
16. time keeping. concise history giving. reasonable discussion
17. Time keeping,results ready,all relevant members present when discussion takes place,all clinical notes available,no interuptions
18. Time keeping, Core Members present, good organisation
19. Time IT working correctly so that we can acccess the relevant imaging-all too often there are problems with this All of the relevant individuals in attendance Adequate dataset of information re: each patient to be discussed Physical comfort of the MDT members
20. Thorough pre meeting planning which results in a clear agenda of patients timetabled accordingly to allow the right people to be present for the right sections (our MDT includes anal and liver section). Strong leadership from the Chair keeps the meeting running smoothly with support from the attending MDT co-ordinator. The venue and technological support should allow easy visualisation of data, access to patient results and teleconferencing with other experts in order that case discussions are successful and cost effective. The MDT co-ordinator should have access to a PC for use during the meeting in order that outcomes can be recorded directly on to a dedicated MDT process management system. Consultants should present their own cases or by a Higher Surgical Trainee from their firm when they are not able to attend. A short synopsis of the patient's history and a description of the purpose of MDT discussion should be presented to avoid delays in the meeting. Core members should remain in attendance for the duration of the meeting (whenever possible) thus allowing valued input and minimising the need for rediscussion.
21. the relationship of the mdt co-ordinator/chair and the CNS
22. the relationship between members and the leadership skills of the person in charge

23. The correct people attending and the clinical information system working!
24. the co-ordinator
25. The Chair managing time
26. The 'Chair' keeping discussion relevant and timely to the patient
27. teamwork, preparation, roles and responsibilities, respect, quiet environment (no talking), mdt lead to clearly state decision plan, not rushed,
28. teamwork among all core members and drinks available during the meeting
29. team working, ownership of mdt and patients by core members
30. TEAM WORK. PARTICIPATION ON DISCUSSIONS. TIME MANAGEMENT
31. Team work and all of the above I have said previously
32. Team work
33. team work
34. team members fulfilling their roles. technical equipment working.availability of clinical details.
35. Team members co-operating with each other and respectful to each other
36. team involvement
37. Strong leadership Keeping MDT on time
38. Strong chairmanship.
39. strict time keeping, making sure the last patient is allowed as much time as the first if appropriate
40. Stong chairperson, timekeeping, prior preparation
41. sticking to the point good chairing respect for others
42. Sticking to agenda -not discussing ad hoc patients.
43. staying focussed, members present, patient notes and results available
44. starts on time well prepared mutual respect
45. starting on time. effective decision making
46. Starting on time. All information being available. Someone able to record in notes as going along to ensure that nothing is missed. A robust system of referral once the meeting has ended to ensure smooth interaction of care.
47. Starting on time all members present. Decisions made for treatment plan Cns patient advocate to help with decision options All notes and reports available
48. staff not rambling on!
49. someone to chair, and availability of results
50. Smooth running. Keeping things moving along. Allowing no pts to be added during meeting. In specialist meeting where we are allocated last time slot, this has a knock on effective on us, and if the meeting runs late can mean that our pts are rattled through quickly
51. Set time and venue which all members know. Agenda sent to members in advance so all results can be available and preparation is done. Agenda is organised to take in to account member availability and conferencing schedules thus avoiding delays. Strong leadership from the Chair who keeps discussions succinct and allows members contributions to be heard. Ability to capture data in realtime for audit purposes etc.
52. right organization
53. respect of all opinions and effective communication of opinions
54. Respect for collegue opinion and good communication, with the focus being on the patient's care.
55. Reduction of non relevent discussion. Sticking to the agenda/list Good preparation, involving the availability of reports/test results
56. punctuality, focus on topic, clear detailed and accurate information provided including scans and histology and past medical history
57. Protected time and environment from other work committments. Punctual attendance co-ordinator/ chair keeps meeting moving along, summarizes complex cases where appropriate.
58. Proper planning- see prvious text box. Good charing of meeting. Good team working- mebers being repectful and curtious to each other- meeting not to be dominated by one person or hospital site. Adequate time.

59. Promptness Working technology Availibilty of case notes, imaging etc Quiet environment
60. Prompt time keeping , effective presentation, good communication, lisening to all, summarizing outcomes
61. Prompt start, focused discussion, clear planning
62. Prior preparation, an effective chair, members understanding the purpose of the MDT, their own and others roles in patient care.
63. Preperation
64. Prepartion by core members
65. Prepared summaries. Agreement that all personnel offer input, perhaps agree an appropriate order eg Clinical finding, tests (eg bronchoscopy), radiology, pathology, CNS, Oncology
66. preparation/leadership
67. Preparation.
68. preparation,protected time
69. Preparation, precisness, teamwork and good patient knowledge
70. Preparation, partnership, effective use of time and communication, teaching and a common goal
71. Preparation prior to, and leadership during the MDT meeting
72. preparation of agenda,core members present,Staging results available
73. Preparation and good leadership to make sure MDT runs well and there are no smaller meetings going on during the MDT
74. Preparation and good leadership
75. Preparation and co-ordination
76. preparation and availablility of team members and notes etc
77. preparation effician MDT co-ordinator
78. Preparation
79. Preparation-notes, scans, reports, appointment dates etc. are easily accessible. Good communication and time management by chair.
80. Planning, availability of information, designated MDT coordinator
81. Planning and organisation
82. planning and enough time, difficult to attend sometimes due to work load.
83. Planning Punctuality Responsibilitiy by Chair person
84. People turning up on time! Notes being available.
85. Patients being clearly presented with all relevant information given so that clear patient focused plans can be made
86. Participation, valued contributions and accurate documentation of decisions. Chairmanship effectiveness.
87. organisational aspects in place, the correct disciplines present on regular basis
88. organisation,co ordinator
89. Organisation, prior preparation and punctuality of the team members. Respect for other disciplines input and professional opinions.
90. Organisation, planning, a maximum numer of cases to ensure adequate timings, more time for complex cases, an opportunity for all to contribute. Timings of meeting and location, technology support, administration support
91. organisation, availability of pts results from relevant investigations
92. organisation of the information, attendance of the core members and that discussion is documented
93. Organisation and preparation. Also not allowing some core members too much 'floor time' and bringing cases ad hoc...radiology are good at this!
94. organisation and preparation
95. Organisation and leadership
96. organisation and dedication
97. Organisation and cooperation
98. Organisation
99. organisation
100. only neccessary cases discussed

101. only absolutely appropriate cases discussed, clear chair, good prep before hand, having technology available
102. Nice approachable people, good organisation and tea and biscuits
103. Need an operational policy how each mdt should run
104. necessary paperwork (proformas) in notes ready. Necessary request forms available.
105. mutual respect, good organisation
106. Moving swiftly from one case to the next. Not discussing cases/items not directly related to the MDT
107. Members prepared - all information available on each patient- regualr attenadnce by core members or deputies
108. members not getting distracted by using it as an opportunity to argue about managerial issues not relevant to the decision making of care provision.
109. Members arriving on time, chair person ensuring all minimum dataset, staging and MDT decision accurately recorded
110. Meeting start on time, MDM arriving on time,chair person, no outside interuptions e.g phones, bleeps, coordination
111. mdt coordnator turning up on time+
112. mdt coordinator, people arriving on time adequate preperation by co-ordinator, radiology, pathology
113. MDT chair and Co-ordinator relationship communication is vital.
114. Making sure all necessary information is available not deviating from discussing patients on the MDT list
115. listening to each other, one peson talking at a time, each member valued equally
116. Listening and not talking at same time
117. Listening Being respectful of others when talking/presenting. Organisation
118. Leadership/discipline in keeping order. Following a set order as defined by the MDT co-ordinator. Room layout/seating/temperature. Orderly discussion.
119. leadership. Keeping everything focused
120. leadership,organisation,time management,team working,good morale
121. Leadership, ensuring all members listen to each other, and that a final decision and plan is made and documented.Patients are discussed in order and patient identification checked with results.
122. Leadership and preparation
123. lack of chit chat and anecdotal stories. A co-ordinator is essesntial for effective mdt meetings
124. Knowledgable,professional,effective chairperson,efficient MDT Co-ordinator,info readily available,good attendance from varied,knowledgable MDT members.
125. Keeping to the agenda so that we are not having to rush at the end. All the information and personnel being readily available
126. keeping to agenda, only discussing kown or suspected cancer patients, ensuring all pts are discussed within timescale, prompt attendance, good prior organisation ie having all documentation required to hand
127. keeping the discussion on target. If the care is protocol delivered there is no need to discuss the case at length.
128. IT that works
129. input from the mdt and effective result giving and information
130. If all members attend in a timely fashion. All notes to be eaily available well organised MDT coordinator
131. Hospital notes available, all info and results available, team members have prior knowledge or access to current best practice
132. Having the correct information. Meetings starting promptly. Not over-running.
133. having everyhting available and on hand at the meeting
134. HAVING ALL THE PEOPLE NEEDED ARRIVING ON TIME STARTING ON TIME LEAD TO DIRECT CONVERSATION
135. Having all the information available. Good teamworking. All members need to be able to express their views
136. having all results and sticking to the patient being discussed

137. having all information available and the person presenting knowing the case history
138. Goodleadrership and communication
139. Good working relationships. Succinct question to be asked so that pt outcome is benefited by being discussed. Timeliness.
140. good timekeeping, less "chitchat", separate operational discussions, appropriate people attending (radiology, histology etc)
141. Good timekeeping / regular attendance Concise and precise presentation of patient information Multidisciplinary discussion Effective outcome and implementation of recommendations Teamwork
142. Good time management. Clear decisions for documentation. Enabling all members to contribute
143. good time management, controlled discussions without deviation. If possible protocols to aid treatment flow. full attendance of core members.
144. good time keeping, having all relevent clinical information available
145. good time keeping effective chair person organisation of MDT coordinator
146. Good teamwork and coordination of cases and discussion.
147. Good team working, good admin from mdt coordinator
148. good team working and everybodies opinions are seen as valuable. Time is essential as everybody has other duties to attend to and sometimes mdt can be difficult to fit into the daily schedule.
149. good team work, preparation and individuals getting along and having mutal respect
150. good team work and preparation
151. Good preperation by team members. mutual respect for each others contribution to the meeting.
152. GOOD PREPARTION. GOOD COMMUNICATION. TEAM WORKING.
153. Good preparation, timely start to the meeting- a good chair person, all notes/Xrays etc present
154. Good preparation, coordination and representation of key professional groups.
155. Good preparation, all core members being present. teleconferencing working well.
156. GOOD PREPARATION FROM THE MDT COORDIATOR. GOOD CHAIR TO KEEP THINGS MOVING.CLEAR STATEMENT OF OUTCOME FOR EACH PATIENT SO ALL MDT KNOWS AND AGREES
157. good preparation beforehand
158. Good preparation and willingness to participate
159. Good preparation and time should not be spent on discussing issues that don't relate either to the meeting or to the patients being discussed.
160. good preparation and good attandance
161. good preparation and communication, being succinct, allowing every members contribution as equally valuable
162. Good preparation and communication
163. good preparation and availability of core members, technology running weel for LIve Link part of meeting with the cancer centre
164. good preparation punctuality nof all members
165. Good preparation
166. GOOD PREP WORK BEFORE HAND, SMOOTH RUNNING OF MEETING, NO TECHNICAL PROBLEMS WITH PAC'S ETC,
167. Good pre meeting preparation. Starting on time.
168. Good participation from everyone & acknowledgement if a non core member has information to share.
169. good organsiaiton, prompt start and adequate leadership and direction
170. good organization, good leadership of the chair
171. Good organization and good communication skills
172. good organisation, everyone attending on time.
173. good organisation prior to meeting. A time when most members can attend and not be rushing off for other duties
174. Good organisation and resources

175. good organisation and leaderships qualities within the team. Sticking to time, prioritising cases for discussion when time is precious
176. Good organisation and having all paperwork to hand. The radiological examination results need to be available for discussion
177. good organisation and good attendance
178. Good organisation
179. good mdt co-ordinator no limit to attenders time available
180. Good leadership/coordination. Following ground rules. Time management. making notes and someone who documenats the outcomes and all are in agreement!
181. good leadership, those presenting well prepared
182. Good leadership, the chair should be strong enough to bring discussion to a conclusion, and decide if certain cases are relvant for discussion to save time.
183. Good leadership, strong team dynamics,
184. Good leadership, good presentation of each case
185. Good leadership, attendance and patient representation
186. Good leadership to prevent side tracking!
187. good leadership skills from chair, effective preparation for the meeting, people arriving on time
188. Good leadership & organisation
189. good leadership
190. Good leader with mutual respect for collegues working in the same field.Having everyone onboard.
191. Good leader who can keep the meeting on track! Breakfast & drinks to keep us going!
192. Good effective systems,processes and protocols. Mutual respect. Effective leadership and chairmanship. Good communication with ALL members of the MDT and breast team; core,extended and admin staff including those not part of the MDT such as clinic clerks etc. Effective documentation of events.
193. Good control by Chair
194. good communication, well prepared notes etc
195. Good communication, planning, good chairperson, access to all required information.
196. Good communication, good organisation and an effective chair.
197. good communication, everybody to feel valued.
198. Good communication between members and organisation. An experienced efficient MDT co-ordinator is vital as they bring it all together. This ensures the time is used effectively and time is not wasted.
199. good communication between all members. A strong Chair to lead the meeting.support and time
200. good commitment and organistation
201. Good co-ordination. Communication between members, other teams & GP's. Commitment to weekly attendance. Documentation. Venue. Access to IT. Shared views & consensus
202. Good co-ordination, proforma & following a standardised format, chair who summarises well
203. Good co-ordination of results etc and technology working optimally (scans etc)
204. Good co-ordination and starting on time and avoiding "chit-chat"
205. good co-ordination
206. Good co-ordianor, effective chair that allows all core members to be involved in discussions and not just clinicians. Outcomes are faxed to the spokes and GPs.
207. good co-ordianation and team work
208. Good clear leadership No anecdotal chit-chat
209. Good Chairperson who keeps discussions moving and keep to time
210. Good chairmanship, keeping team focused and not allowing distractions. Equality between members so all involved can give a clear clinical picture of each case
211. Good chairmanship Promptness of core member attendance Regular attendance of core members + extended teams Concise and efficient reporting of information/diagnostics Availability of all relevant information + results Clear and

concise reporting Smooth internal referral process to all services / team members Well considered treatment options Team concentration maintenance Good decision making/team approach Non interruption policy Agreed MDT appropriate inclusions only Good clinical options discussion/debate within accepted time scales Clear delivery of treatment management decisions/outcomes Good meeting planning and adequate data collection Timely intervals for individual patient case discussion Accurate proforma documentation/? electronic preferable Adequate/accurate documentation in patient health records Clear and concise information to be relayed to patients/carers by appropriate clinician, following MDT

212. good chairmanship
213. Good chairman who is able to move the meeting on when individuals try to digress.
214. Good chairing of meeting to move between cases, to prevent unecessary 'chatter' All information at hand
215. Good chairing clear case deliverance all electronic information available and easy to access
216. good chairing cases prepared before presentation focused discussion and decision making
217. good chair. good selection of patients. avoid other non relevan discussions. ensure all core members feel safe to contribute
218. Good chair. Committed members. Good admin. Organised CNS
219. good chair, good preparation by mdm co=ordinator, relevant information being available, prepared presentation of cases, time to discuss cases.
220. Good Chair ensuring smooth running of meeting Organisation prior to the meeting by the MDT co-ordinator and by all professionals presenting cases
221. GOOD CHAIR AND CLEAR OUTCOMES FOR RECORD
222. Good chair Keeping focused Pre-planning
223. good chair having all the information to hand good overheads having scans and histo ready
224. Good attendance. Good leadership.Appropriate discussion.
225. good communication/ preparation and information
226. Getting on with the relevent discussion and using the time effectivly
227. Focus, strong chairmanship, access to resources, manageable number of cases.
228. focus on the cases decsion and move on to the next case.Effective listening group decision on the written proforma for all individuals before going to the next pt
229. focus
230. excellent working relationships
231. excellent chair and mdt coordinator results being ready to review
232. Everyone taking responsibility for the role that they play within it. A shared approach.
233. everyone signs attendance, notes available , pathologist in attendance, photographs available of lesions, wel coordinated
234. Everyone on time, everyone concentrating, coordinated approach, multidiscipinary input and proper discussion when relevant and feedback to GP.
235. Everyone being able to contribute
236. EVERYBODY ATTENDING ON TIME. ALL NOTES/RESULTS THERE ALL EQUIPMENT WORKING
237. equipment working rel personnel present respect
238. Ensuring that it is organised well and group discussions are appropriate to the subject being discussed.
239. Ensure all information and results are availble for the meeting, and a member of the team has met the patient
240. Efficient presentation of patient cases. Effective equipment. Efficent chairing of meeting etiquette.
241. Efficient preparation by all members of team, prompt & regular attendance
242. Efficient planning and coordination with effective documentation
243. efficient MDT coordinator, respect for others opinions
244. Efficiency & concentration on the job in hand.

245. effective time management in the discussion of patients
246. effective leadership.
247. Effective chairmanship
248. Effective chair. All relevent infomation available. Knwledge of the patients general wellbeing and personla health beliefs.
249. Effective chair summarising and moving things along
250. Effective Chair ensuring members don't start getting off track!
251. Discussion of appropriate patients, quick concise clinical information.
252. disclipline and a structured approach very strong chair person
253. difficult not to have it during our lunch break due to other work committments
254. Courtesy, respect for each others views. All know our role, but all have a voice. Decisive
255. CORRECT SURROUNDINGS REFRESHMENT CLEAR CONCISE PAPER WORK IT AVAILABILITY EFFECTIVE MDT LEAD RESPECT
256. Core attendees having time to attend.
257. Coordination,preparation,named leader(chairperson) to move along the cases,good communication
258. coordination and communication
259. coordination and a good chair
260. coordinated efforts of lead and coordinater responsible for notes and other information needed
261. cooperation and good team working from all involved
262. Concise summaries of cases and accurate documentation of outcome. We are having very significant problems with encrypted CD ROMS as we are unable to open them at times if the password has come seperately thus delaying patient discussions. This is a significant clinical governance issue.
263. Concise presentation of issues
264. Concise discussion with no deviations
265. concise decision making, with no ego involvement.
266. concise and applicable patient info required to make the decision
267. Communication, Respect for other members information
268. communication, an effective chair
269. Communication between breast care nurses and the co-ordinator before mdt list typed to ensure all those who should be discussed can. Timing is essential. Not too large a group of staff at MDT.
270. communication between core members , effective use of all skills/time.
271. communication & preparation
272. COMMUNICATION
273. communication
274. Comfortable environment, appropriate equipment, good chair person, all information to hand and accurate record notes typed live
275. Co-Ordination/Having an agenda/Effective Communication/Facilitated discussion
276. co-ordination. Time constraints and leadership
277. Co-ordination, organisation, punctuality.
278. Co-ordination, organisation, communication, equipment that works
279. co-ordination to avoid long waits between presentation of patients
280. Co-ordination and time
281. Co-ordination and respect for others opinions.
282. Co-ordination and conciseness by those presenting cases
283. Co-operation from all the members of the MDT. Being listened to when discussing patients, and having a designated person who wants to chair the meeting. All members turning up
284. co-operation time awareness keeping to the point
285. Close liaision between MDT co-ordinator and CNS. Good Chair who keeps meeting on track and ensures agends flows efficiently.
286. Clinicians not using it as venue for mini meetings in background or signing clinic letters etc. Basic courtesy really

287. Clearly prepared MDT packs, orgainised in meeting running order. Every one arriving on time. All core members present. A good chairman who stops the meeting from getting off the point. A small half way break between new patients and follow -ups
288. clear leadership, planning ahead, grouping of patients
289. clear decision making
290. clear concise discussion, complete data available prior to discussion, efficient VC facilities, efficient/effective chair
291. clear agenda, preparation of attendees especially those presenting, no late comers
292. Clarity, good organisation and an effective chair person
293. Clarity of purpose and roles, information, resuolts and images to hand,punctuality from MDT members and timely notification of abscence, especially core members
294. circulation of adjenda beforehand prompt start availability of all core members from the start of the meeting effective chair effective co-ordinator
295. Chairing of the meeting. Adequate preparation. Completion of proformas. Prompt start. Adequate breaks. Clear decisions re discussion - written format. Roles & responsibilities of team clear.
296. Chair keeps momentum and focus
297. Chair and co-ordinator must have a good knowledge of each others roles and responsibilites. I feel some people attend meetings when they dont need to be there. I understand students need to learn, but secretaries for one speciality will attend whilst none of the secretaries for the other specialities do. There needs to be consistency. Lunch is provided at our meeting as it is done in a lunch period and this attracts lots of non core people who just want a free sandwich. There are very sensitive issues being discussed at these meetings and if I was a patient I would be horrified to discover who had sat in and listened whilst my case was being discussed. Although the NICE have recommended there should be a minimum number of MDT members, I think there should also be a recommendation for only having people at the meetings who have a REAL need to be there and who are KEY to that patients care.
298. chair being able to hear
299. Cases are presented concisely, apologies are given in a timely manner so the meeting can be planned effectively, attendees arrive on time
300. being well planned and co ordinated. and easily accesible
301. being on time, video equipment working properly
302. availability of relevent information running to schedule comfortable environment good communication
303. Availability of information and attendance of all members
304. Availability and coordination of results, effective team working, respect for all MDT members opinion
305. Problem with numbers is with the time targets there is urgency with all new cancers as they need to be discussed and treated in a short space of time so numbers are not really controllable. You can not delay somebody when the clock is ticking and they need to be treated.
306. Effective communication both verbal and writtern. Having the correct information re. patient care. Having a core of staff that are able to make decisions re. what to offer the patient. Good written information taken by the MDT Co-ordinator to reflect the discussions. Checking of this information and having it signed off by the Clinician.
307. An overall awareness of the whole situation. An effective, dynamic Chairperson.Communication.
308. An organised mdt co ordinator and a good chair
309. An MDT co-ordinator. However there are discrepencies in their job descriptions over the network and they are not on equql pay bands. If they had equitable JDs they may be able to be more effective.
310. An excelent coordinator which we have
311. an efficient MDT coordinator , lead clinican chairing and an MDT where members both core and non core, have a voice when discussing individual cases and their

journeys

312. An efficient Chair person to summarise patients and ensure meeting is kept on track, and digression does not detract from the decision making. Commitment from other core members to ensure information availible and meaningful discussion takes place.
313. An effective co-ordinator.A strong Chair.Anyone with a valid point should be able to make it.
314. An effective chairperson. Respect amongst clinicians and AHP's to allow all points of view to be heard and considered.
315. AN EFFECTIVE CHAIRPERSON
316. alternating cases between consultants, prioritising cases
317. All the preperation work completed prior to starting, early attendance of professionals to meeting.Lead person keeping others within agenda. Decision outcomes written down by co ordinator.
318. All relevant information being available about each patient. Core members being in attendance or knowing in advance if they are not.
319. All members of the team actively involed and jobs delegated equally amonst all members. Having a MDT Co-ordinator would be most helpful in assisting to co-ordinate and ensure it ran effectively
320. All information available. Efficient coordinator and chair. Quality discussion
321. All information available and the meeting starting on time.
322. all information available attendance of all core members appropriate cancers discussed (exclude level 1 and non-cancers)
323. All core team attending pts only on after all results of test completed good team leaders ,electronic data ,fast feedback & effective communiction within the team.
324. ALL CORE MEMBERS AVAILABLE MEETING STARTING ON TIME DRINKS AVAILABLE
325. All core member are present on time and case presented by someone who knows the patient very well.Results of investigations also available at the meeting
326. Adherence to terms of reference
327. Adeuquate preparation & the clinican presenting case must know the patient - individual charactersitics may not be documented
328. adequate time to discuss each case equal opportunities for all members to contribute
329. Access to all relevant information,preparation.Focus of the clinical team .Avaialability of support/admin staff
330. A well organised MDT pathway navigator with appropriate notes slides X-Rays available. Core members on time and prepared having reviewed their case input prior to the meeting.
331. a strong chairman
332. A good chair. core members arriving on time. Timely discussion of each case. All technology up and running. Core members or cover present. Presence of relevant medical notes, results, all radiology and pathology present
333. A good chair, good preparation, concise presentation and a good summary of discussion leading to a clear decision
334. a good chair in an ordered but not hurried manner
335. A GOOD CHAIR
336. A designated MDT co-ordinator and deputy.
337. A chair to move thr discussion forward. Preparation to ensure all relevant information available. Attendence by all core members.
338. A chair that takes control and time keeps. Good preparation
339. 1. Prompt start 2. Effective Chair/ Leader 3. Good preparation 4. Participation of all members
340. 1. All relevent investigation results to hand. 2. Medical notes in order - to aid ease of finding relevent sections. 3. All members arriving on time. 4. Chair to minimise 'chat' that is not relevent to patients. 5. Agenda to be circualted prior to meeting and each member to have a copy at meeting. 6. Clinicians to be familiar with patient case.

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?

148 nurses responded to this question.

1. Written communication between Oncologist, surgeon and GP.
2. within a clinic where multi-disciplinary members are present
3. We would have to have a separate meeting which is not feasible, within haematology a high proportion of patients are reoccurance and it ensures following national guidelines appropriately.
4. We always discuss this group at our MDT prior to discussion with the patient
5. Use of agreed protocols
6. Update on system outside of mdt Written in medical records
7. unsure
8. Treatments are largely protocolised for a number of stages of relapse so decisions could be made on the basis of locally agreed protocol
9. treatment protocols which have been agreed
10. Treatment pathways / guidelines for uncomplicated cases to standardise care.
11. treatment pathways
12. Treatment decision made with patient and their significant other. This information can then be recorded at an MDT so that all members are aware. If CNS available good practice to have them present during oncology discussion with the patient.
13. treatment changes could be made within agreed local/national guidlines
14. This should not happen in an ideal world.
15. They should be discussed at the mdt
16. they should be discussed at the MDT
17. They should be discussed
18. They should be discssed at MDT
19. THEY SHOULD BE ALWAYS DISCUSSED AT MDT
20. They should all be discussed at MDT
21. these pts are discussed anyway
22. These patients should be discussed at a MDT. There could be Palliative care MDT's set up where by professionals from teams previously involved with the patients are invited to attend and discsuss
23. There case should be put through the MDT
24. the oncologist is always able to discuss and ask for a second opinion on any case but if following Nice guidance the next choice of treatment is often laid down already and would only be varied if the patient is not fit for a particular regime. Most members of the MDT are not in a position to comment on the actual treatment only whether it is a relevent course of action. Oncologists will ask the opinion of other oncologist who are not at the MNDT meeting which is a better opinion than the MDT members
25. the majority of our patients have advanced disease so get discussed at mdt
26. The decsion of the clinician in charge of the case should beable to make the decision not for any further active treatment, as usually recurrent/advanced disease tends to be clear. If for any reason the clinician is in any doubt about the patient's condition or treatment plan they should then present the case at the relevant MDT.
27. The Clinical oncologist is the person who has assessed / reviewd the patient most. It is my experience that the forum we use is a discussion with our pateint /carer & the their GP/Macmillan Team first if the treatement options are XRT Or chemo.If surgical intervention is an option the oncologist will re-list at MDT

28. That would be at the discretion and experience of the oncologist, who balnces treatment options against quality of life.
29. Telephone discussions with key members and then documented
30. teleconferencing
31. Standardised protocol for 2nd line treatment. Peer support discussion outside of the realm of MDT
32. Standardised pathways could be drawn up locally.
33. Standard protocols & clinical judgement
34. standard is that the MDT agrees any tests and then patient will be seen in oncolgy clinic so that they are involved in any treatment plan
35. Standard care protocols / pathways for the specific disaesae can
36. SPCT
37. sometimes the way forward is striaght forward and it does not need to be discussed, complex issues should be
38. single clinician who sees them but sometimes I thinkthe mdt would have made a different decision.
39. Should be discussed at MDT only
40. Should be discussed at MDT meeting but if there is a need for fat action, the individual teams offer appropriate treatments to patients.
41. Should be discussed at MDT
42. should be discussed
43. shared care with palliative care or if in community to ensure they are known on gold standards framework, serious fax sent to Gp and dissemniated to district nurses.
44. separate mdt!
45. Referral to SPC teams (acute/community) via medical team/GP/AHP's.
46. rational decision making-communicate to other members,involve pt in their decision making ,if its complex it should needs to go through mdt
47. Protocols and national guidelines
48. Protocols
49. pre-agreed protocols
50. Phone or face to face discussion outside of the MDT between Surgeon/Oncologist & other relevant individuals ie: CNS
51. Pattern recognition & intuition
52. patients with advanced disease that are too poorly for further treatment and have been referred to the hospice should be discussed retrospectively
53. Patient with recurrent disease should be undergo the same model of decision making applied to new ptients with sthe same time frames and priorities alloacated to them. Patients with advanced disease should have the same clinical decision making format applied to them. This may include a discusssion in this instance about a 'no treatment' option and planning palliative interventions only. There would need to be extended information gathering relating to the advanced catergory i'e' co morbitites related to treatment options, patient wishes, Quality O Life projections etc. these are the patient who probaly warrant more dicussion relating to their clinical management as they do not 'fit' neatly into pre determined clinical protocols.
54. patient should be discussed so that the team is aware of patient treatment
55. Patient could be asked to attend a follow up clinic and the lead clinician for that clinic must give the CNS and the palliative care consultants the opportunity to be there. However discussing them at an MDT is the best model for this group of patients
56. patient centred/evidence based
57. Palliative care team advice always sought.
58. palliative care pathway, care of the dying pathway. Locally agreed site specific protocol
59. PALIIATIVE CARE REFERRALS
60. Ours are discussed
61. Only need MDT discussion if the treatment plan is unclear - often it requires no

discussion. Putting ont he MDT is mostly to inform the rest of the team

62. One option might be for oncologist to review pt with another similar site oncologist + patient
63. oncology/pallative care/radiology/specialist nures discussion
64. oncology m d t
65. ONCOLOGY DECISION BUT NEEDS CNS INPUT REGARDING INDIVIDUAL PATIENTS OPINION
66. oncologists are able to bring back complex patients with recurrence back to the MDT if appropriate, however protocols are in place within the network to enable decisions to be made re chemotherapy or radiotherapy.
67. oncologist will decide the managemnet of care
68. often these patients will be discussed atan alternative mdt, such as palliative so it would be nice if the original mdt were made aware of the patients advanced disease.
69. O.P.D review with assigned Consultant in presence of C.N.S who knows the patient well to ensure prompt treatment and referral to best supportive care. Use of G.P/M.D.T proforma to disseminate information.
70. not sure as I think they should be discussed by the mdt
71. not sure
72. Network guidelines
73. N?A as i think they should be discussed.
74. MDT the most appropriate forum
75. MDT INPUT SHOULD BE ESSENTIAL - IF NOT AT LEAST ONCOLOGIST AND PALLIATIVE CARE SPECIALIST AND CLINICAL NURSE SPECIALIST
76. MDT guidelines
77. mdt forum is correct way to discuss this group of patients.
78. Maybe a pathway if numbers are difficut but best practice should be to discuss with a room of experts and the opportunity to discuss with the MDT
79. Main consultat inform others of possible patient requirements
80. Local/national guidelines & protocols
81. Local team meetings
82. Local discussions in Histology or Radiology meetings.
83. Local discussion
84. Its easy to add a patient for discussion if they are running into trouble.
85. It would have to be on an informal basis
86. It should not happen, they should always go back to an MDT.
87. It is essential within our field. Patients are brought to MDT to discuss the benefits of debulking. this is a well established process
88. It depends on the type of cancer and what outcome can be achieved. The network has agreed pathways of treatments available for each disease site and pts can therefore follow pathway.
89. Involve others as appropriate
90. Informal support
91. individual discussion with another member of the core MDT's advice could be sort- many relapsed patients are discussed but it is a time issue that all of them are not.
92. Individual consultant decision making, possibly in consultation with colleagues.
93. if there were locally/ netwrok agreed protocols
94. If referral pathways are already in place the oncologist can refer to the appropriate speciality. The MDT is not just a paper exercise to dot the i's and cross the t's
95. Ideally patients with recurrent disease should be discussed at an MDT but soem MDT's are so large this would be difficult e.g a local inner east london breast MDT generally takes 4 hours to discuss screening, symptomatic, post op patients and results for pateints inc receptor status. Ocasionally patients with recurrence are discussed but discussinfg al would add a large number to an already busy list.
96. I think they should still be discussed.
97. I think there is a difference between recurrence and advanced disease. Talking through the best management re reurrence may benifit from the wider team input. Advance disease is more about best supportive care, and i feel this can be

managed by a palliative specialist, who will co ordintate care locally.

98. I think all these patients should be discussed
99. i think all patients with recurrent progressive disease should be discuss if possible but exceptions occur
100. I personally believe all pts should be re-discussed at mdt if recurrence/disease progression
101. I feel all these patients should be discussed at MDT to keep all team members fully informed about care
102. I dont know
103. I believe all paitetns with recurrent disease should be discussed at an MDT
104. have seperate meetings here re these pts
105. Haematology has guideline on these.
106. guidelines could be developed to cater for this
107. GP to be informed so they are informed when curative active treatment is no longer appropiate and we are aiming for best supportive care
108. Formal MDT agreed protocol
109. following nationally agreed protocols
110. Firstly all these patients should come through the MDT if not then they should be discussed with the consultant ,oncologist,radiologist and histopatholigist before any descision is made on their care and beforediscussing the outcome with the patient.
111. Each trust has guidelines so patient pathways have been agreed previously. if they differ it can be discussed.
112. Each patient should be assessed individually. i think the palliative care MDT is not utilised enough by Oncologists in our area.
113. DON'T KNOW
114. Don't know
115. Don't know
116. Don't know
117. Do not know
118. Discussions directly between Oncologists and Specialist Teams
119. discussion in joint clinic, where there is at least a part of the mdt available
120. discussion between oncologist and treating consultant
121. discussion between clinicians but not necessarily through an MDT meeting.
122. Discussion at a supportive/ palliative care MDM could be more appropriate in some cases
123. discuss with Palliative care
124. Designated clinic slots for suspected recurrence/advanced disease with CNS attendance or CNS-led. A proforma utilised to keep all members of MDT informed of disease progression that can be kept in notes so accessible to anyone who has reason to be in contact with patient and copy to GP. Whoever 1st person informed of possible recurrence a proforma to be initiated then with investigation and/or treatment plan documented. Protocols in place for requesting of tests/appointments depending on symptoms - this will avoid delay in GPs trying to speak to hospital doctors - CNSs knowing what in principle needing tobe done but not having authority to pursue without delay. Option of patient to see whichever clinician/professionka they feel most comfortable with in st instance
125. Depends on tumour type and site.
126. consultant/ specialist nurse/ patient discussion
127. communication with specialist nurses to coordinate care
128. Communication between disciplines is essential
129. Colleague to colleague discussion, then discussion with the patient to hear their views. Discussion with the palliative care team.
130. Clinicians should ensure they follow recognised guidelines.
131. Clinical trials, expert opinion in other areas of country
132. Case conference
133. At the very least a decision should be made with the nurse specialist or the nurse

specialist should offer sessions with patients to talk through their treatment options

134. Are usually seen at the centre then discussed at the central MDT
135. always discussed
136. All treatment decsions should be taken with the MDT for support
137. All patients should be discussed initially at diagnosis but MDT agreed guidelines can be used for managing patients without further discussion at the MDT. This frees up time to discuss patients with complex problems which aren't able to be managed within the guidelines.
138. All patient with recurrence or progressive disease should be discussed at MDT
139. Agreed treatment pathways protocols for recurrence
140. agreed protocols/pathways
141. agreed protocols
142. agreed protocol
143. A sub group of the oncological team could have a regualr meeting. Protocols for treatments available agreed by oncology team. Join more closely with palliative care teams.
144. a smaller oncology MDT to discuss patients with advanced disease involving clinical & medical oncologists, histolpathologist, radiologists and CNS Macmillan +/- GP/community input
145. a seperate mdt, ? palliative care mdt. or similar to one that deals with people who have recurrence who are on hormone treatment eg hormone resistant prostate cancer
146. A seperate "recurrence" MDT
147. ?
148. ?

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

252 nurses responded to this question.

1. when the patient is assessed in clinic for example it is decided that they are not fit etc
2. We work as part of a shared paediatric oncology service. Initial treatment decisions are not made by our MDT this is all done by the PTC. We are involved in treatment recommendations but we usually make these with the PTC and professionals from there.
3. usually patient choice
4. Usually after re-looking at the histopathology reports
5. Uncertain if theses questions relate to palliative care treatments/ recommendations
6. The patient declines the offer of treatment/management as discussed in the MDT. The patient is too unwell (performance status 3/4) to receive treatment. The patient has other emegency co-morbidities to manage before that treatment can be offered for eg. post surgery and awaiting healing of wounds before chemo. is offered.
7. The most common reason is patient's condition deteriorating by the time he/she is seen in clinic after MDT discussion
8. That would be up to the Consultant who makes the ultimate descision
9. Tertiary nature of referrals means that the general health status of the patient is not always fully known to the MDT and these may prevent our recommendations from being actioned.
10. Surprise' scan or histology findings. Patient choice Incomplete or inaccurate medical history which may exclude for any of the treatment modalities
11. suggestions sometimes given but individual clinician does not feel appropriate on

further assessment of patient

12. someone who knows the patient can give opinion on appropiateness of treatment dependant on patients ability to cope with treatment/intervention
13. Some patients will still insist on surgery even though the option may not be suitable and consequently they may still require further treatment when surgery is complete. If patients are informed of the potential consequences then patient choice sometimes takes priority.
14. Recommendations may not be implimented either through patient choice or if condition/ Performous status has changed since first review/ invesigations
15. Rapid deterioration of patient condition
16. pt view/choice
17. pt deemed not fit for treatment when seen by the consultant pt choice
18. Pt choice
19. pt choice
20. pt choice
21. pt beinging seen prior to meeting, person seeing pt not at meeting
22. Private patients - MDT discussion rarely influences the treatment given hence i do not believe that they should be brought to an NHS MDT
23. poor communictaion between teams
24. Poor communication Individual beliefs regarding treatment plans-doctors donot always agree
25. Performance status stopping someone being fit for the treatment and this info n/a at MDT. Patient choice - esp where there are options.
26. Performance status or wishes of patient not taken into consideration
27. patietns poor health or patient choice
28. patietn choic
29. Patients wishes change in patients health
30. Patients tend not to be seen until after the MDT discussion and if they are they are told an MDT discussion willtake place and this is when we will go through their treatment plan in full.
31. patients suitability for treatment and their decision.
32. pATIENTS SOMETIMES DISCUSSED RETROSPECTIVELY SO CAN HAVE THEN BE REFERRED ON TO CANCER CENTRE
33. patients refusal or clinical deterioration of the patient
34. Patients presenting with a different outcome, unknown co morbidities, patients declinig treatment.
35. Patients preference. Sometimes patients are discussed prior to being seen and and when reviewed the patient has different wishes
36. patients performance status declining
37. patients health and choice.
38. patients deterioration,patient declined,pt wants second openion
39. patients chosing a different option Doctors wanting to be able to recommend their own treatment recommendation rather than that of the MDT. Drs still like to think they should be making these decisions.
40. Patients choice. On clinical review performance status or comorbidities not previously noted may influence change of MDT plan
41. Patients choice.
42. patients choice or detrioration in condition
43. Patient wishes.
44. Patient wishes no further treatment
45. Patient wishes
46. Patient unsuitability/refusing treatment
47. Patient status changes
48. patient reluctance/decision to decline.change in patients health status
49. Patient preference

50. patient preference
51. Patient passed on
52. patient not wanting treatment
53. Patient not agreeing with plan
54. patient not agreeing to treatment
55. Patient needs assessment - may have been a tertiary referral, or referred by physicians
56. PATIENT MAY SEEK A SECOND OPINION DEATH PATIENT REFUSES TREATMENT RECOMMENDATIONS
57. Patient is unfit or declines treatment option offered
58. patient fitness/condition/choice
59. Patient fitness, patient decision
60. Patient fitness for treatment. Patient declines treatment
61. patient fitness for treatment ie co morbidities and patient choice, including 2 nd opinion
62. patient fitness patient choice payent clinically different when seen
63. Patient does not wish to follow the MDT decision Other problems highlighted after MDT
64. Patient discission, lack of communication between centre/hospital, poor continuity of care
65. patient disagrees with treatment plan, patient unable to proceed with plan
66. Patient deterioration.
67. PATIENT DETERIORATION OR REFUSAL/ OCCASIONALLY POOR COMMUNICATION
68. Patient deteriorates and is not fit for recommended treatment. patient choses not to go ahead with recommendation.
69. Patient declining treatment plan
70. patient declines. lack of resource, consultant disagrees with decision
71. Patient declines treatment. Patient is unfit for treatment
72. PATIENT DECLINES
73. patient declined or patients are not as well so would not tolerate treatments
74. Patient decisions and because of a lack of oncology input.
75. patient decision lack of availablility change in circumstances
76. patient decision
77. Patient decides she does not want treatment.
78. Patient condition changes
79. patient choices
80. Patient choice/physical condition
81. patient choice. Referral on for central review.
82. patient choice. Patient deteriorates.Do not have funding required
83. Patient choice. Further investigations revealing more disease
84. Patient choice. Individual clinician opinion
85. Patient choice. Formal treatment recommendations should not be made before MDT meeting
86. Patient choice. Availability of tests.
87. Patient choice.
88. Patient choice.
89. Patient choice, Patients becoming unwell.
90. Patient choice, patient deteriates, PCT funding
91. patient choice, or fitness may preclude a treatment
92. patient choice, death.
93. patient choice, consultant decision,
94. patient choice, clinican decision based on new medical assessment (e.g. if pt

admitted as emergency with non-cancer severe health problems such as MI or CVA)

95. Patient choice, clinical changes
96. patient choice or when patient becomes too unwell for treatment
97. Patient choice or suitability
98. Patient choice or staging is surprising.
99. patient choice or situations eg patient not well enough. occasionally tumour has changed and different option is more appropriate
100. Patient choice or performance status
101. patient choice or medical conditions
102. Patient choice or deterioration of their condition
103. Patient choice or deterioration of condition
104. patient choice or decreasing health of the patient
105. Patient choice or change in clinical condition
106. patient choice and clinician decision
107. Patient choice and changed physical state of patient
108. patient choice / prevailing medical conditions
109. Patient choice / patient deterioration
110. Patient choice
111. patient choice change in clinical condition
112. PATIENT CHOICE
113. PATIENT CHOICE
114. PATIENT CHOICE
115. Patient choice
116. Patient choice
117. Patient choice
118. Patient choice
119. Patient choice
120. Patient choice
121. Patient choice
122. Patient choice
123. Patient choice
124. Patient choice
125. Patient choice
126. Patient choice
127. Patient choice
128. Patient choice
129. Patient choice
130. Patient choice
131. Patient choice
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141. patient choice
142. patient choice
143. patient choice

144. patient choice
145. patient choice
146. patient choice
147. patient choice
148. patient choice
149. patient choice
150. patient choice
151. patient choice
152. patient choice
153. patient choice
154. patient health deteriorates patient choice
155. Patient's condition or patient choice
156. Patient's condition has deteriorated. Patient has declined treatment offered and is going elsewhere.
157. Patient's clinician is not a member of the MDT and has already made their own decisions regarding treatment.
158. Pateint deteriation
159. Pateint choice
160. Our patients are acutely unwell and some die prior to transfer. patient and family wishes are always taken into account and can alter the agreed pathway
161. Oncologist
162. not sure
163. Non compliance of patient. Up dated information provided to MDT
164. Non attendence of manageing consultant
165. No treatment decisions are made outside the MDT Patient performance status has been incorectly assessed Patient declined treatment Deterioration in patient condition
166. no feedback to say either way
167. More clinical information becomes available outside of MDT
168. miscommunication and no realtime documentation of outcomes
169. might be patient choice
170. MDT outcome not in notes, patients not fit for recommended option
171. MDT not being aware of all the facts and then the clinician treating the patient brings te patient back to MDT
172. Lack of knowlege of patients performance status at time og MDT
173. lack of communication to the relevant clinician who does not attend the mdt
174. Lack of communication between teams and loss of notes. Patients come from 7 other hospitals so do not always see the team at the site of the MDM decision so it decision is not recoreded in the other set of notes.
175. lack of availability of core members at mdt discussions (eg during annual leave) Patient choice
176. Initial treatment recommendations are not usually made until after MDT discussion. Usual reason for not implementing recommendations is patient choice or patient not fit.
177. INITIAL TREATMENT DECISONS ARE ONLY MADE AT THE MDT PATIENT CHOICE,PATIENT UNWELL
178. Information comes to light that was not available at MDT Patient Choice Condition changes eg patient has MI
179. Individual patient's choice
180. individual clinician decision when they review patient to discuss treatment
181. In our area treatment recomendations are only given after an MDT discssion (this applies to breast, colorectal, lung,gynae, UGI and urology) - i would estimate that this happens as much as 90% of the time. Recomended treatment decisions are generaly not followed when the patient has not wanted to take the recomended option.

182. iF PT CONDITION ALTERS, OR TIME FRAME ISSUES WITH LIST CAPACITY ETC
183. if patients condition has deteriorated from when seen by clinician and then discussion at MDT
184. if patient are not discuss
185. If clinical oncologist not available in MDT
186. I have never witnessed this
187. I do not think this information id collected. Do we really know if MDT recommendation is followed?
188. Following patient consultation post M.D.T and infromation provision, patients may decline intervention/treatment, Conditional deterioration, reducing tolerance/fitness for treatment from initial diagnosis.
189. following assessment of patients in clinic
190. Fitness for surgery
191. Face to face assessment of psycho-socialcircumstances is needed
192. emergency admission or patient unfit for treatment on clinical review
193. due to death of pt,pt declining,pt not fit
194. Don't know
195. don't know
196. documentation of discussion not made properly. outcome influenced by some influential clinicians even though others may have had a different opinion.
197. do not know
198. Disagreement regarding the effectiveness of short-course neoadjuvant chemoradiotherapy.
199. different opinions or clinicans not attending
200. deterioration or refusal by patient
201. Deterioration of patient
202. cost of treatment, if treatment is not NICE approved. Breakdown in communication.
203. Consultant whose patient was discussed was not present at meeting
204. Consultant preference
205. Co-morbidity precludes some treatment options
206. Clinicians wanting to make their own decisions, particularly surgeons.
207. Clinician review and treatment not appropriate
208. clinician disagreement
209. clinical reveiw, patient choice
210. CLINICAL INFORMATION OBTAINED LATER OR PATIENT CHOICE
211. clinical decision when dr sees patient i.e. wide local excision but when dr clinically reviews patient not technically possible. Also if chemotherapy decision but then the patient upon clinical review isn't fit enough or patient does not accept treatment plan
212. clinical changes to patient, re -staging, patient choice
213. Changes in patient condition.
214. Change of status of the patient / patient choice
215. change of patient status
216. change of circumstance or patients choice not to pursue treatments offered
217. Change in the patients condition ie deterioration
218. CHANGE IN PTS CONDITION/PTS CHOICE
219. Change in pts condition or patient choice.
220. Change in patients medical condition/status
221. Change in patients condition. Patient choice.
222. Change in patients condition following MDT, Patient declining that particular option.
223. Change in patients condition

224. Change in patients condition
225. Change in patients clinical condition or patient choice.
226. Change in patients circumstances from MDT meeting. Lack of full information at MDT meeting i.e. Co-morbidities
227. change in patient physically or mentally
228. change in patient condition/choice
229. Change in patient condition.
230. Change in patient condition or wishes; unusual case, unknown benefits
231. change in patient circumstance
232. change in patient's condition
233. Change in disease progression/patients general condition
234. Change in condition of patient Sudden disease reccurrence Patient choice to refuse option Patient death Further discussion between clinicians requiring further review at MDT
235. change in a pts condition
236. Change in a patients condition or patients wishes
237. Because they're not acceptable to the patient.
238. because the patient is too frail or declines treatment recommendations
239. At clinic, patients PS has fallen Patients choice
240. Assessment of the patient during a face-to-face consultation may alter the decision-making process as a patient may not be physically fit for a certain treatment regime
241. assessment of patients
242. as palliative its difficult to assess, treatment may involve occupational therapy/ rehab, medication altering. if not always carried out have to be with patient consent and at times gp agreement.
243. As a keyworker it is usually due to a patient rescinding the treatment, further complexities/ morbidities and sometimes terminal illness / death
244. all treatment recommendations are implmented unless contra-indicated e.g. patient medically unfit
245. After physical or psycological assessment
246. After discussion with the patient they don't want the treatment recommended by the MDT.
247. Acute emergencies. Patient choice.
248. a poor grasp of the performance status of the patient during the discussion
249. A change in the patients condition or an unexpected result from an investigation.
250. 1. Patient choice. 2. Nature of tertiary referrals means performance and co-morbidity status not always well known and this may affect implementation of plans.
251. 1. Patient choice 2. Clinical choice
252. ?unsure unless they are impossible to implement for some reason

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

229 nurses responded to this question.

1. When patients seen in clinic form to be filled out and faxed to MDT co ordinator.
2. We have a system in place for all histology's from Severe Dysplasia/Adenocarcinoma, & Suspicious findings on Imaging are referred to the colorectal nurses on a weekly basis which ensures patients are not missed
3. We have a monthly print from Histology which is crosschecked. Patients who do not have biopsies are referred to MDT for discussionfrom Ward rounds OPD etc. We have a mechanism in place from radiology pathology and all specialities which alerts teams to cases for potential discussion. eg Radiology alerts us of an unexpected finding of Tumour on CT or Usnd req from GP etc . Cancer services have a weekly print from Clinical Coding and this highlights Cancer cases.
4. we discuss 100% cancer cases they are generated from pathology with confirmed histology. Any suspected cancers without tissue confirmation are also discussed
5. Via 2ww tracking
6. use of resources such as infoflex, fast track system and effective lines of communication through the respiratory team
7. Use of pathology and radiology 'red flag' system backed up by clinician alerts.
8. Use of co-ordinator, education of hospital staff
9. Trust wide agreement with all consultants. Pathway for referral to the MDT. Communication of when patients will be discussed. Invite to attend and present their patient. Feedback to team to instigate management decision.
10. trust communication, paperwork etc
11. To have dedicated MDT coordinator and have the whole team supporting the MDT principle.
12. to ensure a list is provided for all patients following invasive procedure and post-operative
13. Through pathology and the breast care nurses.
14. through consultants an dpathology
15. they should be already!
16. They currently are.
17. The TWW system seems to work well now
18. The responsibility of individual clinician who make the diagnosis to refer case the MDT personally
19. The CNS role is crucial at this point and I always ensure any new cancer patient will be put on the next MDT list.
20. That's MDT Co-ordinator's remit, & they need to liaise with Histopatholgy.
21. Teamwork/effective communication pathways
22. TEAM WORK BUT NOMINATE ONE PERSON TO CHECK AGENDA AGAINST KNOWN PTS TO BE PRESENTED.
23. team work
24. streamline referral processes liasion with other departments -radiology, histo-pathology
25. Standardised referral protocols to all MDTs
26. Staff training
27. Sometimes patients from the medical side are referred late - making it mandatory that they should be referred early
28. Some delay in physicians refering for treatment would suggest direct referal to MDT from endoscopy for all patients with a suspected malignancy then if not assigned to a surgeon this could be done so at the MDT
29. service level agreements, improve knowledge of where mdt's are and how to access them
30. seem to be good systems in place although some emergencies ar not referred until they have been discharged when histlogy is available

31. SECRETARIAL SUPPORT, POST SCREENING/DETECTION DIAGNOSIS PTS SHOULD AUTOMATICALLY BE DISCUSSED AT MDT
32. Robust systems of referral
33. robust referral pathways
34. Robust referral criteria, communicated as widely as possible
35. Robust protocols. Staff training.
36. Robust operational policies. CNS and Consultant informing MDT coordinator Histology dept informing MDT coordinator
37. responsibility of all teams to supply names to the person setting up the list
38. repeated written reminders to staff giving criteria and contact details for refferal
39. regular audit
40. Referral to UGI CNS and/or MDM coordinator. Knowledge of pathways of care and management. Red flag system for suspected cases.
41. referral pathways
42. REFER TO CNS AS SOON AS A CANCER IS SUSPECTED
43. Rapid referals are captured on database, ensure effective communication skills between team members for all emergency admissions
44. Raising the profile and the need.
45. Put national country wide template in place so the all hospitals/pcts country wide are doing the same thing no matter wjere the patient is seen
46. Publicity of new cancer waiting times Demonstrate positive impact of MDT management of care
47. Provide an electronic intra-network referral system to streamline the transfer of information. Compatible PACS would allow streamlined radiology provision.
48. Protocol
49. Process mapping, audit, protocols, effective systems, review of systems and change if required.
50. Policies and protocols for referral to MDT. Educating health care professionals about importance of referring to MDT
51. Operational policy outlining referral process into MDT
52. on doctor inductions is very important or let CNS know
53. not usually a problem for us
54. not sure
55. not sure
56. Not sure-financial penalties for doctors who don't refer?!
57. No propect of referral onward if p/t not discussed.
58. New onco-alert process
59. new diagnosis of cancer should be picked up weekly by a cancer tracker and the MDT co ordinator informed, so the patients case can be discussed at the next meeting.
60. Need data co-ordinator to enable correct data collection.
61. Need all members of MDT to notify, its better to be told about the same patient several times rather than not at all
62. national proforma - then as doctors rotate, the system remains the same in whatever hospital they are practising
63. National guidelines, local defined best practice.
64. Most new cases are discussed however, if this is a national target then health care professionals will discuss all new cancer cases.
65. More trackers
66. members of the team should be accept more responsibilty of ensuring patients are referred to MDT co-ordinator
67. MDTC role is already vast all disciplines have huge time restraints so data collection,audit should be seperate role if to be done properly
68. mdt cordinator will put them on mdt list-if it turns out to be no cancer clinician will notify so co ordinator will be able to update the database
69. MDT coordinator accesses 2ww to check all confirmed cancers are discussed and other presumed cancers are also added
70. MDT co-ordinator/CNS is informed of all new cancers

71. MDT co-ordinator role in tracking
72. Mandatory and matching waiting times data that highlight a positive biopsy.
73. make sure all doctors on a team understand the importance of doing so
74. make it the respondsibilty of all disciplines to add patients to the mdt not just the CNS
75. make all departments aware of who to and how to
76. Madatory notifcation to mdm coordinator which becomes an auditable standard
77. local policies, procedures and practices. recognition that dicisions are made in the MDT and should be discussed there as a matter of course
78. lists produced by pathology department showing cancer diagnosis can be checked against cases discussed
79. It should be the responsibility of all members to inform the MDT Co of a new diagnosis and the responsibility of the CNS to ensure that new cases are discussed
80. It should be practice with all MDT members and other HCPs that CNS and MDT Co are informed of suspected cancer
81. information collected from histology results on a regular basis
82. Inform MDT Co-ordinator
83. Inform and raise awarenss to other MDT leads of this set up. Effective communication to all relevant clinicians and CNS's. The CNS's are sometimes the key person to inform an MDT of a new case.
84. individual teams should have their own policies (that do not soley rely on individulal clinicans) to ensure that all new cancer diagnosis are discussed at an MDT
85. Individual data managers using robust data systems
86. Increase local knowledge of referral criteria and who MDT co-ordinators are and their contact details.
87. Increase awareness of MDT working
88. improve data collection methods at point of new referral or visit on in patients
89. Identify key worker for patient with reponsibility for this purpose
90. identify a core member to ensure this happens, cns, mdt co-ordinator or lead clinician
91. I wish i new the answer to this as nobody seems to want to take responsibility for this.I feel it is best placed largely with the pathology department.
92. I do not know. We are doing what we can. Allpatients should be referred to the local team. For example, Lyphomas diagnosed by surgeons should be discussed locally not directly referred to Centre. It may not be appropriate, also what about those diagnosed in CATS etc. These patients are not being referred appropriately.
93. HOSPITAL POLICIES AND PROCEEDURES
94. Histology inform Cancer services of any positive Histology, Radiology should do the same so that any new cases can be checked to see if they have been referred on. As a CNS I review all 2WW letters for Gynae which gives me a overview of any potential new cases which I can then follow up.
95. Histology create a weekly list
96. Highlighting cases to MDT coordinator
97. Highlighted through tracking system
98. health care professionals who are responsible for tracking should ensure that all patients with confirmed cancer are put forward for MDT discussion
99. Having clinician involvement
100. Having a robust system to ensure transfer of all patient cases to MDT meeting
101. Having a co ordinator to track all suspected cancer cases. Ensure they are refered when a diagnosis is made.
102. Have good local procedures in place for referral
103. have an mdt co-ordinator
104. Have an effective flagging system from histopathology to CoOrdinators
105. have a system where every new diagnosis is channelled through one particular person to co-ordinate
106. have "fall back system" usually from histology dept.

107. guidelines, hopsital policies and procedures, referrals
108. Guidelines to ensure appropriate referral and discussion of cases within the Trust and outside of the Trust
109. good team working, agreed pathways
110. good team communication or electronic alerts within sub departments.
111. Good liason with Drs and CNS's with MDT co-oridinator, protocols
112. good liasion between team members eg CNS, pathway/MDT co-ordinators and consultants etc
113. Good communications
114. Good communication. Ensuring that the importance of MDT is included in Drs Induction.
115. Good co-ordination and collaboration between teams and administartive teams
116. good clear referral processes
117. give the CNS a more interactive role in the mdt especially within the 2ww tracking. I tried this and when I was tracking 2ww I knew of all the impending cancer cases, when I stopped breaches followed
118. Formal arrnagements and guidence for refrral to MDT. Use of Clinical Nurse Specialists to be aware of newly diagnoised colorectal cancer e.g. referral via endoscopy and radiology
119. following patient pathways, liaison with other MDTs
120. follow protocols- everyone responsibilty
121. Follow national guidelines
122. Fail safe system of entering to data base
123. Everyones individual responsibility to work to best practice
124. every person has a responsibility to add pts to the MDMs and need to know the referral process
125. ENSURING THAT ALL STAFF ARE AWARE OF THE MDT-EFFECTIVE COMMUNICATION
126. ensuring non cancer professionals know how to put their patients forward for discussionSenior nurses on noncancer wards need to ensure that CNS are made aware of cancer patients on their wards
127. Ensuring all members are aware of pathways for referral to MDT
128. Ensuring a referral process is in place and making sure other disciplines know how to contact to report a new cancer case
129. Ensure that every new patient has ab identified key worker who is responsible for taking new patients to MDT meetings. Protocol based care which includes MDT discussion Develop pathways which include MDT discussions Agenda iten which includes new patients Developing data sets whereby this informating has to be collected as part of reporting processes
130. Ensure support and time given to pt tracking/co-ordination pt pathway
131. ensure strict local guidelines /process for referral arein place and known
132. Ensure protocols are in place and it is allocated to one person to ensure correct patients are discussed.
133. Ensure FAX number and Pro formas are available to ALL staff involved with patient referals
134. Ensure colorectal cancer surgery is carried out only by dedicated colorectal surgeons. Ensuring that the CNS is made aware of all new cases so that names can be added to MDT lists.
135. Ensure all team members are aware ALL new cancers need to be discussed not just those with histology
136. Ensure all team members are aware
137. Ensure all personel are aware of the MDT and refer their patients to the Cancer Services
138. ensure all know pathways and designated people informed
139. Ensure all Consultants make each team member aware of the M.D.T protocol and C.N.S involvement in it's co-ordination and preparation.
140. Ensure all consultants inform the CNS of new patients as the keyworker.
141. engaging all clinicians in the MDT process

142. electronic pathways, intergrated systems
143. efficient referral systems
144. Effective communication so that all clinicians and GP's have access to the referral pathways - intra and extranet access.
145. Effective communication between the histopatholagy and all the MDT co-ordinators
146. effective communication between all those professionals dealing with suspected cancer patients
147. Effective communication between all department included in MDT.
148. effective communication
149. Education/staff awareness Systems in place to flag up and refer cases eg with histology and radiology
150. education, path lab
151. education, information on MDT's on Intranet, build good working relationships with colleagues in Histopathology, Oncology and Radiology
152. Education relating to the role of the MDT coordinator.
153. EDUCATION OF PRIMARY SECONDARY AND TERTIARY PERSONNEL
154. education of GPs and other hospitals to ensure they know the service is avaiable
155. Education of clinicians
156. Education for all clinicians in both primary and secondary care
157. education and audit
158. educating all clinicians of the referral process for newly diagnosed cancer patients including GPs
159. don't know
160. Direct link between histo/path team and MDT coordinator
161. database alerts system
162. Databaase Integrated reports from pathology labs
163. Data managers. There is no time for MDT co-ordinators to collect clinical database information
164. current ops policy does ensure this
165. cross over systems to ensure that know patients are lost to the MDT process-
166. communication to all non-mdt members
167. communication through junior Dr's meetings
168. communication from all members.
169. Communication between referring hospitals, consultants & GP's
170. communication and sharing best practice
171. communication
172. Communiation within MDT and between MDT coordinators
173. Collaborative working between the MDT coordinator, tracker and clinicians
174. co ordinator and cancer registration
175. co operation between all staff members, especially secs and mdt co ordinators, use of tracking system from clinic which is responsibility of all clinical staff to complete
176. CNS Co-ordination of all patients. They receive all + histology/radiology and reconcile other info and ensure non core member teams (eg Care of the elderly /medics) patients are discussed/transfered to the cancer MDT core members
177. Clear referral guidelines for colleagues to refer into the MDT which are available on intranet systems.
178. Clear pathways of communication between clinicians and MDT co-ordinators and CNS.
179. Clear easily acessible referral pathways- i feel intranet sites easily accessible from ward and clinic areas would be an ideal way of managing this. Also by making clear to non cancer teams that cancer management plans being made are dependent soly on presentation at an MDT. Also scope needs to be found for allowing generic medical teams to have access to oncology advice when diagnosing potential cancer patients- i think this is a particular gap in current service provision- quite strong proceses are in place for managing patients once a

cancer is diagnosed but i dont think there is adequate support for generic teams investigating some one with very non-specific/unclear symptoms.

180. clear defined ref pathways
181. Change the process of the patient journey
182. Cancer trackers
183. Cancer lists, good communication to MDT co-ordinators
184. By working with all key teams to promote awareness of referral criteria and pathways. To have clear protocols for referral and proformas that capture all relevent data without adding a lot to clinical workload. By having good induction programmes for junior doctors.
185. By utilizing the co-rdinator. Having a system whereby positive histology results are copied to into co-ordinator for inclusion. Good liason between the wards and departments who undertake biopsies.
186. By utilising every avenue to ensure patients with suspected cancer are adequately tracked from referral
187. by tracking the pathway
188. By promoting the MDT and communication to peers.
189. By promoting the efficacy of MDT working
190. By making it everyones responsibility to flag up these patients, not solely the Consultant.
191. By histology results being channelled through a single co-ordinator
192. By having robust systems in place
193. By having good communication and working practice with the MDT co ordinators
194. By having a good communication system in place
195. by ensuring they are referred to either the relevant clinician or CNS
196. By ensuring that each cancer group has a recognised key person/specialist nurse, and that their role is understood and know within working environment.
197. By ensuring good communication within the team
198. By ensuring all first points of contact are aware of this requirement, ie. endoscopy, bowel screening programmes etc
199. by ensuring all data is captured
200. By educating our peers on the referral process
201. By each member having access to putting patients on MDT. By close coordination with MDT coordinator
202. By auditing that this is happening and taking action when it is not
203. BY ALL TEAM MEMBERS ACTIVELY ADDING PATIENTS FOR DISCUSION
204. By all parties working with the MDT co ordinator
205. Build this in to referral pathways
206. Better education of professionals as to importance of MDT referral
207. Audit current levels - work out action plan to capture missing new patients - evaluate
208. Audit & performance
209. At present GP alerts to possible cancer, histology flag up the results and keyworker and MDT co ordinator track the patient this seems to work well.
210. appropriate configuration of referrals process ; centralisation of referrals to specific point by tumour group, established pathway for processing referrals, audit,
211. any suspected cancers at endoscopy, radiology and clinic should be tracked until confirmed or not and any positive histologies brought to MDT
212. All system for referal and diagnosis link in to the co ordinator
213. All staff involved know that is necessary - all staff able to query with team if not discussed. Not only consultants who can request pt on list for discussion
214. all new referrals go on a register which is updated by the MDT co-ordinator
215. All new or suspected cancers should be referred to a central office so that they can be tracked
216. All new cancer pathology is flagged up via our pathology system.
217. all memebers bear responsilbily to ensure any cancers are put on the MDT agenda

218. All members know to put them on the mdtm
219. all mdt memebrs have responsibility to notify co ordinaotr of new cases
220. All hospitals should adhere to guidelines anyway but government policy should also include private patients who often get missed by MDT members and miss out on the support network they require. Many patients feel going private will put them a head of the game when actually it is more of a hinderance.
221. all histology results for melanoma and squamous cell carcinomas, merkel cell carcinoma are sent to specialist nurse and MDT coordinator, all are automatically added to next MDT meeting
222. All histology can be accessed by MDT co-ordinator + rapid access patients, otherwise it is up clinicians to present cases
223. all histology brought to meeting by histopathologist - protocol wihtin trust for ALL patients to be referred to Lung cns/chest physician for review.
224. all depts work together and bring to the attention of relevant mdts
225. Access to electronic records during the meeting. Electronic record of patient discussion so that it can be reviewed at any time, especialy in emergency situations when hard copy is not available
226. A robust referral process and recognition of that process
227. A clear referral policy Alerts in histopathology
228. 1. Any patient suspected of having a cancer added to an MDT and discussed
229. ???

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

218 nurses responded to this question. In addition 2 nurses answered 'Yes' to this question, appearing to be agreeing that it should happen but not stating how it should happen.

1. written with proposals in notes then patients decision
2. written who disagreed with what and why
3. Written on MDT outcome proforma
4. Written in case notes
5. written and online.
6. written and electronically concisely.
7. Within the MDT record either electronically or manually
8. within pt records, reasons for split decision and majority decision recorded
9. Within MDT minutes and patient records
10. within MDT letter and minutes
11. Within case notes mdt record with reasons for split decision but without indibvidual names of dissenttors
12. With the initials of those with different views next to their recommendation on the proforma
13. With honesty and all parties involved should sign
14. We usually manage to come to a decision
15. we never encounter this in our MDT
16. unsure
17. typed in patients notes as with other recommendations
18. Truthfully
19. to discuss with patient and offer choices
20. this should be noted in the patient notes - "options of treatment include.....
21. this rarely occurs pts would be informed if there were other choices or options
22. this doesn't happen as a rule but if it did this would be documented through

lucada. the patient would be informed of the possible treatment choices and this would be recorded in medical notes

23. This does not happen in our MDT, if there is an outstanding query re pathology / radiology etc then we write outcome pending & re-list the pateint for the next MDT in 2/52
24. They should be regularly examined in detail with all members of the MDT as a learning tool
25. They should be recorded on MDT proforma or in case notes
26. They should be recorded in the patients notes and reviewed by a third party if the decision is inconclusive.
27. They should be recorded accurately giving the reasons for the split in treatment recommendations.
28. There should be consensus over best treatment recommendation and therefore this should not be an issue
29. the whole team should agree on a plan
30. The two recommendations should be documented with a caveat stating that it will be put to the patient allowing them to choose.
31. Tactfully
32. Summary of issues and what concensus decision was and how it was arrived at within a proforma filed in patient case notes and with indication that patient has been involved.
33. summarise who disagrees and why, and what majority decision is
34. Split decisions should not be accepted unless it is the patient making the decision
35. Should be recorded with name, job title and decision
36. Should be recorded that decision is difficult, and that options should be discussed with the patient.
37. Should be recorded on the outcome proforma and discussed with the patient.
38. should be documented on the MDT summary and in the patient's notes
39. Should be documented in Minutes
40. should be documented either electronically or on proforma - mdt discussion pro/cons
41. Should be a consensus opinion. IF not then both should be recorded with rationale. Once options discussed with patient-their choice should then be clearly documented referenced to the MDT decision entry
42. Second opinion from centre.
43. Recorded with rationale and the names of those with recommendations
44. Recorded on proforma and in notes with copies to GP
45. RECORDED ON FORMAL MEETING NOTES AS PART OF DISCUSSION
46. recorded in the notes on the mdt proforma
47. Recorded in outcome sheet
48. Recorded in medical notes and a final decision clearly recorded
49. Record the objections & ensure the patient is nformed of the difference of opinion so that they can make an informed choice
50. record different treatment recommendatons and the reasons and explained to patients both
51. PTS NOTES
52. Patients notes Gp proforma Should this be happening?
53. Patients medical records. Patient should be made aware of differences of opinion and be fully informed so they can make their own decision.
54. Patient notes/MDT proforma
55. Ours are referred to outside Trust for another opinion eg Whipps Cross
56. Options of treatment should be recorded in the proforma. Discussion of potential treatments discussed with patient. The consultant in charge of their care should make the final decision with the patient.
57. options listed consultant explain to patient consultant/patient decision whenever possible
58. Only came across this once when it was a decision regarding external beam

radiotherapy and lazer treatment,the respiratory consultant was adamant it should be external beam but the clinical oncologist was not available at the MDt so the decision was to be reviewed by oncologist and she was to make the decision

59. On treatment and MDM record
60. on the proforma/ patient records
61. On the proforma, whther majority or unanimous and in letter to Patient's GP
62. on the proforma as all outcomes are recorded.
63. on the proforma and in the patients notes.
64. On the patients MDT proforma.
65. On the patient proforma and the patient should be made aware of their noptions and given the choice.
66. on the patient MDT proforma, as well as in the patients notes.
67. on the MDT proforma, or in patient notes.
68. ON THE MDT PROFORMA
69. On the MDT out come forms or in the patients notes
70. On the MDT forms and in the pts notes
71. on the MDT data base with the reasons for differences and those that disagreed
72. on the electronic proforma
73. on the cancer register. After discussion with patient in their notes.
74. on the cancer database and in the patients notes.
75. on pt outcome proforma
76. On proformas, giving the discussed options + resulting decision. In patient health record and for tracking purposes
77. On proforma in patients notes
78. on proforma
79. on minutes
80. on mdt record sheet
81. on MDT proformas of patient
82. on mdt proforma and in pt notes
83. On MDT proforma
84. on MDT proforma
85. on mdt proforma
86. On MDT paper work
87. on MDT outcome sheet
88. On MDT outcome forms and in the notes by the Cosultant.
89. On EPR along with reasoning for each argument
90. on each occasion
91. On data base and in notes
92. ON DATA BASE
93. on an mdt proforma which is filed in patient notes and on the database
94. on an electronic database stating who decided what the treatment should be and reasons behind this decision. The opposing opinions should also be recorded in full as should any "concerns" which are highlighted by MDT members.
95. Offer to patient as a choice with full explanation/information
96. Number of members at discussion, their professional role and who decided what
97. noted
98. not sure as there is usally a majority decision made
99. Not sure
100. Not experienced this problem. Often it will be one or two choices depending on the patient decision
101. not applicable
102. name of clinician documented
103. N/A
104. minutes on a database

105. minuted with hopefully some resolve.
106. Minuted but can't recall this being a problem
107. minute taking thenofficially recorded as data
108. MDT records and proforma
109. Mdt proforma and patients notes
110. MDT minutes/notes should be kept which documents this. The Clinician or Key Worker should have the ability to make the final decision once they have taken on board all discussion and informaton
111. majority vote should be chosen and it should be stated that this was how the decision was made
112. Majority agreement should be the recommended management. If split decision, this should be recorded in the medical notes.
113. live minutes record the discussion and treatment preferences of the MDT
114. Lead consultant and majority should rule on decision
115. It should be documented and explained to patient in such a way to see if they have a preference for treatment options.
116. It needs to be fully documented and patients should be aware of the choices and can select their treatment plan which suits them best.
117. In writing with names and reasons
118. in writing in patient notes and on data base
119. In treatment plan, choice of treatment to be documented. Thankfully I have never in 5yrs known this to happen.
120. in the patietn notes and data collection proforma
121. in the patients notes and on the electronic database
122. in the patients notes
123. in the patient notes and to GP on outcome proforma
124. in the notes specifying who says what and help the patient to decide or to see both clninicans
125. In the notes
126. in the minutes of the review meeting and kept on the shared computer drive.
127. In the minutes of the MDT and the reasons for each persons opinion included. The opinion taken forward should also be documented with the reasons why.
128. In the minutes as a split decision!
129. in the minutes and in the patient notes
130. in the minutes
131. In the MDT minutes
132. In the fre text box on the M.D.T proforma highlighting outcomes and treatment planning.
133. In the documentation
134. In the clinical notes
135. In the case notes and discussed with the individual patient
136. in the patients notes and the mdt notes with plan of action
137. In patients notes.
138. in patient notes/mdt proformas
139. In paper or electronic format
140. in notes as discussion re mdt outcome
141. in minutes
142. in medical notes and patient should be given the options and allowed to amke there own choice
143. in medical notes and MDT proforma
144. in medical notes
145. in mdm notes
146. in MDM minutes
147. in full on proforma.
148. In case notes and MDT sheet
149. In case notes and clinical letters

150. If this happens then record as such. treatment A or B reccomended at MDT. minutes of MDT could give more detail if necessary
151. If the outcome is probably 50/50 allow the patient to choose with informed consent. Outcome should be "discuss with patient'
152. I guess the majority?
153. I dont know! this does sometimes happen and usually the decision goes with status rather than anything else
154. hopefully they could be resolved rather than be recorded
155. Honestly and concisely
156. HONESTLY
157. Honestly
158. honestly
159. have never had a disagreement over treatment but would expect to record what action would be taken if split decision eg referral for second opinion etc
160. formally on the mdt descions
161. formally in the notes. Get a 2nd opinion or discuss at network MDT meeting
162. Factually in the patients medical notes giving full details of all options discussed and reasons for decisions and outcomes
163. electronically on mdm proforma, copies of which would remain in the patients notes
164. Don't know
165. doesn't really occure
166. Documented on the proforma
167. Documented on proforma and rediscussed.
168. documented on patient MDT proforma but with clear information about way forward i.e. for the patient to be presented with treatment options
169. Documented in minutes of meeting
170. Documented as a discussion. As long as none of the decisions are unsafe, there's no problem.
171. Documentated in patient's notes
172. Discussion with the super centre
173. Discussion summary should be logged and patient should be consulted accordingly.
174. Discussing the options with the patient
175. database
176. CONSENSUS / SPLIT OPINION IN NOTES
177. Clearly documented on proforma and signed off by lead Clinician
178. Clearly and concisely and explicitly remembering that the patient will have access to the proforma.
179. Clearly
180. clearlly so outcome can be seen and rationale
181. clear and concise
182. Case notes, care plan, database
183. Can be held as minutes.
184. By recording both opinions and who made them
185. By recording both clinical opinions and reasons for and against. There should also be a presentation to the patient of both treatmt options so that a choice can be made
186. By a vote
187. By a neutral person Agreement that this should happen by all team members
188. Both should be recorded then if to be discussed with patient final treatment decison should be recorded
189. Both decisions should be recorded on the MDT outcome forms and then discussed with the patient along with the reasons why decisions were split.
190. Both decisions recorded
191. As two potential decisions presented with reasons for selection and plans to discuss with patient documented on proforma and/or notes. Names not

necessary

192. as to what the disagreement is and why this occured
193. As they present.
194. as they occur and fully in print
195. as that and with pt discussion where applicable
196. as that
197. as such
198. as split decisions however in practice this is unusual
199. as real time, and if needed brought back to mdt with different mdt members present
200. as part of MDT discussion - with overall outcome confirmed at end - if occurs post MDT - as an addendum again with clarity of final decision recorded
201. As clear simple statements with relevant supporting information/evidence (i.e. reasons why they consider their decision to be right) for each side.
202. as any other MDM mins.
203. As an evidence based discussion, clinical trial evidence
204. as alternative decision and then put forward to patient so informed choice
205. As accurately as possible. Who supports what treatments and what patient wishes
206. As a vote. If split decisions are evenly distributed, this should probably be conveyed to pt.
207. As a choice for the patient to decide their preference unless clear evidence available
208. all views should be written down and discussed with the patient and the reasons given for the preferred treatment
209. all should be recorded in the minutes
210. all opinionsshould be recorded with the rationale for the decision made
211. All opinions should be recorded and written in the MDT entry. Ultimately, a decision should be made in order to present to the patient.
212. All decisions should be recorded and presented in a non-biased fashion to the patient
213. Accurately, with both options / all options listed and reasons given for disagreement.
214. Accurately with the reasons behind each treatment recommendation.
215. accurately in the MDT record and patient notes
216. Accurately
217. a consensus of aopinion is always reached otherwise the discussion continues until decision reached
218. 1. In writing with names, dates and rationale for decisions made

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

374 nurses responded to this question.

1. Whom has met the patient and talked to them
2. Whoever knows the patient and has met with them previously. Often as a CNS we can see them prior to MDT but sometimes our first knowledge of them is at MDT when a Diagnosis has been made.
3. whoever knows pt best.dr/CNS
4. Whoever has met/spoken to the patient and/or carers, either previous to MDT or in the past
5. Whoever has met with the patient.
6. Whoever has met them.

7. whoever has met the pt
8. whoever has met the patient
9. Whoever has had contact with the patient
10. Whoever has been involved the most. Usually the CNS
11. Whoever has assessed the patient in clinic
12. Whoever has actually met the patient prior to the MDT
13. Whoever did the assessment
14. Who ever has the most contact with the patient
15. who ever has that knowledge
16. who ever has met them the most
17. Who ever has met the patient
18. Whichever clinician has been best able to establish a relationship encompassing more than clinical signs & symptoms with the patient
19. which ever MDT team member knows is there key worker or who has had the most interactions with them
20. varies depending on who knows the patient
21. USUSALLY THE CNS OR IF NOT THE LAST PERSON INVOLOVED IN THEIR CARE OR HAVING LAST SEEN THEM.
22. Usually the Lung cancer Nurse Specialist or the doctor who has seen the patient
23. Usually the keyworker/specialist site specific nurse.
24. Usually the key worker (Clinical nurse specialist) or the person who has met the patient
25. Usually the CNS, or the doctor who has treated the patient, if the CNS has not yet met the pt.
26. usually the CNS, as they have a link up with the patient either face to face or on the phone.
27. usually the clinical Nurse specialist, who is normally their keyworker.
28. Usually the Breast care Nurse, as they often have built a relationship with the patient and carers and are normally aware of the patients prefernces (which patients usually say they dont wish to bother the doctors with)
29. Usually CNS's
30. Treating Doctor or Supporting Specialist Nurse
31. those most involved with the patient
32. This depends it is an MDT deciesion.
33. Ther person who has seen them and elicited their views
34. Themselves or CNS
35. their consultants and specialist nurses
36. their clinician or anyone who has been involved in the patients case
37. The team member who has met the patient. Probably the surgeon or breast care nurse.
38. The surgeon/clinician or breast care nurse who has met the patient
39. The specialist nurse or the person who knows the patient the best
40. the specialist nurse
41. The professional who has most involvement with the patient
42. the professional that knows the patient and understands the treatment being offerred
43. the person with the main contact
44. The person who knows them best, Dr/CNS
45. The person who knows them best - key worker or CNS
46. The person who knows the patient best. CNS or consultant.
47. The person who have seen and assessed the patient
48. the person who has spoken, got to know patient most
49. The person who has spent the most time with patient. Usually the CNS.
50. the person who has spent most time with the patient during the diagnostic phase
51. the person who has spent most time with the patient
52. The person who has seen them

53. The person who has seen the patient and has taken a history and also has taken the time to get to know the patient.
54. The person who has seen and assessed the patient, and who has discussed treatment with them.
55. The person who has seen and assessed the patient
56. The person who has most comprehensively assessed the patient with regard establishing their views and preferences for ongoing investigation and treatment.
57. The person who has met with the patient be it consultant or nurse
58. The person who has met them, be that Dr, Nurse or AHP
59. The person who has met them
60. The person who has met the patient if possible. If not then to ensure that the CNS is aware of the patients views who will discuss them at the MDT meeting
61. The person who has met the patient i.e. the surgeon or the colorectal cns
62. The person who has met the patient and discussed the problem/treatment possibilities with them. (Assuming pt not there as the practicalities of doing this would be impossible)
63. The person who has met the patient
64. the person who has had the most contact with the patient and is familiar with their disease, circumstances and wishes
65. The person who has had the most contact orhad significant conversations.
66. The person who has had greatest input with that particular patient.
67. the person who has had contact with the patient. A dr in all cases and sometimes the CNS
68. The person who has had a talk with th patient when they have been given their diagnosis ie. CNS or support nurse. They have had time to talk things through with th epatient/carers.
69. The person who has given the diagnosis
70. the person who has assessed them
71. the person who has spent time with the patient in discussing their views
72. The person that knows them best often the Specialist nurse or the Consultant they have presented to initially
73. the person bringing the patient to the attention of the mdt
74. The patients lead clinician/specialist nurse
75. THE PATIENTS KEYWORKER WHICH IS USUALLY THE cns
76. The patient.If the patient is not present then their views should be expressed by someone who has met them and discussed their wishes
77. The patient or their chosen representative
78. the patient or the physician who has spoken with the patient.
79. The Nurse Specialist at the end of the meeting has the resposibility of reporting back to the patient.
80. The nurse specialist (keyworker)
81. The member who has met the patient and assessed them
82. the MDT
83. the lung cancer nurse specialist
84. the keyworker who has met the patient. or the cns who may want to advocate related to social, emotional and fertility aspects
85. The key worker
86. The key worker
87. the key worker
88. The key worker - usually the CNS
89. The key worker - normally the clinical nurse specialist
90. The Key Worker - CNS/NP/NCons
91. The dedicated keyworker for the speciality or the Consulatant in charge who has met the patient
92. The core member who has supported the patient throught the initial investigations

93. The Consultant who is managing the patient's care.
94. the consultant who has met them with input from others if they have met them and have particular concerns
95. the consultant or CNS involved in their care
96. the colorectal nurse specialists is the keyworker for all pts discussed at the MDT. Patients may be transferred to another key worker and will be informed. all pts discussed at MDT meeting will be seen on the day of the meeting or contacted by phone by mutual agreement and informed of their management plan. all GPs and other clinicians are faxed the treatment proforma on the day of the meeting
97. The colorectal nurse practitioner who is the patients keyworker
98. The CNS.
99. the cns usually assumes key worker role but often has had no previous contact and preferences and views will not be known
100. The CNS or ward nurse who has already met with the patient and family
101. the cns or the doctoer who knows the patient
102. The CNS or Consultant
103. The CNS is the keyworker and represents the patient's views
104. The CNS and the person who has made the assessment of the patient.
105. The CNS
106. The cns
107. the CNS
108. the CNS
109. the clinician who is looking after the patient
110. The clinician who has met the patient. The CNS is usually seen as the patients advocate but this cannot be the case if they have not met
111. THE CLINICIAN WHO HAS MET THE PATIENT EITHER MEDICAL OR CNS
112. The clinician who has examined the patient and/or the CNS who has met them
113. The clinician or nurse specialist who knows the patient best
114. the clinician or CNS
115. the clinical nurse specialist or the consultant who originally saw them if the CNS has not had any contact with the patient
116. The clinical nurse specialist or clinician in charge
117. The Clinical Nurse Specialist (CNS)
118. The Clinical Nurse Specialist
119. The Clinical Nurse Specialist
120. The Clinical Nurse Specialist
121. The clinical nurse specialist
122. the clinical nurse specialist
123. the chest physician or nurse specialist
124. The C.N.S involved with the patient or their consultant
125. The best person is the patient themselves, however as this does not happen and is not offered, whoever has seen the patient ie this could be more than one person OR the professional the patient has chosen to represent them.
126. The 'clinician' whether doctor or nurse who has seen the patient recently
127. Th eperson who has assessed them
128. surgical team
129. surgeon and breast care nurse
130. speciliast nurse
131. Specialist or research nurse
132. Specialist Nurses/Keyworkers
133. Specialist nurse.
134. Specialist nurse or the person who has met the patient and is aware of their views
135. Specialist nurse or the consultant managing the case.
136. Specialist Nurse or Doctor who has had contact woth the patient

137. Specialist Nurse if she has seen the patient, failing that a surgeon or clinician
138. Specialist Nurse (if they have met the patient)
139. SPECIALIST NURSE CONSULTANT/TEAM MEMBER PALLIATIVE CARE NURSE
140. Specialist Nurse
141. Specialist nurse
142. specialist nurse
143. specialist nurse
144. someone who knows them and knows their wishes- diagnosing consultant or CNS
145. Someone who knows the patient well
146. someone who has spoken to them
147. someone who has met them, and is aware of situation,
148. someone who has met them and discussed it with them. ideally a nurse
149. someone who has met them
150. Someone who has met the patient and discussed the individuals options with them.
151. someone who has met the patient
152. someone who has been dealing with them
153. Someone who has assessed the patient, however often it is not the case at first discussion, with patients who are not known by the team we will either arrange for them to see one of the team or liase with GP
154. several people depending on who has met the patient and who was involved in their care
155. Referring clinician or CNS
156. PTS SPECIALIST NURSE
157. Probably the CNS but the referring clinician has insight.
158. presenting Clinician or CNS
159. Physicians or Senior Nurse who knows the patient.
160. physician/nurse specialist
161. Person who has met the patient
162. person who has met patient, possibly CNS
163. Person who has met & assessed them, would usually be CNS but could be doctor involved in consultation
164. Person who has had the most involvement with the patient. Consultant or Nurse.
165. Person who has had most contact that has involved an holistic assessment - most often CNS. Re 31.9 keyworker usually CNS who ought to be there - if unable to be there or keyworker in community - designated person should pass info on
166. Person who establishes and maintains theraputic relationship with the patient and family
167. person responsible for treatment/who has had contact with patient
168. person identified by the patient
169. patients designated advocate
170. Patients Consultant or Key worker ie CNS
171. Patient would be if they were able toattend or if not their nominated representative
172. Patient themselves
173. Patient representative - usually keyworker
174. patient or CNS
175. PATIENT CHOICE OF REPRESENTATIVE SHOULD BE SOUGHT
176. Often this is the local CNS
177. Often the nurse but not exclusively.
178. nurse/drs
179. Nurse Specialist or professional the patient wishes to be their advocate.(e.g main carer/supporter could be stoma care nurse or palliative care nurse or

consultant)

180. Nurse Specialist / Consultant
181. Nurse Specialist
182. Nurse Specialist
183. Nurse Specialist
184. Nurse specialist
185. Nurse specialist
186. Nurse specialist
187. nurse specialist
188. nurse or doctor who know sthe patient
189. Not relevant. Decision made on available evidence (with evidence where possible from a clinican who has met them and knows their situation) then presented to patient who can accept or reject.
190. Needs an MDTM approach ie clinician may have different view compared to the CNS, or SALT
191. Named key worker
192. Medics, CNS or AHP.
193. Main consultant caring for patient
194. Lung CNS
195. lung CNS
196. keyworker/consultant
197. Keyworker or whoever has had most contact
198. Keyworker if they have one or consultant in charge of their care
199. keyworker if known to them
200. Keyworker usually the CNS
201. keyworker
202. keyworker
203. keyworker
204. key worker, or who knows the patient best
205. Key worker, member who has met the patient
206. Key worker or the clinician who has assessed them most recently
207. Key worker or some one who has been involved in their care.
208. Key worker or CNS
209. Key worker or clinican who has had direct contact with the patient
210. Key Worker or Clinical Nurse Specialist
211. Key worker or any member of the team who has met the patient
212. KEy Worker often the clinical nurse specialist
213. key worker at that time often clinician or lung cns
214. Key worker / specialist nurse
215. KEY WORKER
216. KEY WORKER
217. Key worker
218. Key worker
219. key worker
220. key worker
221. key worker
222. key worker
223. key worker
224. key worker - often nurse specialist
225. ke
226. it depends who is involved-most of the time chest physician,some time cns ,if its progression and no response then oncologist -needs approprite prson who is caring the patient at that time
227. In our set up the gynae nurse specialist is usually the best person as she has spent considerable time with them.

228. in my opinion it is the CNS if they have had the opportunity to meet the patient before the MDT, otherwise it is the doctor who has met the patient
229. In most cases the specialist nurse if they have met the patient but in some cases other members of the team such as OT or psychologist or SALT may be better placed if they have more involvement with the patient.
230. In most cases Specialist Nurses/Stoma nurses
231. If met the patient the CNS
232. I suppose no one better than patient but ? not practicalmay be too ill. It is important patient kept up to date with information to be given and outcomes from MDT to help them make decisions in their care
233. I feel from personal expirience that if a nurse specialist is involved in care then they are often best placed to represent patient views.
234. Health professional
235. Generally the CNS
236. Generally the clinician in charge of the patients care and/or the CNS.
237. Everyone can contribute - key worker may be the best person if they have met or spoken to the patient prior to the MDT.
238. Either the treating consultant or key worker if they are different form the consultant.
239. either the consultant or CNS
240. Either the CNS or the medical staff involved in their care
241. Dr. who has met Nurse
242. Core Lead of the MDT
243. Consultant/CNS
244. consultant/cns
245. consultant, nurse specialist, registrar
246. Consultant or key worker (CNS)
247. cONSULTANT OR CLINICAL NURSE SPECIALIST
248. consultant
249. consulatant and specialist breastcare nurse
250. Colorectal CNS
251. CNS/BCN
252. Cns who has met the patient and consultant
253. CNS or Surgeon?Oncologist
254. CNS or referring Dr who MUST know the patient.
255. CNS OR PT'S CLINICIAN
256. CNS or person who first saw the patient
257. CNS or medic who has assessed patient
258. CNS or key worker
259. CNS or Dr who is familiar with patients views
260. cns or consultant who has met patient
261. CNS OR CONSULTANT IN CHARGE OF CARE
262. CNS or consultant
263. cns or assessing doctor
264. CNS occasionally doctor
265. CNS INVOLVED IN CARE
266. CNS if they have met the patient
267. CNS if patient known to them, or clinician if not
268. CNS consultant who made the initial assessment
269. CNS AND CLINICIAN
270. CNS
271. CNS
272. CNS
273. CNS
274. CNS
275. CNS

276. CNS
277. CNS
278. CNS
279. CNS
280. CNS
281. CNS
282. CNS
283. CNS
284. CNS
285. CNS
286. CNS
287. CNS
288. CNS
289. CNS
290. CNS
291. CNS
292. CNS
293. CNS
294. CNS
295. CNS
296. CNS
297. cns
298. cns
299. cns -ONCE THEY HAVE MET THE PT OR PARENT TEAM IF NOT REFERRED THROUGH TO ugi cns YET
300. CNS- AS THEIR KEYWORKER
301. Clinician, Nurse or key worker. Someone who can be their advocate
302. clinician with a wide role not specific focus. often a CNS
303. Clinician who initially saw patient together with named key worker
304. Clinician who has seen the pt in a clinical setting (NB could be nurse consultant. Not always a doctor)
305. Clinician or nurse - whoever has actually been involved in their care
306. clinician and nurse
307. Clinican or CNS who have met and undertaken assessment of patients psychosocial and phsyical needs
308. Clinican or CNS who has meet the patient
309. Clinican and Site Specific Specialist Nurse.
310. clinical nurse specialist/key worker
311. Clinical Nurse Specialist/ Practitioner or the patient's own Consultant.
312. Clinical nurse specialist/ key worker or their Consultant
313. Clinical Nurse specialist.
314. Clinical nurse specialist.
315. Clinical Nurse Specialist provided they have met the patient.
316. clinical nurse specialist or other key worker
317. clinical nurse specialist or dr who has met the patient
318. Clinical nurse specialist or consultant
319. Clinical Nurse Specialist or Clinician
320. Clinical nurse specialist or clinician
321. Clinical nurse specialist or any member of the team who has met them.
322. Clinical nurse specialist keyworker
323. clinical nurse specialist involved in the patients care and who has a therapeutic relationship with the patient
324. Clinical nurse specialist if they know the person reasonably or doctor if they have had a lot of contact with the patient
325. Clinical nurse specialist if they have had contact with the patient

326. CLINICAL NURSE SPECIALIST
327. CLINICAL NURSE SPECIALIST
328. Clinical Nurse Specialist
329. Clinical Nurse Specialist
330. Clinical Nurse Specialist
331. Clinical Nurse Specialist
332. Clinical Nurse Specialist
333. Clinical Nurse Specialist
334. Clinical Nurse Specialist
335. Clinical Nurse Specialist
336. Clinical nurse specialist
337. Clinical nurse specialist
338. Clinical nurse specialist
339. Clinical nurse specialist
340. clinical nurse specialist
341. clinical nurse specialist
342. Clinical Nurse Specialist--Key Worker
343. clinical nurse
344. Clincial nurse specialist
345. Cancer Nurse Specialist
346. can vary, but should be the one who knows the patient which is often the nurse.
347. Breast care nurse specialist
348. breast care nurse specialist
349. breast care nurse and consultant because they have met the patient
350. breast care nurse acting as patients key worker
351. Breast Care Nurse
352. Breast Care Nurse
353. Breast Care Nurse
354. As a CNS I feel that I am in the best position to fully represent the patienrts views if I have had the chance to meet with them prior to the MDT
355. Anyone who has met them but that person will not always be present. Most helpful would be good documentation of any outcomes of any conversations had with the patient by any health care professional relating to the problem being discussed
356. Anyone who has met the patient and had this discussion with the patient
357. anyone who has direct involvement with patient eg. CNS, doctor
358. Anyone who has been directly involved with the patient
359. any person who has met thepatient and developed a rapport
360. any of the core members who can explain the MDt process to the patient and then take their concerns to the mmeting
361. any member who has met the patient
362. any member who has actually met and spent time with the patient
363. Any MDT member who has had the patients views, concerns or explicit wishes expressed to them
364. Any health care professional who has bothered to find out their views!
365. ANP
366. An identified Key Worker or the patient/parent themselves
367. All that have met the patient and are aware of their circumstances
368. ALL INVOLVED WITH PATIENT FROM CONSULTANT TO NAMED NURSE SHOULD REPRESENT THE PATIENTS VIEWS
369. a professional who has met the patient (or the patient themself)
370. A person who has met the patient and had more than a 5 minute conversation with them
371. A person who has been directly involved in any part of there care
372. A person chosen by the patient
373. A CNS or Consultant who has been in contact with the patient.

374. A clinician who has actually met and assessed the patient.

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

359 nurses responded to this question. In addition, 16 nurses referred to the response they had given to the previous open question [Q32].

1. Whoever is initiating first treatment or clinical nurse specialist
2. WHOEVER IS DELIGATED AS THE KEY WORKER OR WHOEVER SEES THE PATIENT NEXT EITHER IN CLINIC OR ON A WARD
3. whoever has met the patient
4. Whoever has had most meaningful contact - medic or nurse - be different for different people
5. whoever has agreed to do this, pt choice
6. Who ever the MDT feels is best pleaced to do so.
7. Who ever meets them in clinic.
8. Varies
9. Usually identified in MDT outcomes. OPA or telephone appt then made to facilitate this
10. Usually CNS's or clinicians
11. Treating Doctor
12. Treating consultant.
13. treating clinician or keyworker
14. This should be agreed with the patient in advance of the meeting
15. This should be agreed at each MDT dependent upon who knows the patient, role could be either clinican or cns
16. Their key worker or the physician seeing them/speaking with them next
17. The surgeon/clinician
18. The surgeon,oncologist or breast care nurse depending on the course their treatment will take.
19. The specialist nurse
20. The respiratory consultant and CNS
21. The referring doctor or the Lung Cancer Nurse Specialist if negotiated already with the Patient - see the National Lung Cancer Forum for Nurses Guidelines on Communicating Key MDT Decisions to Patients
22. The referred clinician who is currently or subsequently taking over the care of the patient, in addition/or alternatively to input from the site CNS, as appropriate, by agreement
23. The professional who is currently involved in the care of the patient, preferably who has attended the MDM and who can discuss treatment options with pt.
24. The physician who first saw the patient
25. the physician or specialist nurse
26. the person who will be performing the treatment
27. the person who is to deliver/perform the recommended treatment along with the nurse specialist
28. The person who is known to the patient and has built a rapport.
29. The person who is going to give the treatment with the CNS
30. The person who has met them
31. The person who has had contact with the patient
32. The person that arranged for the MDT discussion to take place should communicate the decision with the patient or arrange for another member of the team eg CNS to do so where more appropriate
33. The patient's clinician.
34. The most applicable person

35. The lead consultant where at all practical
36. the lead clinician or the specialist nurse
37. The keyworker, cns or the surgeon
38. The keyworker or lead clinician
39. the key worker, however any member of the team who may be seeing the patient before the key worker can do this. whatever the decision it must be recorded in the MDT outcome form
40. The key worker (CNS) as they generally have met the patient and formed a relationship with them and can also pass on information in more timely manner. This is how we manage our patients and have no complaints.
41. The Key Worker
42. The key worker
43. the key worker
44. The first clinician to have contact with the patient after the meeting.
45. The doctors and nurses seeing them on the front line
46. The Doctor who has brought the case for discussion or the clinical nurse specialists.
47. The doctor or the nurse.
48. the Doctor in charge of their care
49. The consultant.
50. The Consultant with the CNS
51. The consultant with a colorectal cns present
52. The Consultant Surgeon/Oncologist +/- CNS
53. The consultant or a member of the team.
54. The consultant in charge of their care
55. the consultant in charge of the case
56. the consultant caring for the patient and if it has been pre agreed with the patient the lung cancer nurse can deliver key MDT decisions
57. THE CONSULTANT AND THE CNS
58. the consultant and CNS
59. The Consultant along with the Clinical Nurse Specialist
60. The Consultant
61. the CNS or the consultant as above
62. The CNS or the Consultant
63. The CNS or Doctor
64. The CNS can communicate this if it had been mentioned prior by consultant as a treatment option. If it is the first mention of treatment then consultant should inform patient.
65. The CNS
66. the clinician who will be leading the treatment with CNS support
67. The clinician who sees them in clinic
68. The clinician who has initiated investigation
69. The clinician who fills of the proforma should action the system of the patient recieving the decision.
70. The clinician when they are next seen in clinic or the keyworker by telephone if appropriate
71. The clinician or nurse specialist who knows the patient best
72. The clinician or nurse specialist
73. The clinician initailly involved with the patient
74. The clinician in charge of their care
75. The clinician in charge of the patients care.
76. The clinician and the CNS who can also provide written info
77. the clinician
78. the clinician
79. The Clinical nurse specialist or clinician in charge
80. The C.N.S and /or Consultant.

81. TEAM MEMBER WHO HAS HAD MOST CONTACT
82. surgical team
83. Surgeon/Oncologist supported by BCN
84. Surgeon/ oncologist/ specialist nurse
85. surgeon,oncologist,clinical nurse specialist present
86. surgeon and breast care nurse
87. surgeon /doctor
88. Specialist Nurse or Doctor referring patient to the MDT
89. Specialist nurse or consultant managing the patients case
90. specialist nurse or consultant
91. Specialist nurse
92. specialist nurse
93. Someone the patietn trusts. Nurse Specialist
94. Senior clinician and/or CNS
95. Responsible clinician and key worker together
96. relevant medical personnel & key worker
97. Principle Clinician or CNS
98. physician/nurse specialist
99. Person who will be undertaking the treatment or who instigated the investigation
100. Person who the patient has seen previously and built a rapport.
101. person who has previously treated patient
102. person who has met them but usually it is the CNS
103. Person should be identified at meeting but generally CNS
104. Patients Consultant
105. patients clinician or clinical member of the MDT
106. patient advocate - eg keyworker and/or person who will be treating them
107. Patient's consultant supported by the CNS
108. Parent team, and it should be clearky recorded who is informing pt in the outcomes to avoid confussion.
109. ONLY the clinician who will supervise/undertake the treatments.
110. Oncologist
111. Nurse Specialist
112. Nurse Specialist
113. nurse /drs
114. NORMALLY GIVEN TO CNS
115. Named consultant
116. Medical or nursing team
117. medical and CNS
118. Medical & nursing staff
119. Medcial team.
120. MDT team
121. Lung CNS who has previuosly met the patient.
122. lead clinician for the patient or the CNS as appropriate
123. Lead clinician
124. lead clinician
125. lcns if known to them and patient preference. Otherwise chest physician
126. keyworker/consultant
127. keyworker, either consultant or cns
128. Keyworker if they have one or consultant in charge of their care
129. keyworker if previously agreed by them with the patient
130. Keyworker and consultant
131. keyworker
132. Key worker/Dr involved with their care.
133. key worker/consultant

134. key worker/consultant
135. Key worker/ specialist nurse / consultant
136. Key worker or CNS or clinician
137. Key worker or clinician who has had direct contact with the patient
138. Key worker
139. Key worker
140. Key worker
141. key worker
142. key worker
143. key worker
144. key worker
145. key worker - often nurse specialist
146. it depends on what they are if it is an intervention it should be a doctor, if it is recommendation for further investigation it can be done by clinical nurse specialist
147. It can be agreed at MDT. Usually it is senior clinician.
148. It all depends. The person who initally seen the patient should inform the patient of the diagnosis.
149. In our Trust it is myself (CNS) so that everyone is aware that the decision is being communicated back to the patient.
150. In-patients should be by the Cons/Snr Reg after the meeting. If an OPD appt is imminent then it should be then by whoever sees the patient. This needs to be somebody senior and experienced not a junior Doctor. Often a phonecall from the patient to the CNS is offered when biopsies are performed. Distance and travelling can affest this process.
151. If the patient is aware of diagnosis and discussion at MDT then the Clinical Nurse Specialist
152. IF POSSIBLE THE PERSON WHO HAS PREVIOUSLY MET THE PATIENT
153. If met the patient and thepatient knows their diagnosis again the CNS
154. I feel the specialist nurse is best placed to do this if supported by the consultants. Other core members
155. For continuity should be either clinician who has already met pt or CNS
156. Either the person who presented the patient at theMDT or the key worker who was present at the meeting
157. either the person who has assessed them or lung cancer nurse specialist
158. either the patient's consultant at their next OPD or the specilist nurse by telephone if previously arranged.
159. either the Dr or CNS
160. Either the consultant or nurse who has had dealings with the patient
161. Either the Consultant in charge or the CNS
162. Either the CNS or the consultant.
163. either doctor or BCN
164. Either consultant or clinical nurse specialist
165. Either a member of the medical team or the breast care nurse. I believe radiographers with the right training/support could also perform some of this activity.
166. Drs & CNS
167. dr/cns
168. dr or clinical nurse specialist
169. dr in charge of case
170. Doctor/Specialist Nurse
171. Doctor/CNS
172. Doctor with Nurse specialist present
173. Doctor who discussed treatment options with them
174. Doctor or nurse who is most closely involved with the patient at he time
175. Doctor or nurse

176. DOCTOR OR KEY WORKER
177. Doctor backed up by keyworker/cns
178. Doctor and Keyworker
179. doctor cns
180. designated person, who knows patient - CNS wherever possible
181. Depends Usually in out patients or via telephone from CNS or with CNS in clinic at F/U appt
182. depends on local practice, as long as someone identified dont think matter much
183. Depends if it is as expected or if it is news to the patietn - Clinician should impart major changes to the plan - otherwise key worker could do it
184. Depending on what is to be communicated either Consultant or Nurse specialist
185. Depending on the patients awareness of the results being discussed it should be either the Colorectal Nurse Practition (Keyworker) or the consultant (e.g. if pt aware he has liver metastases the colorectal nurse to inform pt, but if unexpected finding of metastases on staging investigations, it should be the consultant.)
186. Depending on how complex the situation is, it could either be the Nurse Specialist or a senior medical staff member. Patients however generally prefer the medical staff to discuss these outcomes with the patient and the family.
187. Consultants.
188. Consultants offering treatment and CNS
189. Consultants
190. consultants
191. CONSULTANT/TEAM MEMBER SPECIALIST NURSE
192. CONSULTANT/SPECIALIST NURSE
193. Consultant/Reg or CNS depends on individual patients
194. CONSULTANT/REG OR CNS
195. Consultant/medical team or clinical nurse specialist
196. Consultant/Keyworker/CNS
197. consultant/keyworker
198. Consultant/Dr responsible for care
199. Consultant/Doctor BCN
200. Consultant/Doctor
201. Consultant/CNS
202. Consultant/CNS
203. consultant/cns
204. consultant/cns
205. Consultant/ key-worker
206. Consultant/ Dr, Nurse, or who the patient has the best relationship with
207. Consultant, SpR, CNS in some circumstances.
208. Consultant, Senior DR or Specialist Nurse depending on local agreement within the MDT
209. Consultant, Dr or CNS who knows the patient
210. Consultant with whom their care is held /CNS
211. consultant with support of breastcare nurse
212. consultant with cns present as she /he will be reiterating or explaining further or if pt known to cns then they may be best placed to comm. allowing time for thought and deliberation by the pt. and take back to mdt
213. Consultant with CNS
214. CONSULTANT WITH BACK UP FROM REST OF THE TEAM
215. Consultant who patient is under at the time
216. consultant where possible
217. Consultant urologist or oncologist if radical, Specialist nurse regisrar if otherwise non radical
218. Consultant team with Clinical Nurse Specialist support present.
219. Consultant team

220. Consultant surgeon or oncologist depending on recommendation
221. Consultant surgeon or CNS
222. consultant supported by Key worker
223. Consultant should to enable patients to discuss more in depth if needed.
224. Consultant should discuss treatment options but only with a CNS present to assess the comprhension prior to decision making/ or the CNS should be the information provider
225. Consultant responsible for the primary treatment at that time or clinical nurse specialists where applicable.
226. consultant or specialist nurse
227. consultant or specialist nurse
228. Consultant or nominated deputy and or key worker.
229. consultant or key worker
230. consultant or dr in the team
231. Consultant or CNS. face to face or by phone if patient agrees before hand
232. CONSULTANT OR CNS
233. Consultant or CNS
234. Consultant or CNS
235. Consultant or CNS
236. Consultant or CNS
237. Consultant or CNS
238. Consultant or CNS
239. consultant or CNS
240. consultant or CNS
241. consultant or cns
242. consultant or clinical nurse specialist
243. Consultant or agreed, named other eg specialist nurse
244. consultant in charge of thier care
245. Consultant in charge of the patient
246. consultant in charge of care
247. consultant in charge of care
248. consultant in charge of care
249. consultant in charge
250. Consultant giving the treatment
251. Consultant and/or nurse specialist in support and aafterwards to check understanding, questions etc
252. Consultant and the Clinical Nurse Specialist
253. Consultant and key worker together
254. Consultant and cns
255. consultant and CNS
256. Consultant and breast care nurse
257. Consultant / Specialist Nurse
258. Consultant / Nurse Specialist
259. CONSULTANT / CNS
260. Consultant CNS Key worker
261. CONSULTANT
262. Consultant
263. Consultant
264. Consultant
265. Consultant
266. Consultant
267. Consultant
268. Consultant
269. Consultant
270. Consultant

271. Consultant
272. consultant
273. consultant
274. consultant
275. consultant
276. consultant
277. consultant
278. Consultamt or CNS
279. cons / spr / cns
280. colorectl CNS
281. CNS/NP/NCons/Consultant/SpR. In some circumstances med/nursing jointly
282. CNS/CONSULTANT
283. CNS/Consultant
284. CNS/Consultant
285. CNS/Consultant
286. CNS/BCN
287. CNS/ Dr
288. CNS.
289. CNS or Reg / consultant who was at MDT meeting
290. CNS OR PT'S CLINICIAN
291. CNS or Key Worker This could also be done in a joint clinic with the CNS and Clinician which is how we often communicate treatment options and recommendations
292. CNS or Dr
293. CNS or doctor
294. CNS or consultant.
295. CNS or Consultant
296. CNS or Consultant
297. CNS or Consultant
298. CNS or consultant
299. CNS or consultant
300. CNS or Surgeon/Oncologist
301. CNS if possible, clinician if not
302. CNS AND CLINICIAN
303. cns and assessing doctor
304. CNS +/- Clinician
305. CNS
306. CNS
307. CNS
308. CNS
309. CNS
310. CNS
311. CNS
312. cns
313. Clinician/Key worker
314. clinician/key worker
315. clinician responsible for the care in a clinic situation or via another network clinician who may be holding a clinic to see the same patient
316. Clinician or Nurse
317. clinician or key worker
318. Clinician or CNS
319. Clinician or Breast Care Nurse
320. Clinician in charge of care or the specialist nurse depending on the treatment. Or both together which would be the ideakl.
321. clinician and nurse

322. Clinician and CNS
323. clinician and clinical nurse specilaist
324. Clinician
325. Clinician
326. Clinician
327. Clinical Nurse Specialist/medical staff
328. Clinical Nurse Specialist or Clinician
329. Clinical Nurse Specialist
330. Clinical nurse specialist
331. clinical nurse specialist
332. Clinical Nurse Specialist--Key Worker
333. Clinicain or Specialist nurse.
334. breast care nurse
335. Both Consultant with CNS present
336. best person identified at MDT- could be Nurse, Consultant, Oncologists- whoever knows patient- it is often already known when the patients next appointment is, or nurses have arranged to call patient after MDT to discuss treatmment oiptions with them
337. At our centre it is the colorectal specialist nurse unless the team decide otherwise
338. As I hopefully with have the most established relationship with the patient I feel that I am in the best position to inform the patient of the meeting outcome
339. As above with the support of nursing staff
340. as above or clinician
341. as above depending if patient is an inpatient or outpatient
342. as above / consultant
343. As above - or the senior clinician who can explain the options with support from eg CNS
344. anyone of the MDT who knows the patient
345. Anyone from the consultants team
346. Any team member
347. Any person trained to do so, clinicians CNS's
348. Any one of the core members
349. Any member of the team who has been involved in their care
350. Any member of MDT or the professional who will be giving that treatment
351. ANP/consultant
352. Agreed between Nurse Specialist and Consultant
353. agreed at MDT
354. again it depends-who is caring at that timeor allocate a ppropriate mdt in their abscence
355. A Memebr of the MDT usually the Consultant or the CNS
356. A member of the team Again could be nurse or doctor
357. A HCP known to them
358. 1. Nurse Specialsit or Clinician
359. \the keyworker

Measuring MDT effectiveness/performance

What other measures could be used to evaluate MDT performance?

56 nurses responded to this question.

1. working together with the XX [area] cancer network. Attending thoracic meetings to share new ideas and best practice and ultimately using network protocols
2. While I think performance should be evaluated it is just more admiin and paperwork and I am not sure we have the resources to undertake properly and resources are scarce.
3. We need to audit the process from our referring units perspective to assess the level of service they feel our MDT provides
4. Timing of treatment decision from referral
5. Submission to national databases e.g NBOCAP. Key worker evaluation through ongoing internal audits. Peer Review
6. staff questionnaire
7. speed in accessing investigations
8. REVIEW OF MEMBERS THOUGHTS
9. review a selection of cases quarterly to evaluate the decisions made and the outcomes
10. Quality of life questionnaire
11. Quality of life questionaires for patients and carers
12. Positive outcome from treatment to quality of life.
13. Peer Review should have some use in feeding back how effective MDTs are in some aspects of patient experience/pathway
14. peer review
15. Patient satisfaction questionnaires are nor robust. Many are so grateful to the clinicians and healthcare staff that they place them on a pedestal. Most patients only see the superficial aspects of hospital workings and especially in cancer care, are just grateful to have someone looking out for them. Ensure managers include MDT members in their discussions regarding commissioning and targets. Sorry not evaluations but suggestions for improvement!
16. Outcomes in terms of efficient of decison making and patient pathway. All team members feel supported in decision making.
17. Obtaining the views/experiences of health care professionals outside our MDT. Those that visit the MDT or access and refer to it
18. Not sure
19. not sure
20. Measuring what audits have taken place and whether these results have been inculded in the team's servce development plan. Assessed by undertaking further review audits to see if changes have taken place and the incorpratrion of audts and their results into the teams annual review and future work plans.
21. Measurement of effectiveness of a standaradised MDT proforma which would better support the dissemination of the clinical decisions made.
22. mdt core members satisfaction survey
23. MDT's in POSCU's function very differently to MDT's in the PTC and adult site specific environments. Care must be taken to ensure that any tools to support self-assessment and performance measures are appropriate and applicable to the specific MDT. It could possible be part of the peer review process and be built into that
24. Many of the above are not applicable to specialist palliaitve care MDTs
25. Issues with organisation...notes, films or histology not being available and causing delays
26. Individual attendance records. Review cases to monitor treatment recommendations adopted. Patient satisfaction survey to review discussion and options.

27. In accordace with evidence base
28. patient satisfaction around information, communication of staff, accessibility of key worker and supportive care availability
29. I think we have enough already thank you.
30. I don't think you can incompus all MDT's with the same set of guidlines. I think they would have to be tumour specific.
31. I don't agree with these measures for effectiveness for individual MDTs
32. GP satisfaction survey
33. Good Trust performance in cancer service as a whole will reflect that and NOT another tickbox or paper exercise to measure it
34. FOllow up patient care post treatent
35. DON'T KNOW
36. Don't know
37. don't know
38. data collection in general. surical verse non surgical and survivl rates
39. data collection
40. communication/discussion and documention
41. Can't think of any
42. Benchmarking against standard treatments
43. Audits
44. Audit of treatment decisions to check consistency and adherance to appropraite guidance
45. audit of timeliness that patient is presented at mdt discussion and subsequently has their appointment with the centre clinician
46. audit of new tumours aginst pts discussed
47. audit against NICE recommendations
48. AUDIT
49. audit
50. assess differences between TWR and non TWRs pathways
51. anoyomous questionairres to all members of the MDT asking there opinion of MDT functioning prior to MDt training and following this facilitor support to work through the MDT issues
52. An external auditor to visit MDTs to ensure all taking part, and that recommendations are followed as per meeting decision.
53. all of the above!
54. all equally important
55. all above
56. Against national guidelines

Supporting MDTs to work effectively

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

261 nurses responded to this question.

1. would like to have around 30 mins more to do it in
2. We have a fantastic team
3. void all egos before hand. Request all outcomes are typed!
4. Videoconferencing
5. Video-conferencing equipment
6. Venue
7. Try and secure more buy in from senior clinicians and stop them from spreading negativity throughout the ranks
8. to have discussions prior to MDT meeting regarding personal involvement in care of patients
9. tO ENSURE ADEQUATE COVER FOR CORE MEMBERS SO THAT mdt's ARE NOT CANCELLED. mdt's NEED TO BE ALLOCATED AS A CONSULTANT SESSION SO NOT EXPECTED TO ATTEND THEM IN OWN TIME.
10. to be more structured/free of interruptions all core members there on time and for whole meeting
11. timing to be within working day
12. timing
13. Time of meeting
14. Time of meeting
15. Time management from core members who constantly turn up late
16. time management by members
17. time keeping
18. time keeping
19. TIME AVAILABLE
20. Time
21. they are effective
22. The way in which the MDT meeting is chaired
23. The waffling!
24. The video confrencing
25. The venue
26. The time
27. the nurse specialist does less administraiton work and fulfills the role of the CNS
28. the coffee
29. The co ordinators ability to prepare the list sooner.
30. The clinician referring the patient to the MDT should present the case if they are not a regular atendee of the MDT
31. The ability to record patient outcomes at the time of the meeting on the MDT pro-forma (hopefully coming soon).
32. That we all met face to face at less twice a year maybe more if possible
33. That the junior medical staff are responsible for putting together/presenting the patients presenting complaint, and any co-morbidities for training purposes
34. that requeste for further investogationa are made at MDT, i.e bone scan/MRI forms completed snd examination requested
35. Summarising of cases
36. Summarising and documenting the clinical management decions made. Often talked about but not always explicity summarised; espcially for 'other' aspects of patient managemen that aren't the 'main event' For example decision making

around the need for enteral feeding; or adjustments to clinical prtocols and /or guidelins to accomodate for considered influnential co morbidities. alcohol withdrawl, smoke cessation, socially or demographic relevant factors relating to patient ability to undertake some treatments.

37. Stronger leadership
38. stop some members talking about other subjects when a colleague is trying to present a patient
39. stop individual members being critical of others' decisions.
40. Starting on time and all members attend
41. Start promptly. Ensure that the agenda contains appropriate cases for the MDT. Core memebers to present and on time.
42. Start on time have one person talking at any one time not all at once
43. Speed up implementation of the Somerset Cancer Registry database to improve electronic MDT proforma & ease of access to previous co-morbidities, treatments, tests & decisions
44. set time limits on case disscussion to prevent deviation.
45. Seating plan Getting patients in timely manner
46. scrapping video conferencing
47. Remove heirarchy and engage with all members. Only 3 people speak at our MDT and everyone else just spends 2 hours listening to them clash.
48. Regular, reliable attendance levels which would be possible if the meeting was not at lunch-time
49. referrals taken at mdts rather than duplication post mdt
50. REARRANGING THE PHYSICAL STATE OF THE ROOM
51. real time database/proformas to create less paperwprk post meeting.
52. Quite hard to sit for a long time and concentrate Results/radiology arrive at centre mdt
53. put the patient on the meeting sooner!
54. Punctuality of all team members when attending the MDT.
55. Punctuality
56. Provision of refreshments - they are often at breakfast or lunch times.
57. provide lunch, as meeting is over lunchtime and I think it would improve punctuality and reduce stress when clinicians have to be in clinics etc after the meeting
58. protect the time for all MDT members
59. Prioritising cases for discussion as it becomes a numbers game and not an MDT discussion.
60. Preparation time allowed in working day
61. Preparation of cases electronically and real time completion of the MDT plan
62. Physical environment
63. Permenant MDT co ordinator
64. people who turn up on time, and participate
65. Pathologist and radiologist attendance at every meeting
66. Part of a session instead of as an add on. This would stop people arriving late due to am session commitments and leaving early due to pm session committments. Too much expectation that as network wide MDTs come on line (eg anal) this can be added on before the working day (eg 07.30) impacting on family time
67. Ours seem to work very well
68. OUR MDT MEETING MUST CHANGE TO BE IN SESSIONAL TIME - IT IS CURRENTLY BEFORE THE WORKING DAY
69. organisational support
70. Organisation
71. only just got co-ordinator and clerical support for palliative care MDTso this should help. Palliative care as important as any other MDT-operational

agreement

72. only have patients presented when the documentation is ready to prevent the same person being presented a week later when all results tied together
73. only 1 tumour type with only core members
74. NUMBER OF PATIENTS DISCUSSED
75. nothing pratical as i would like to avaoid linking up with other trusts-would like to have evrything under one trust-its not practical-our mdt is good
76. NOTHING
77. Nothing
78. Nothing
79. Nothing
80. nothing
81. not so many late additions that are not cancer
82. not always chaired by dr
83. no mobile phones
84. no interuptions of any form unless vital
85. New proforma
86. needs sessional time at present to many patients not enought time
87. need to change from the traditional st5yle of MDT chair needing to be a surgeon or medic could equally be lead by histopathologist/Radiologist/CNS
88. need to allocate more time
89. need longer to discuss each patient - feels rushed when we get to the end of the allocated session at times.
90. need a data collecting person as core member of MDT
91. My understanding of the terminology better
92. Move the time to have it within working hours.
93. MORE TIME
94. MORE TIME
95. More time
96. More time
97. More time
98. more time
99. More time - by having weekly instead of fornightly meetings, so we were less rushed.
100. More structure to case presentation and MDT discussion as a whole
101. more specific treatment decisions i.e not just surgery but 'tah bso or unilatera oophorectomy.
102. more people should feel able to contribute
103. More people attending.
104. More hours for MDT co-ordinator
105. More group away days
106. more frequent and therefore less time at each meeting
107. more effective use of mdt co-ordinator
108. More effective chairmanship ie better mutual respect, understanding of roles and summarising of discussion and outcome.
109. microscope attendance availability of notes
110. members being more objective - remembering they are they for decidion makeing for the benefit of the patient not to pursue their own agenda
111. MDT to nominate the chair, change in chairperson
112. MDT Co-ordinator or administration support
113. Make sure that only people who need to be there are there (no sandwich hunters!) and that patients have not been discussed or planned for treatment BEFORE the meeting has taken place. Sometime the patient has been told they will have surgery before the actual meeting!

114. make it shorter
115. longer time to discuss patients.
116. locally nil, network much stronger chairmanship
117. Locailty MDT.....Oncology input and enough Radiology/Histology cover. Can not think of any changes to Network MDT except Histology cover.
118. live minutes
119. Listening to all professional groups, not just consultant voices
120. Listen. Everbody needs to listen before making judgements.
121. Less time spent discussing benign patients
122. Less time in the specialist meeting.
123. Less prima donna activity - ban on mobile phones!
124. less medically focused- more holistic
125. less irrelvant chat and more focussed
126. length of time spent discussing sases
127. Leaving personal likes and dislikes of certain members outside the MDT discussion.
128. leader
129. Layout of room
130. it would be helpful if we had a list of patients who were to be discussed at mdt before hand so that we were aware and therefore could inform other members of the team if there were any potential problems or queries
131. it is very didactic!
132. Interect in cancer patient's
133. install VTC at my trust. This would stop travelling to other hospital and ensure fastwer response for patient feedback
134. increased mutual respect between members
135. Increased attendence for the whole meeting
136. Increased attendance
137. Increase attendance ,
138. Inclusion of CNS and AHP opinions in deccsion making
139. Include CNS input/patient representation
140. In hours and not out of hours
141. Improving the seating arrangement away from speakers so that communication channels are clear not compromised
142. Improved interaction between team members.
143. Improved chair and clinical leadership and communication between organsiations
144. I think peer review should include attendance at mdt meetings and provide comment and advise re improvement if needed
145. I feel as we have a lunch time MDT that the provision of refreshments would ensure that people arrived in a more timely manner and would not feel the need to rush off to grab lunch before afternoon sessions commence
146. Having oncologist present every week
147. having a strong effective chair
148. Have work sessionalised for medical staff so it becomes a part of their formal work plan.
149. have the MDT weekly
150. Have patient summary pre-prepared by person who intends to discuss that patient, saving time on searching through notes during MDT
151. have more time available
152. Have an effective chair/leader
153. Have a dedicated urology MDT coordinator whose time is not split between other MDT's
154. Good time keeping.
155. Good support from the top management

156. good mdm documentation
157. Give us more time-our meetings are often compressed by a Neuroscsiences meeting which runs over time, and then discussioin regarding each case is rushed. I think we need to be more specific about the exact things we discuss, adn the MDT administrator needs more information from the referring clinicians re: each case.
158. get a co-ordinator
159. Full partisipation
160. For the MDT co ordinators to be more pro active
161. For it to be less consultant focussed
162. For individulas to speak up more and challenge each other.
163. faster turn around on diagnostic tests
164. face to face rather than tele-linked
165. FACE TO FACE MEETINGS RATHER THAN VIDEO CONFERENCING
166. everyone would bring their patients to it
167. Everyone comes in for 8am some in there own time before clinic would be nice to have dedicated time available
168. Equipment working properly. All members able to go to each meeting
169. environment for meetings
170. Environment
171. environment
172. environment
173. Environment - need a dedicated room.
174. ensuring the summary of the MDT decision is clear to all and that there is ownership of the discussion and decision making
175. Ensuring everyone arrived on time.
176. Ensure that it takes place in protected time. Not lunch time when it is rushed in order to get to afternoon commitments.
177. Ensure that every member is present on time
178. ensure all core members are represented during annual/ study leave
179. enhanced case presentation from some of the clinical teams
180. Encourage regular attendance and have oncology input.
181. Encourage a member of staff to present her patients which is currently never does.
182. Electronic notes
183. Electronic data collection
184. educate consultants in leadership and communication skills
185. easier for all disciplines to attend, some are blocked by their management.
186. Each person should have appropriate time to attend.
187. Each individual being listened to. Sometimes there is more than one person talking at a time
188. dont know, works well at the moment
189. don't know
190. Documentation in patients notes not just about regimen of chemotherapy but number of cycles, how and when response will be assessed and any does reductions due to other comoribidites
191. documentation
192. Doctors - especially surgeons not being so arrogant
193. discuss patients with progressive disease; not just the new cases
194. Designated Upper G.I meeting rather that joint Colorectal/G.I as the meeting is disjointed when people leave and display a lack of interest in the cases being presented.
195. Data collection support
196. Data collection

197. data base that contains a list of evidence based clinical information that would make discussion about benefit verus risk of therapy easier at the meeting
198. Cover for core members during annual leave
199. core members need to be at the whole MDT not just to present for their patients. Ensuring patients cases are discussed at a timely point so that their cases do not have to be brought back to the MDT as some information is missing. This ,also , prevents delays in decision making
200. Consistency of people comming each week.
201. communication training for ALL members
202. communication and support for individuals with regular team meetings which doesnt happen
203. COMMUNICATION
204. CNS input as an agreed and important inclusion for every patient
205. closer team working
206. Clearer verbal summary of outcomes and clinical decision - can sometimes difficult to hear chair although projector helps
207. Clearer roles and responsibilites
208. change of position of chairs in room
209. chairman being on time!!!!
210. Chair to focus the discussion on patient. Not an idea forum for detailed discussion on techniques.
211. CHAIR LEAD
212. breakfast as it starts at 08-30am
213. Break for ten minutes for refreshment break
214. Bigger room!
215. Better trained MDT co-ordinator
216. better time keeping
217. Better tele-conferencing
218. better team spirit
219. better relationship between working parties more generally.
220. Better quality of info from referrers
221. better prepare so notes reports investigations are always be in the meetings
222. better preparation of case presentation
223. Better organisation and guidance for co-ordinators to ensure meetings run smoothy and outcomes recorded efficiently and effectively.
224. Better interaction with all team members
225. better inter disciplinary communication
226. BETTER COMMUNICATION
227. better chair person
228. being more selective of which patients are discussed
229. Being able to visualise treatment decisions during the mdt
230. BEING ABLE TO HEAR EACH SPEAKER
231. Being able to find clinical details straight away in patient case notes
232. Away day looking at each others role. One of our MDT's role played a typical patient journey through the MDT. Many were not aware of each others roles, what information was given to patients at each stage. This was very beneficial to this team
233. Availability of technology which is working properly
234. attendance by colleagues form other MDTS
235. attendance
236. At the moment the room and equipment
237. as above
238. Appointment of a dedicated MDT co-ordinator

239. although our meeting is 2 hours long each week extra time would always be helpful however clinical committments make this impossible at present
240. Allowing protected time for meetings to encourage more members to attend, specifically, surgeons.
241. Allowance of time
242. allow time for discussion for differing opinions, ensure there is a summary and agreement for each patient
243. allow sessional time for the mdt
244. Allocated time that is not straight from a clinic at lunch time.
245. Allocated time that is free from all other commitments for all core members
246. Allocated time rather than doing it in lunch break and overlapping clinical sessions
247. All core members to be present
248. Agreed structure nad guidelines
249. Admin support
250. Actually would not change anything.
251. Acknowledgement of the non core members who have a huge role in patient care.
252. access to project proformas
253. A more level playing field - equality amongst members.
254. A designated MDT room with all equipment available every week.
255. a chair for the meeting
256. a better team approach
257. a better room less cramped.
258. A better chair who is democratic rather that autocratic, a better leader. Tends to get angry easily and can be very rude to members, othertimes can be the opposite. We need consistency.
259. 2 things- in equal importance full attendance every week of all members and vidio conferencing
260. 1. Leader with effective communication skills
261. ?

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

167 nurses responded to this question.

1. Would like to get other nurses to come along but not always possible due to staff shortages
2. with time +experience
3. where i work now encourages contribution - in my previous job, contributions only came or were listened to if they were from a Consultant I feel quite confident in my contribution at mdt
4. we are looking at implementing CADIS (Somerset Cancer Register) for CNS use so that this can be projected at the time of the MDT's
5. Understanding the radiology and pathology
6. trainingthat will help improve standards
7. Training.
8. training and discussion with those who have a greater knowledge.
9. To present straight to test patients
10. To not feel intimidated with so many 'big' characters around
11. To learn to be less stressed when people don't turn up on time or say they can't attend
12. To gain an even more indepth knowledge of the disease process and the impact on the individuals health. I feel assertive enough already to contribute to MDT
13. To be honest, I've had Clinical/physical assessment training at MSc level, MDT training, Advanced Communication Skills Training & Leadership training ... so I can't think of anything else.
14. To be heard sometimes!
15. To be able to pass on all the important patient's medical information social background
16. to attend other MDT's in the network to observe their ways of working
17. Time.
18. Time!
19. time to see patients for continuity
20. time to get to know each new patient before mdt discussion further training
21. Time to be able to prepare prior to actual meeting
22. time set aside for audit discussion on how to improve the patient pathway
23. Time of meeting
24. Time in my job plan and better understanding from management with regard to my CNS role.
25. Time for discussion of the cases with clinicicans prior to the MDT, and to prepare for the meeting. Team building.
26. Time
27. time
28. The support of a dedicated MDT co-ordinator
29. that one should be able to act as deputy and present cases in the abscence of the lead clinician but this doesnt happen
30. team working/interpersonal skills
31. support from MDT staff in patient record availability
32. Split Level 1 & Level 2 MDT meetings
33. some of the other members behaving better
34. sessional time to prepare properly
35. seeing other MDT's in progress to see whether there are things that we could do to improve effectiveness/efficiency
36. scrapping video conferencing! Ring fenced preparation time
37. Sadly there are times when medics do not want to listen to other MDT contribution. Value the contribution from all. Not to just say that but to act as that is the case as well.
38. Regular service development meetings and team updates

39. Reduced workload
40. reduce time as at present meeting goes on for 3 and half hrs somtime more
41. Recognition of my role by certain other professionals
42. Quicker & more confident use of current EPR system
43. protective time to prepare for presenting patients. as i do this effectively in my own time
44. Protected time to contact patients and inform them of plans
45. Protected time for attendance
46. protected study leave
47. Professional development of speciality
48. Prior short meeting with nursing colleagues
49. prior knowledge of all the patients
50. perhaps a public speaking course
51. Peer support and ensuring that the video conferencing link takes place in my absence, to ensure patients receive prompt review and appointments within the network
52. other than time, there is a good support network within our MDT
53. observation of other MDT's in other areas. Protected time for MDT
54. Nothing in particular. I contribute when appropriate and necessary.
55. Nothing I personnaly feel able to voice my opinions and participate in the MDT meetings I attend.
56. nothing
57. Nothing - we have a functional, supportive and motivated team
58. not sure
59. not sure
60. Not aware that i can contribute anything at present. Very medically orientated, but i can contribute if needed. there isnt a need.
61. none
62. N/A
63. My understanding of terminology in ALL areas of treatment
64. Multidisciplinary working didn't suddenly start with the introduction of of formal MDT meetings. I have worked with my medical colleagues on the basis of equals for most of my career, while recognising each others areas of expertise. I give my contribution to MDT as & when I need to - anything else & I would be failing my patients.
65. More time to prepare.
66. More time to prepare for the meeting
67. More time to prepare cases
68. More time to prepare and more time in the meeting
69. More time to prepare
70. more time in the role (lack of experience currently impedes me and speaking out can be intimidating)
71. more time in my normal workday to do anything other than clinical related work. There are many issues that could be discussed at our MDT but by the end of 2 hours discussion which has usually run from 12 until 2 there is no time or energy left
72. More time for prep and audit
73. More time for mDT's at present they are over lunchtime on a Friday, they are hurried and we do not have adequate professionals to support us, no radiology or histology staff
74. More time and greater respect for CNS input. MDT very medically driven
75. more time and electronic records
76. MORE TIME
77. More time
78. More time
79. More time

80. More time
81. more time
82. More tiem for preparation and more training around report writing.
83. More support
84. more planning time more staff on our team-currantly have 30hours CNS for 188 patients a year
85. More participation from the junior doctors and co ordinator.
86. More meetings of MDT core members to trouble shoot
87. more knowledgeable about histology
88. more knowledge
89. more evidence based information
90. members of the team recognising our imput re the patient
91. mdt times are often duplicated and so can only attend each one alternative weeks. due to be a part of a large acute trust and different times have been tried but due to all core members time restrictions difficult
92. Managerial and leadership training
93. Less patients being discussed from the entire county, allowing more time to discuss ones that belong to our own locality.
94. less medical focus
95. Leadership/ confidence training
96. Increased support from the cancer center team to allow preparation prior to the MDT and admin support to allow real time documentation of the MDT decision/treatment plan
97. Increase confidence
98. Improved memory.
99. improve my knowledge on gynae cancers, still developing
100. If there is personality differences leadership of the meeting makes all the difference. I think MDT training would be a wate of time.
101. if members of the MDt would value a CNS input
102. If it was used as a teaching as well. Slides and images are reviewed but no one ever points out what is what, it is assummed everyone in the room knows what a myeloma etc cell looks like
103. if I knew all patients being discussed prior to the meeting
104. I usually feel confident in contributing to the meeting
105. i prove the information that is needed at mdt at present. i think as i develop within my role then so will my input
106. I have spent time with all members of the core team in their respective roles /work place. this was a good insight to other peoples pressures of work it would be useful for all new members to do the same
107. I have no problems in making contributions when appropriate.
108. I feel very lucky that my contribution is valued and I am actively encouraged to participate
109. I feel that I contribute heavily and my personal contribution is much greater than other team members, so I would welcome more support
110. I feel quite satisfied that my contribution is valued
111. I contribute comfortably at all the MDTs I attend
112. I am quite appy at the present time. I feel valued and my opinions are listened to.
113. I'm fairly new to post and I have found that learning the priorities of an MDT most beneficial i.e. who to put on and when.
114. having the time to meet some of the patients prior to the meeting
115. Having some of the surgeons listen to CNS views about the patient as they will know the patient better than the doctor.
116. Having other members know the patient/case instead of just me
117. having dedicated time
118. Have more time to prepare
119. Happy to contribute now...8 years in post...but found the arena intimidationg in

the beginning. Confidence gained through own professional development.

120. greater knowledge of different aspects of the care patients receive as I'm fairly new to post
121. For the input of a clinical nurse specialist to be valued and respected.
122. Focusing on the learning needs of the group and illustrating specific cases as a learning opportunity with opportunities to question
123. feeling valued as an equal team member
124. Feeling that contribution was valued
125. FEELING AS THOUGH MY ROLE WAS IMPORTANT AND WORTHWHILE & THAT I WAS ACTUALLY PART OF THE TEAM WOULD BE A BIG HELP
126. Feel that the CNS is not just a nurse but an important member of the team as a whole. I'm not always called to meet patients at diagnosis
127. Environment more open to communication.
128. During case discussions all personally involved with that case should be invited to voice their concerns/opinions and this should be duly recorded
129. Don't know as I fully utilise my potential
130. different pattern of presenting patients and discussion
131. Designated slot for CNS input, feeling that CNS opinion is valued.
132. contributing to the education slot
133. Continuos updating in treatments.
134. Continued support from MDT members
135. continued support from management and to continue to have a dedicated MDT co-ordinator
136. Clerical support
137. clearer understaning of cancer treaments and pathways
138. clear understanding of other team members' perspectives
139. Changing it from an exercise if ticking boxes for peer review to a meeting that truly valued the process and the intent of MDT to improve patient care.
140. Chairing meetings I Chair the TYA supportive care MDT) and attendence form other core members of MDTs is weak - its not seen as important as heir site specific MDT - with some notable exceptions
141. better understanding of the varied disease processes and staging
142. BETTER 'MEDICAL KNOWLEDGE ' OF DISEASE PROCESSES
143. Being valued by all members of the team.
144. being valued and listened to if I have a contribution about the patients wishes or concerns of a psycho-social or fertility aspect. Being actually asked.
145. Being recognised for the valuable contributions regularly made instead of being taken for granted and utilised when it suits
146. Being informed in advance of new patients for discussion so that I can meet them to gain understanding of their hopes and wishes
147. being allowed to speak at MDMs without feeling that my opinion is second class as I'm a nurse not a doctor
148. BEING A VALUED MEMBER OF THE TEAM
149. because of time constraints our mdt does not provide any educational or learning opportunities, especially aimed at my level. this is definitely a missed opportunity
150. Be less avoiding when it comes to challenging MDT activity. Either step up to or step down from MDT Lead activity.
151. BASIC EDUCATION IN OTHER SPECIALITIES
152. attitudes of other team members
153. At SPC MDT, nothing. At cancer MDTs, an ability to attend every meeting (staffing issues) to therefore be seen as more part of the team and therefore more known and trusted.
154. Assistance with admin
155. Assertive training
156. as before- a little more time during MDT
157. Another CNS as i cover a large geographical area for two cancer types.

158. Already contribute as lead nurse and colonoscopist for screening program
159. Admin support an more MDT co-ordinator time.
160. Access to training and communication within a multiprofessional team, this should be done as an MDT team away from the hospital environment, training should require the team members to work together to solve problems
161. A second CNS to allow suffiecient time to meet and support all patients with suspected lung cancer throughout their investigations
162. A formal invite from Chairman, within each patient discussion, to relay any social, emotional issues, inc current family situations, relevant to the meeting,which may influence the decision making process
163. A formal handover to the MDT if covering for a core memeber.
164. a clearer understanding of my role
165. A better understanding of my job role by other MDT members
166. A better electronic proforma which is pre-populated & stays updated throughout patient journey
167. 1. Feeling valued as a team member

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

60 nurses responded to this question

1. Whatever it is it should have been implemented before now
2. Water pistol Gags Fast forward switch. Plain English speaking lessons. Patience practice. Neck and shoulder massage. Role reversal activity. Video a sesion and look back at behaviours; helpful v not so helpful ie self awareness training.
3. Visit to other same specialitity team to observe and take on effective pratice
4. Video conferencing training.
5. use of IT
6. unsure
7. Understanding of MDT Co-ordinator role
8. Training in team work Training in charing meeting but also for participation- for some nurses public speaking skills Report writing
9. to look at other mdt around the country to reflect on the effectiviness of them
10. to attend other mdt's to see if things can be improved or changed
11. Time to undertake these is very difficult
12. The National Lung Cancer Forum for Nurses provides this
13. Terms and references to agree reason for MDT.
14. Support of hierarchy and managers that all team members have important role to play in management of patients
15. preceptorship
16. Peer review by other MDT members (live rveiew)
17. peer review
18. Observing other MDT and MDT members
19. Observation of other mdts
20. nothing i can think off
21. Not sure
22. not sure
23. not sure
24. NONE
25. None
26. none
27. None-we have what we require
28. more time

29. More regular training from PTC's.
30. More access to Advanced Communication Skills Courses
31. Measure how other teams iniate and develop their MDT`s
32. maybe a detailed case study once a month to remind us of the individual behind the disease and frame this in a holistic way rather than disease focused
33. IT training for core members to cover during periods of unexpected absence.
34. IT handling of information Online/immediate real time access to referrals for investigations or listing for surgical procedures. Online planning reference for chemotherapy and DXT
35. IT
36. induction package for new team members
37. In house up dates
38. in house training such as communication skills leadership skills dealing with difficult people and perhaps team building skills day courses
39. Implementation of eg. Summerset
40. DON'T KNOW
41. Don't know
42. Don't know
43. Discussion in NSSG meetings
44. discussing old cases to see if the agreement is the same, ? form other networks
45. Communication training, team bonding sessions
46. Communication training
47. Communication training-breaking bad news Facilitated discussion about how the team works and what our objectives need to be in temrs of improving service we provide
48. communication
49. British association of Urological Surgeons produce a nationwide MDT protocol
50. benchmarking with others
51. being allowed to access internet explorers when trying to research things for patients. alot of external resources are blocked by trusts.
52. away day for team building and oppurtunity to reflect upon how mdt working and how it can be improved
53. as above
54. As a nurse there are core competancies that need to be met. It should be that nurses are given the same allowance of study time as medical staff, as at present i am undertaking my MSc in my own time.
55. Are ther any?!
56. Any training tool which is compulsary for the clinicians and can be bnationally policed. The CNS is often the person who attends all the courses and tries to implement change which is then blocked by clinicians.
57. all the above support tools have been used by our MDT
58. All covered above
59. ?
60. ?

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

99 nurses responded to this question.

1. YCN Peer Review Training Workshops Locally service improvement training, plus others such as audit training, coaching for teams or personal.
2. unsure
3. unknown
4. unaware of these
5. Unaware of any
6. TME MDT training aims to do this but it is qestionable that they achieve this
7. The NLCFN annual workshops
8. team away time. busniess meeting to discuss the service encompassing MDT issues.
9. SWLondon Network have arranged training - not well attended
10. Study days provided by PTC's.
11. pelican training at basingstoke
12. Pelican sessions
13. Pelican MDT training sessions
14. Pelican Courses
15. Pelican course
16. Pelican Centre MDT training days for colorectal cancer. Lesley Fallowfield's training days (conducted as part of her resaearch)
17. Pelican centre MDT training days
18. Pelican Centre MDT training at Basingstoke
19. pelican centre MDT training
20. Pelican centre MDT TME Course
21. pelican centre for colorectal
22. PELICAN CENTRE BASINGSTOKE TEMS course . 2 courses by Professor Fallowfield on effective communication as an MDT and on communicating clinical trials to patients and MDT members. the courses were extremely effective they were run by Sussex university for Cancer Research
23. Pelican Centre
24. Pelican centre
25. pelican centre
26. pelican centre
27. pelican centre
28. pelican
29. Peer review. Communication.Assertiveness.
30. Peer review
31. peer review
32. Outside team building consultants. I think it is vital that it isnot in-house training
33. Nothing that I am aware of in the paediatric area
34. Not aware of any.
35. Not aware of any
36. Not aware of any
37. Not aware of any
38. Not aware of any
39. not aware of any
40. not aware
41. Not aware- the only one that might help by proxy, is the advanced communications skills training that some MDT members are required to attend.
42. None!
43. None!

44. none that I am aware of
45. none known
46. none i can think off- there are conferences
47. NONE
48. NONE
49. None
50. None
51. None
52. None
53. none
54. none
55. none
56. none
57. none
58. none
59. none
60. none
61. none
62. none
63. no
64. NIL
65. Nil
66. NATIONAL COMMUNICATION SKILLS TRAINING PROGRAMME - CONNECTED
67. MDT training course at Pelican Centre, Basingstoke
68. MDT co-ordinator study days
69. MDT-TME training at the Pelican centre
70. IT communication skills updates re latest trials and treatments when appropriate
71. i dont know of any.
72. dont know of any
73. DAHNO
74. Communications workshops
75. Communication, leadership, assertiveness, team building courses
76. communication training. qualification for nursing staff dealing with oncology patients.
77. Communication training
78. communication skills training
79. Communication skills Local implementation team support/guidance
80. communication course
81. Cncer peer review workshops
82. ARK at Basingstoke
83. Any communication courses, teamworking courses or relevant IT courses. Such skills should be transferable. Specific training relating to hao an MDT funtions and what the objectives are inrelation to government indicators and outcome measures would have to be a specific course.This should include how core members can come to know and work woith the various systems within aany organisation which would enhance their own professional contirbutions and afford better 'movement' of a patient through often complex clinical interventions...which may even be undertaken at different hospitals!
84. All the ones mentioned plus communication and numerous other ones for all levels of staff
85. Advanced Skills training
86. Advanced Communications Skills course
87. Advanced Communications
88. Advanced communication training team away days

89. Advanced Communication Skills courses
90. Advanced communication courses for MDT members
91. Advanced Communication courses Leadership courses both stand alone or as part of degree programmes.
92. Advanced communication courses
93. advanced communication course
94. advanced communication
95. Advance communication training, etc - Network led.
96. A course in leeds run by their urol team
97. 1. MDT masterclass locally to identify areas for improvement
98. ?
99. ?

Final comments

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

43 nurses responded to this question

1. we work as a diagnostic unit and have to refer cases to centre mdms so it is not easy to measure our performance as the centre decision may differ from the local one.
2. Time is a huge problem on an over worked service. tHERE NEEDS TO BE RECOGNITION FROM EMPLOYERS
3. The MDT Co ordinator remains the key person to facilitate high performing MDT's along with an effective Chairman. The CNS role acting as key worker and patient advocate should be valued if patient centred care is to be achieved.
4. The head and neck cancer SMDT for Essex is new, and needs better leadership, organisation.
5. The current MDT seems to be an exercise in ensuring that all cases are discussed at MDT. It feels less like a clinical meeting and more like a tick box exercise.
6. Team building excercises would definitely provide a good opportunity for all core members to respect each other and work together. the psychometric testing may allow core members to realise in black and white how they are perceived though it is difficult to say how much that would be taken on board in some cases. Good preperation is definitely a factor in the MDT running efficiently.
7. Since we introduced the MDT system at our Hospital, our referral rates have improved dramatically & we often reach 100% in the 62 day targets. It has enabled close cohesion & organistaion between the Cancer Unit/Centre
8. Questionaire is difficult to complete in certain sections as does not relate to supportive and palliative care.
9. Peer review should provide evidence of MDT effectiveness.
10. over the past few years there has been great advances in the MDT working, both internally and using video conferencing within the network, this improves patients care and communications with colleagues, however there are some inconsistencies as some hospitals do not appear to be represented
11. Our best performing MDT took part in Lesley Fallowfield,s away days, understand each other's role within the team, respect each other and have a strong chairman, even in his absence. As a result more patients are discussed, including a rolling clinicalaudit of patients who died.
12. Not having too many cases discussed at once as if a huge MDM MDT memebers are exhausted by time final cases discussed and I wonder soometimes if decision making is as clear.

13. Need more time. Sadly patients at the end of the list do not alway get an adequate discussion because of time constraints. Also members leave the MDT before it is finished
14. My experience is mainly good but I am concerned that one local MDT I attend has NO oncology input at all, sometimes only one clinician and the pathologist exerts too much influence on treatment decision and is heavily biased against pts by age (even those in 60's/70's)
15. Much of this survey is not directly related to Specialist Palliative Care MDTs we are not aiming at currative treatment
16. Most MDTs have been running for many years and have evolved accordingly with each team. Sometimes difficult to arrange a AGM as members are so busy.
17. MDTs vary widely even within same trust. Palliative care one is very different to cancer ones and is very patient focussed.
18. MDT training can only work if all team members attend and take it seriously.
19. MDT's having an explict educational and training remit for thier team members.
20. IOG compliance
21. I think there is an assumption that MDT's have improved patient care but there is no documentation to prove that is so. It was assumed that MDT working did not happen before IOG and it did. I think there is also a misguided notion that an "MDT" is a clinical place and people say they have ref'd to the MDT as though it is eg a clinic and therefore their responsibility for the patient is closed. I also think waiting for MDT decisions can introduce delays. There is insufficient funding to enable MDT's to run properly and the pressure on clinical time has been increased without the staff numbers to achieve it.
22. I strongly believe patient care/treatment has improved in our trust since we started working with MDT's we now have to a certain extent more of a holistic approach to care
23. I have worked in MDTs where all personnel have been valued - currently I work in a Trust where the medical/nursing divide exists in a manner akin to when I trained in the 1980s - this is frustrating for CNSs and of detriment to the patients
24. i have only been in post for 8 months and had never been involved in this process before. i understand that the one i attend is very good but does go on for normally 3 hours which is very long
25. I have observed that when doctors and CNS have good strong working relationship the outcomes are improved
26. I have been in post 3 months, but have been made welcome by the MDT and feel that my contributions are valued
27. I feel we have an effective MDT team and outcome recording could be improved at times
28. I feel if and MDT has evolved into a well defined decision making unit as our has, changing the way we run is not helpful. If an MDT has a problem and seeks help I think it is good to have the resourses.
29. high perfoming mdt indicate no complaints,high pt satisfaction survey,cancer waiting time acievement(no breach),good team working,increased job satisfaction
30. Good team working, strong educational emphasis, focused on the patient All team members feel able to contribute and opinions valued. Regular audit and review of performance Audit and research enouraged
31. good organisation is key
32. Good leadership and chair, good preparation, regular attendence of core members.
33. every mdt need same format; need an effective mdt Trust lead;
34. essential is communication, patient-centred focus, acknowledgement / respect for ALL team members contributions, timeliness and a forum for review : of where decisions diverge, change, death occurs, improvements made.
35. Close relationship and good communication.Each member is valued.
36. attendance
37. As a member of a core MDT we must have reached a senior position to have acquired skills for high performance such as good communication.It is the

dedication and efficiency from individual members is required

38. as a gynae cancer unit the process in place with the gynae Cancer centre is very effective, we also discuss patients locally which has eliminated any potential cancer patient being operated on in the wrong location by the thoroughness of the process.
39. As a baseline questionaire could be circulated around the core members asking them if they are aware of how to or who to contact in the event of a patient needing a particular intervention or needing support from a particular service, or on who and how to include patients onto an MDT. This could go on to be developed into an 'primary audit' deriving the standards from the questionnaire. The effectivemenss of any training or modification of MDT 'stuff' could then measured by re audit.
40. All members engaged in MDT process, consequences for those who don't
41. A well motivated lead and team
42. A sucessful meeting is largley down to a good co ordinator and their organistaional skills.
43. A definition of the key worker role.Job discription, the role is interpreted very loosely.