Multidisciplinary team members views about MDT working:

Results from a survey commissioned by the National Cancer Action Team

Open question responses: Other Doctors (Physicians, GPs etc)

November 2009

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

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

Introduction
This report provides the responses given by **other doctors (physicians, GPs etc)** 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 7

What do you think constitutes an effective MDT? 7

THE TEAM 12

What qualities make a good MDT chair/leader? 12

What types of training do MDT leaders require? 14

What makes an MDT work well together? 15

INFRASTRUCTURE FOR MEETINGS 17

What is the key physical barrier to an MDT working effectively? 17

What impact (positive or negative) does teleconferencing/video-conferencing have on an MDT meeting? 19

What additional technology do you think could enhance MDT effectiveness? 21

MEETING ORGANISATION AND LOGISTICS 23

What preparation needs to take place in advance for the MDT meeting to run effectively? 23

What makes an MDT meeting run effectively? 27

CLINICAL DECISION-MAKING 30

What model of decision-making could be used for patients with recurrence/advanced disease if these patients are not discussed at MDT? 30

What are the main reasons for MDT treatment recommendations not being implemented? 32

How can we best ensure that all new cancer cases are referred to an MDT? 34

How should disagreements/split decisions over treatment recommendations be recorded? 36

Who is the best person to represent the patient's view at an MDT meeting? 39

Who should be responsible for communicating the treatment recommendations to the patient? 41

MEASURING MDT EFFECTIVENESS/PERFORMANCE 44

What other measures could be used to evaluate MDT performance? 44

SUPPORTING MDTS TO WORK EFFECTIVELY.....45

What one thing would you change to make your MDT more effective?.....45

What would help you to improve your personal contribution to the MDT? 47

What other types of training or tools would you find useful as an individual or team to support effective MDT working? 48

Please provide details of training courses or tools you are aware of that support MDT development 49

FINAL COMMENTS 50

Please insert any final comments or observations on the characteristics or indicators of high-performing MDTs and appropriate measures of performance.....50

Domains that are important for effective MDT functioning

What do you think constitutes an effective MDT?

149 'other' doctors responded to this question.

1. Well structured, organised, well attended, and properly chaired, using well designed IT links.
2. well organised, well prepared staff who are willing to challenge and be challenged
3. WELL ORGANISED, WELL DOCUMENTED, RELEVANT PEOPLE PRESENT
4. Well coordinated speedy actions
5. well co-ordinated ie a list given to the pathologist in time for them to review cases, at least brief history known and a core multi-disiciplinary group present to discuss cases. Co-ordinator to ensure appropriate follow-up of patient and decision making. Documentation of different opinions and feedback of what subsequently happens to learn and improve practice
6. We have had 9 different MDT co-ordinators so far!!!! One that sticks with it would be a start!!
7. We have an MDT co-ordinator - who should do the data collection as well - but they refuse to do it (becasue they are not clinically trained ? - not much use therefore)
8. True participation of various members involved. Timely and effective communication of MDT decision to clinician in charge of patient's care. Accurate and comprehensive data collection.
9. True multi-disciplinary discussion
10. Treatment planning Communication Feedback
11. Timely start , list of patients to be discused, presence of all core members, good discussion and a workable conclusion
12. time and good communication
13. The MDT contributes to an optimal patient experience and outcome
14. the core members should include the relevant doctors who diagnose and treat the cancers incl. physicians, surgeons, oncologists. It should also have the MDT coordinator present and CNS' if possible. I f a video-link is necessary this needs to be of good qaulity.
15. The combination of a complete data set, the right people and an effective chair
16. teamwork and good coordination
17. team working
18. Team work,meticulous record keeping and communication
19. team work
20. sufficient time within job plan
21. Starting on time Fully functionning equipment Responsible clinician attending and presenting patient data
22. Stabe, efficient and effective MDT coordinator Good attendance Good facilities
23. Small team discussing the more complex patients.
24. Small group, well defined roles, good communication between members and good personal links with members of other MDT's
25. Skilled and cooperative colleagues. Good support including electronic systems and someone commited to ensuring accuracy and completeness of data
26. Safe, coordinated and efficient patient care
27. Right patients discussed at right time. All relevant information available all necessary disciplines represented. Needs effective admin to ensure patients do not slip through the net and are managed through their pathway rapidly.
28. Respected and knowledgable chair person Efficient MDT coordonator Good IT support
29. reproducible decision-making with clarity and effective communication between members

30. Regular meetings, good communication with clinicians, easy to access and captures all cases painlessly
31. Regular meetings that are attended by the same core members most of the time. Advanced preparation of list of patients in order that radiology, histopathology can have a chance to review slides etc prior to meeting. Good radiology images and support. Close links to oncology and surgery. Presence of Lung CNSt and pallitive care. Good documentation of plans. Clear documentation of responsible person to action plans. Regular audit to ensure continual standards and improvement
32. Regular meeting of all specialists required for the optimal management of the condition
33. regular attendees using constructively critical knowledgeable approach
34. REGULAR ATTENDANCE OF ALL CORE MEMBERS WITH ADEQUATE INFORMATION.
35. Regular attendance by all modalities. Sufficient (protected) time for MDT and its preparation
36. An effective MDT is one that serves the needs of the patients, not the members or writers of guidelines for them!!
37. punctuality, familiarity with patients, core knopwledge, up to date reading
38. Properly staffed, sessions in all attendees job plans, up to date facilites i.e min 3 PCs, PACS projector, mmin 2 screens to read reports, seating and air conditioning, coffe machine, admin and sec support
39. Presence of core members and adequate admin support
40. Presence of all relevant professionals, good atmosphere to discuss cases and enough time to complete discussion. Even handling of all cases
41. prepared and clear case presentation clinical expertise respect across specialities good working relationships abililty to deliver MDM recomendations feedback on decisions / cases
42. Patient as virtual chair Patient inclusion in goal setting Explicit use of care pathway
43. Optimum size of no more than 4/5 core members, multidisciplinary. When group is too big, hard to get a decision. But has flexibity to approach expert who is not core member for very specialist cases
44. Open/helpful discussion with the provision of appropriate results/data regarding each patient and culminating in the optimal treatment plan for that patient taking into account all aspects of care.
45. one with members present, adequate information, and decisions made in a timely manner
46. One which enables discussions of complex patients
47. One where the lead physician is present who knows the patient to present the clinical case. One where all the notes, imaging and pathology, and lung function are to hand One where decisions are not binding, but dependent on a knowledge of the patient, their physical, mental and social situation, and which can be communicated to the patient via the lead clinician for that patient. One in which all the lead players are present (physician, surgeon, radiologist, pathologist, radiotherapist and oncologist, plus cancer nurse. One in which the patient is paramount.
48. One where all relevant specialists are always represented and all histopathology data provided in a timely fashion.One where clinically relevant targets take precedence over arbitary clerical ones
49. One that has meetings that inform me on the effectiveness of my practice. I do not want to attend meetings to be told the obvious. It must make effective use of time.
50. One that focuses on difficult cases and doesnt just tick boxes and wastee time on simple cases
51. One that can make dicisions but as we are the shared care center we talk about socail and local difficultes we need more impute from the Oncology centre to make us feel its not a waste of our time
52. Must be multi-disciplinary Be inclusive of all team members Meet regularly Record decisions Be part of patient journey

53. Multi-disciplinary; should not be dominated by one person; radiology and pathology input is essential.
54. Motivation and commitment of all involved individuals
55. Most of all, effective chairing. Infrastructural posts - data co-ordinators etc - also equally vital
56. members from relevant clinical/other groups. effective chair
57. members from different disciplines good time keeping / focus opportunity for different members to engage clear outcomes / decision making for patients
58. Meets needs of local team as well as the population, is efficient and well organised with prompt feed back
59. mdt coordinator, physician, surgeon, histopathologist, oncologist, junior staff, lung cancer specialist nurse
60. looking at histology and discussing future management
61. Leadership,preparation,organisation, team working, rapid availability of information (CT, Histology etc) to act on, technology
62. Leadership Facilities Good working relationships
63. Lead role, feedback from all parties, clear and common objetives, network pathways, quality measures
64. Knowledgeable professionals supported by adequate admin
65. in my setting - to have medical, nursing, pharmacy, psychology and social care representatives. we have approval for an MDT co-ordinator but until appointed the minutes are taken by myself and other co-ordinator roles picked up by myself or the CNS or my medical secretary.
66. I really don't know
67. Highly skilled clinicians. Excellent communication. Excellent infrastructure for viewing histology and imaging. MDT co-ordinator. Excellent chairmanship to make best use of limited time available. Sound data collection for ongioing audit.
68. having the full compliment of staff,each of whom can do their part properly. In some cases, the hospital have not invested in this
69. having all memebers attend. This is often difficult to achieve.
70. haematologists caring for patients, radiology representation, histopathology, radiation oncology, clinical nurse specialists and trial co-ordinators.
71. Good working relationships. Not overly narrow in view eg not just interestd in surgery or oncology.
72. Good teamwork. An effective lead and the correct make-up of personnel.
73. good team work and liason between pathologists, surgeons and dermatologists
74. good relationships efficient co-ordination reliable representation of main disciplines
75. Good organisation and coordination. Good decision making systems
76. Good organisation and communication
77. good organisation & understanding of role
78. Good leadership, good communication, commited professionals, good organisation
79. good leadership
80. good doctors , adequate time and admin support
81. good cordinator access to all data experts able to attend
82. Good Coordinator. Good chairperson
83. good coordinator unfettered access to histology
84. good communications, clear roles and responsibilities, with everybody agreeing to do waht is good for the patient
85. Good communication, organisation and clinical skills with people taking appropraite responsibility
86. good communication, full engagement of all included hospitals, leadership from the network
87. Good communication to facilitate open discussion about individual patients. The support systems to enable this to occur are key.
88. Good communication between the members. Fully operational X-ray systems and a committed, interested and efficient team.

89. Good communication
90. Good co-oridnator and mutual respect
91. GOOD CHAIR GOOD CLERICAL/AUDIT SUPPORT GOOD AGREED PROTOCOLS GOOD RELATONS WITH MANAGEMENT GOOD WORK ETHIC COMMINICATION
92. Good audit trails so not data lost, and all decisions followed up to ensure have occurred. Care pathways/prootocols to work from. Where we are dealing with tunours we can't treat locally, a clear shared care protocol with th etreatment ccentre (we don't have this at present)
93. Good attendance from everyone. A fundamental belief from everyone that it is a worthwhile exercise. Adequate IT facilities.
94. fully staffed, regular meetings effective group dynamics, good organiser
95. full team
96. Full core membership. dedicated time in job plans. good working relationships. An effective coordinator and chair.
97. Excellent quality information about patients in will equal a good discussion and therefore correct decision on the patients management. Documentation standards with electronic records and recall. Properly resourced data collection or recogition in job plan.
98. Everybody has to be there Everybody has to have opportunity to contribute
99. Environment which enables all members to feel they can contribute effectively to the discussion. This requires the right place, the right people and time.
100. Enthusiastic members
101. ensuring that the appropriate parties are all adequately represented
102. Ensuring appropriate patients are discussed. Having a chairperson. Keeping the discussion focussed and relavant. Ensuring the relevant core members eg radiologists have time beforehand to assess radiology to have an informed discussion.
103. efficient organisation; reliably functioning IT systems; availability of results & expertise
104. Efficiency. Too many simple cases discussed including the majority who have simple management plans
105. effective decision making with record of decisions and facility for audit
106. Effective communication
107. core membership needs to include clinicians with the appropriate clinical knowledge with good working relationship and enough time to discuss cases.
108. complete patient information - complete representation by all treatment/patient service groups
109. communication between all stake holders , accurate reports of descisions delivered in timely fashion
110. communicating team willing to work together
111. collecting and recording all the data discussed with outcomes printed into notes
112. Clinician leading with elimination of all non-cancer csae discussions from the meeting
113. Clearly designated time slot in Job Plan + adequet Radiology display + pathology facilities--requires efficient IT services on site .Requires good data collector and coordinator.Good communication with feeding tertiary centre.
114. Clear referal pathway TWG support in bringing small hospitals on board Protocols AUdit with good data
115. Clear lines of communication, easy access to MDT to expedite cases if clinical need
116. clear decision making and discussing patients only with relevant clinical data available
117. Clear decision-making by the team with an identified team leader. Input from all relevant disciplins within team
118. Clear and relevant information available and clearly recorded outcomes. Adequate time to discuss cases. Attendance by clinician, radiologist, surgeon, pathologist and oncologist.
119. claer definition of reponsibilites for data collection - coordibnation and

communication of patient details and planned outcomes

120. Broad spread of professionals but clear co-ordination of meetings
121. Bringing together of different helping agencies,and focusing on childs/patients needs
122. available resources including , coordinator, telecommunication and protedted time for contributing staff.
123. Attndance byu all specilists involved in the investigation and treatment of patients with that type of cancer. Meetings are not effective and beneficial if not all the treatment modalities are represented.
124. Attendace by medical professionals involved in the care of skin cancers (skin MDT)
125. an organize system to discuss cancer cases and take decisions.
126. An organised MDT co-ordinator with enough time to complete the tasksof preparation and data collection. A suitable room Time for staff to attend rather than sandwiched between other things. Technology and time to record the MDT outcome and inform relevant people in a timely fashion. It would be ideal if we could email the GP
127. An efficient meeting that tracks the patients journey, minimises the need for unnecessary referral letters between members of the MDT, has information available to make effective decisions at the time and co-ordinates investigations, treatment and OPDs to reduce patient attendances.
128. An effective clinical Lead who will take into account the views of all the members without bullying and intimidation
129. All required personnel in post, good facilites, good communication and managerial support.
130. all relevant specialities/ disciplines attending. Good organisation and communication
131. all patietns reviewed, action plan formulated, information disseminated to correct people
132. All members should contribute and core members should attend except on when on leave.meeting should be well structures and supported.Patient should remain paramount and all decisions should be agreed by majority if not all members of team and need to be appropriate to the indivdual patients needs.
133. all involved in care and treatment able to attend on a regular basis. All specialities involved, radiology medical and clinical oncology pathology all of the nursing team administrative and AHP where needed
134. All core members being present Careful screening of appropriate cases for discussion
135. all being there!
136. Adequately resourced, good professional relationships, good data collection
137. adequately represented by various specialities,i.e.respiratory physician,oncologist,radiologist,pathologist,thoracic surgeon ,respiratory lung cancer nurse specialist,palliative care nurse and MDT co-ordinator.Constituents of MDT should be able to air their views and a consensus decision regarding best management arrived at
138. adequate information to make an appropriate decision
139. Able stewardship .
140. abilty to gather pathogy data rapdly and have coordator to organise pre and post discussion matters
141. ability to make decisions
142. Ability to discuss freely in an uninhibited way. For lung MDTs in ur network, there is no specfic funding for data collection etc and this is done by the cancer nurse specialists - not the best use of their time.
143. A range of clinical and pathological specialties, with the support services to back it up. For my own specialty, this means chest physician, radiologist, (cyto)pathologist, surgeon, oncologist, specialist nurse, co-ordinator and data collector. Psychologists/palliative care/social worker less important.
144. A meeting of specialists, both diagnostic and clinical, in which a patients case can be discussed in order to make treatment recommendations that can be put

to the patient. The MDT should offer advice on the patients care at all stages of their disease and should have access to sufficent expert opinion and facilities to make this possible.

145. A meeting of an expert team who discuss individual cases and recommend management plans based on the discusion of good quality evidence and the patient's wishes.
146. A meeting in which staff with a specialist interest in, and knowledge of, their tumour site gather to discuss the relevant investigations and pathology and to plan management. A holistic approach tp care is needed and so the patients wishes and concerns should be known. Data should be recorded, ideally electronically if time allows. We discuss over 50 patients in2 hours (between clinics) ands so it is proving difficult to do anything beyond paper recording and later transfering data to computer. Information should go to the GP directly from the meeting.
147. A group of clinicians and pathologists who can discuss cases where management is in doubt. A group that can set and measure standards of care
148. A format whereby any treatment decision made is directly relevant to the patient. All too often discussions tend to be idealistic rather than holistic!
149. A complete group of core medical professionals, with specialist nursing support and effective case selection and data collection.

The team

What qualities make a good MDT chair/leader?

66 'other' doctors responded to this question. 1 'other' doctor responded 'as above', referring to Q35.

1. who commands respect, leads by example
2. Time management, engagement of all members, to sumarise at the end of discussion
3. Time keeping. Good communication with all members. regular project meetings with core members to discuss issues within the unit's MDT.
4. Speaks clearly, involves all, ensures summary and keeps discussion moving to ensure timeliness
5. Someone who listens and organises well
6. someone who has the time to do it; and puts clinical information gathering and thoguht before ridiculous cancer time targets
7. someone who ensures full,meaningful contribution from the whole team, who makes sure the coordinator is documenting events accurately, who runs the meeting in a timely fashion and ensures decisions are reached and recorded accurately
8. Respect from all member clinicians; excellent communication skills, good committee/meeting management skills.
9. The contributions of all MDT members cannot be of equal weight. Knowledge and experience vary between members. The authority given to a memeber's contribution must reflect this.
10. Presence throughout the meeting, ability to keep a steady momentum and reduce time wasting.
11. Personality!
12. People management skills, organisation and specialist knowledge of the relevant condition
13. Organisation. leadership. Good listener, good at bringing meeting to order when it starts to drift.
14. Organisation
15. Listens to and encourages input from all MDT m,embers. makes a decsion where consensus is lacking. Happy to take advise. Works closely with co-

ordinator.

16. Leadership, punctuality, clarity of thought with good immediate planning skills, persistence, vision for the future
17. LEADERSHIP AND FLEXIBILITY
18. knowledge, not to try and use position to dictate their opinion on management and ability to consider other peoples views. ability to keep agenda moving forward and to manage disagreement between colleagues
19. Knowledge of their subject, good communication, patience and clarity of thought and presentation
20. KNOWLEDGE AND RESPECT
21. knowledge and respect
22. knowledge
23. Keeping to structured discussion & time
24. I think all of the things you have listed [in Q35] are important
25. humour
26. help team members make decisions and keep the meeting moving along at a timely pace
27. he/she should respect all opinions. he/she should be in a position to arbitrate any disagreements - so must be a senior clinician. no bullying
28. good rapor reputation among the different specialities present at an MDT. Ability to steer meeting efficiently and timely through the cases. Identify, discuss with the core MDT and action decisions about MDT practice, poliocy & governance
29. good organisation, able to listen, allow and acknowledge all contributions and summarise outcome
30. good leadership and communication skills
31. good leader with patients best interests as main focus, not a trial recruiting zealot
32. good communicator / facilitator
33. good communication skills/good time management skills/Familiarty with potential treatment modalities used for MDT patients
34. Good communication skills
35. good communication
36. For contunuity, it is best that the same person chairs the MDT. However, the lead role should rotate among the core members.
37. focus
38. expertise in the field and good organisation skill
39. Experienced clinicain with good communication skills
40. EXPERIENCE, KNOWLEDGE, GOOD WORKING RELATIONSHIPS WITH ALL DISCIPLINES, ORGANISATION, UNDERSTANDING OF PRIMARY AND TERTIARY CARE
41. Experience, emotional intelligence,integrity and consistency
42. Experience in leading a clinical 'firm' as well as a good reputation with colleagues. Some degree of seniority is essential as clinical experience is vitally important
43. Excellent knowlage of the field and good communication
44. Ensuring all disciplines have air time, ensuring a conclusion is come to, keeping the meeting focused
45. Don't know
46. decisive and inclusive
47. Credibility Fairness Ability to include everyone
48. coordinate the activity, summarize at the end
49. control - ability to get and allow all members to contribute - organisational ability
50. Communication
51. commitment,respect of members,knowledge of the disease, punctuality
52. co-operation amongst team
53. clear, able to help sumarise a clinical discussion and draw it to a conclusion, clearly communicate that, also be able to manage disent for decisions

54. Clear communication, respect of other members, efficient and organised, passion for patient care
55. Clarity, focus and mutual respect for others
56. being able to listen as well as speak
57. Authority
58. Approachable, good listener, will allow others to talk as well, knowledge of current treatments and their efficacy.
59. An underlying enthusiasm for the whole MDT process. An ability to clearly summarise discussions which have taken place. Good timekeeping. Letting everyone who wants to speak be heard whilst not allowing them to ramble.
60. An efficient, knowledgeable person who listens to others and values holistic care.
61. Able to keep to time and control the process
62. able to hold the respect of all members
63. Able to control the pace of the meeting and ensure all opinions articulated
64. Ability to multi-task. Good level of knowledge and ability to create good atmosphere
65. Ability to allow all team members to contribute appropriately to decision making
66. Ability to reach a clear decision based on information presented

What types of training do MDT leaders require?

55 'other' doctors responded to this question.

1. Training does not help this ability
2. Time management, engagement of all members, to sumarise at the end of discussion
3. They should do this throughout their working lives
4. therew should be training but I am not aware there is such a thing.
5. The MDT Leaders should be of sufficient standing whereby they demonstarte good communication and and leadership. Training should not be required.
6. team managment, leadership, communication
7. Skills on managing teams and specific updates on their field of cancer care
8. skills of chairmanship, teamwork and leadership
9. Should not need it
10. sharing of experience with other leaders
11. practicalites of technology used, techniques of maintaining focus and communication within the demands of the reauired otucomes for any given MDT
12. Perhaps a cancer module of current treatments for their cancers would be useful and a list of clinical trials available,
13. part of core skills no training needed
14. nothing extra over medical school and specialist training
15. not sure
16. None. I am MDT lead and recieived no training but learnt by experience.
17. None!
18. none whatsoever
19. none specifically
20. None specifically - all senior doctors of some standing are used to leading teams - so it should always be a clinician
21. None really needed unless individual is keen.
22. None if the above are extant
23. None
24. none
25. Needs to know basic oncology/chemoradiotheRAPY
26. meeting and time management skills
27. leadership, and meeting mangement skils, conflict resolution is also helpful

28. Leadership training
29. leadership skills if they don't have them
30. leadership development programs may be useful
31. Leadership course
32. leadership and time management
33. leadership and negotaiation skills
34. IT, chairing meeting skills
35. in leadership and time keeping
36. I see the appearance of more "Middlemen" making a fast buck with a new course compulsory for all
37. I've been one for 10 years; I think the best form of training is to see a properly functioning MDM do its stuff. Perhaps some mentoring?
38. Effective leadership and communication skills
39. Don't know this either. I don't know if MDTs are effective
40. DON'T KNOW
41. Don't know
42. don't know
43. Conflict managment and resolution, negotiating skills, IT skills
44. communication/leadeership
45. COMMUNICATION, PRACTICALITIES OF RUNNING THE LOCAL MDT/M, ACCESS AND TRAINING TO CLERICAL AND AUDIT SUPPORT TO ENSURE EFFICIENCY, ESTABLISH FIRM CONTROL
46. communication skills, time management, apprenticeship with an MDT lead and supervision when they first start
47. Communication skills training
48. communication and conflict resolution time managment
49. communication
50. clinical pathway
51. Bone specific
52. As per individual needs.
53. Any would be good!
54. agenda management, people management
55. 1) to be an expert in the disease 2) good diplomats

What makes an MDT work well together?

62 'other' doctors responded to this question.

1. understanding of each others role, trust between members, ability of all members to listen to others
2. time clear objectives to EBM
3. those present have a clinical opinion that is respected
4. The team members need mutual respect and (at least) tolerance - liking would be even better
5. Team with best interests of patient at centre. Good preparation so that time is not wasted. Members attending on time
6. show respect for others opinion
7. sharing a common goal and remembering that the goal is patient care
8. Shared purpose, good technology. Food provided if over lunchtime.
9. Shared goals, agreed pathways
10. shared goals
11. Shared aims and views
12. Respect for each other and the contributions that are made.
13. Respect for each individual's opinion
14. respect for all opinions

15. respect for all members of the team
16. Respect for all members of the MDT
17. Respect and cooperation
18. PROTOCOLS, SHARED GOAL, PROFESSIONALISM
19. professionalism
20. people who can laugh together rather than at each other
21. people who all have the same goals who are commited to the MDT and can communicate well
22. particiaants willing to listen as well as talk
23. Mututal respect for professional skills of all members
24. Mutual trust and respect
25. Mutual respect, shared objectives, commitment.
26. Mutual respect, shared goals
27. Mutual respect and professionalism
28. mutual respect and competence
29. Medium sized team, no interpersonal problems, equal effort by each team member in preparation for the MDT.
30. knowledge
31. Involvement of all parties concerned
32. If everybody feels they can contribute
33. if each member is appreciated and there are no personality clashes
34. I've no idea
35. Humour, respect
36. good understanding and respect for each others role and mutual support
37. good team relationship
38. Good management
39. Good interpersonal relationships
40. Good interpersonal relationship, mutual respect, refreshments.
41. Good communication with all members and interested parties including patients and GP's.
42. Good communication and shared goals.
43. good communication
44. good commnication - ability to listen
45. good chairman
46. FRIENDLY
47. Everyone is respected Communication is good
48. Effective leadership
49. dk
50. Communication, good leadership, clear objetives
51. common interest
52. Common goals and aims
53. Common goal to care for patients with patient autonomy as the prime aim
54. common aims
55. committed individuals, team identity, protected time, admin back-up
56. Clear goals for the team Mutual respect Members keeping themselves up to date with clinical knowledge, guidelines and recommended management of various cancers
57. Already commented on
58. All core members have the same objective. When all members are benefiting from attending regular MDT eg colleague support, educational, optimum patient care
59. aim to work for the patients benefit
60. acknowledgement of others skills / good communication / negotiation and compromise
61. A sense of common purpose
62. A common aim, good communication and good leadership.

Infrastructure for meetings

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

101 'other' doctors responded to this question.

1. Wrong information being fed into the MDT
2. working of prjector, microscopy etc
3. we have a telemedicine link so are not in the same room, this definitely makes personal interaction difficult
4. We are meant to discuss all BCCs - this is not really useful allocation of time - we should discuss only incomplete or recurrent disease
5. video links taht do not work properly, poor quality hisltogy projection
6. Unreliable technology and unavailable information
7. Uncooperative members and lack of patient data.
8. time, IT and money
9. time
10. The video-link between siters: audio in particular is poor and this severely limits communication.
11. Tele linking image clarity
12. Technology placement and effectivness
13. technology failure
14. Technical problems
15. Sufficient staff to manage the work load of patients needing diagnosis and treatment
16. starting on time!
17. space
18. Small screens, suboptimal projection equipment, poor training
19. room too small, no visible diagnostics, no access to IT facilities
20. retrieval of diagnostic material
21. Relationships between senior clinicians
22. Radiology availability and function
23. pressure from management not recognise it as DCC activity and sell short preparation and meeting time
24. Post sound/picture quality in the electronic trans hospital network
25. Poor view of the screens
26. poor videoconferencing links
27. poor technology for key diagnosics
28. Poor sound and picture quality in AV linked MDTs
29. poor sound and cant see the scans
30. poor seating arrangements...unable to view visual aids/histology/climincal pictures
31. Poor quality sound and video links between sites
32. poor IT
33. Poor information on the patients to be discussed
34. poor acoustics
35. people not being there without a substitute
36. people being unable to hear all that is being said
37. optimum group size, effective IT, attended by all core members to facilitate useful discussion
38. notes not available
39. Not enough space/poor infrastructure; poor projection facilities.
40. not enough space for everyone to sit
41. not enough seats

42. NOT BEING ABLE TO SEE THE IMAGES ROOM TOO SMALL SEATING PLAN LACK OF WORKSURFACES FOR THE RELEVANT PEOPLE
43. not being able to see the diagnostics , hear the presentation or having No IT working
44. Not being able to see or hear one another.
45. Not being able to see one another or the screens
46. not being able to see everybody, also too many peole stops good interaction between the core members
47. Nosie or queit voices
48. none
49. Non avaialblity of results and non-attendence of core members.
50. no room, inability to view histology
51. No experience of videoconferencing - but suspect it is not as good as "real life"!
52. no discussion room available
53. My answer is partly relevant to video conferencing.
54. Members unable to see each other well
55. late arrivals -sitting at the back and not being heard
56. lack of time and general managerial disinterest
57. Lack of space
58. lack of patients clinical and social details
59. Lack of audio-visual equipment and poor preparation
60. Key people not attending Teleconference facility not working
61. Key members not present, pathology/imaging not available.
62. IT not working
63. Interpersonal rivalries
64. insufficient information on each case
65. Incomplete availability of data
66. inappropriately small size of room
67. Inability to see the screens
68. inability to see the scans
69. Inability to see radiology and too little space
70. inability to see or hear other members
71. improper location
72. if the room is too large and members cannot hear each other.Video-link that is not working properly
73. If sound and picture quality on a videolinked meeting is not good enough
74. Having X-rays to review - system doesn't always work, making optimal decision making impossible
75. having a variety of times so that there is choice to when we can attend. if it is always on the same day of the week it can exclude some every time. Need some daytime and evening meetings
76. Good multiconferencing facilities essential, Clinical TIME
77. Geography, personalities,
78. Functionning (lack of) technology
79. Failure to access or open up to date proformas if there are hardware/software problems.
80. failure of telecoms
81. Failure of key members to attend or poor personal relationships
82. Failure of imaging, absent core members. Hungry team members, doctors running late for clinics and operating lists.
83. Failing teleconference equipment
84. equipment that fails to work or PACS sysems which keep crashing
85. Effective visualisation.
86. Dont understand the question
87. DON'T KNOW
88. Don't know

89. Core members not being present at start of meeting
90. clinicians non atttendance due to other work committments
91. clinicians needing to travel from different hospitals to get to MDT meeting results in time wasted in travelling and sometimes in members turning up late
92. clear timetable for its duration
93. bright light
94. Boredom
95. Being unable to access results
96. Being able to get there as we work across site
97. Availability of room with appropriate technological support eg imaging
98. attendence
99. adequate space
100. Access to information
101. Absence of key members of the group.

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

94 'other' doctors responded to this question.

1. widens expertise available to discuss cases
2. When it works its great, when the system fails its useless and stops the MDT from functioning at all.
3. We don't use. I do not think it is appropraite for my speciality. I believe face-to-face discussion is far superior. I believe it would slow down an MDT, not contribute effectively and would simply act as a "tick in th ebox" that someone has attended.
4. Videoconferencing allows local hospitals and treament centres to interact
5. Video conferencing will not start at my Trust for a few months. My personal opinion is that video conferencing is better than nothing but will not replace face-to-face clinical discussions. teleconferencing is useless
6. Video-conferencing is the only way we have of getting surgical input to our MDM. The technology is creaky and the image and vocal quality is poor. It's better than nothing but still far from ideal, as in effect we have to have a separate surgical MDM as our surgeon is not available when we have our MDM
7. Video-conferencing can be good when it works, but can be very complex, and can leave some centres out.
8. Very negative slows it down and much is lost in translation
9. updating the care
10. turns into circus
11. Tried unsuccessfully
12. Too impersonal Cant read body language and verbal cues over video
13. time wasting too dependant on rubbish technology and too expensive without any benefit to effectiveness
14. time wasting if ucases unsuitable for surfgery are discussed
15. Time delays, audio selectivity i.e rustling papers can obscure quality, like wathching a 1950's movie
16. Teleconferencing is difficult but videoconferencing at least improves interaction. This is still better face to face
17. Technology needs to be working well for effective interaction
18. Speed!
19. So far it has never happened at our meetings, because of technical difficulties.
20. slows - less good interaction
21. Significant both positively and negatively.
22. see above

23. saves travel time for some of core members who can make an effective use of their time provided information is disseminated electronically
24. Real time teleconferencing would be useful for rarities such as referral ot the skin lymphoma MDT (supraregional)
25. Positive impact
26. positive impact - as long as there is good technical support
27. Poor set up so that there are difficulties with audio and visual quality/availability.
28. people attendance and interaction is less
29. Only works if volume of sound and quality vision are appropriate to truly engage at both ends of system
30. often works poorly
31. Often inadequate, usually not working for whole of meeting. Person at other end gets substandard meeting experience.
32. not used
33. none until management takes it seriously and invests in technological support
34. None
35. none
36. No experience
37. No experence of this, I suspect the nuances of some discussion might be lost!
38. negative. never seems to work
39. negative impact if the system is unreliable
40. negative impact- technology failures and time wasted in getting connected positive impact- ability of all clinicians to participate
41. Negative effect. People on teleconference are rarely devoting their full attention tio the matter in hand
42. negative due toi frequent breakdown with eqiupment
43. n/a
44. More people can be involved where appropriate
45. Makes it possible but chaotic
46. mainly negative. face to face always beter unless qulaity of VC excellent. Too much use of very poor technology. unable to see histology. poor qulaity sound
47. little experience but face to face seems to provide more interactive discussion
48. Lack of interest/attention. Poor quality of video conferencing and delay in picking up questions. limits discussion
49. Keeps everyone's interest, as long as equipment works reliably
50. just more people
51. It slows the meeting down and the members who tele-conference do not have the same engagement with the issues as the ones who are physically present.
52. It enables our XX [area] specialist MDT to function. Without it the whole thing would not work in our relatively rural area i.e. it is vital.
53. IT can lead to less discussion sometimes
54. It allows interaction with referring hospitals far out in our network and also interaction with extended members at our other campuses. MDT facility not always available because of competing demands from various MDTs
55. improve attendance. If cases for discussion is small and meeting is short, it is difficult to justify clinician travelling for more than 1 hour to attend for a meeting that lasted for less than 1 hour where his or her opinion may not be required for the cases discussed. For example, oncologist attendance to local skin MDT
56. Image quality is not as good. failure of IT. Difficult to get all members involved.
57. if there is poor videoconferencing linkage it can make linking up almost pointless and patients need to be discussed again over the telephone
58. If equipment not functionning reliably, it is very frustrating
59. I think it helps team work & consistency across the network, and reduces errors.
60. I thing the main advantage of an MDT is the discussion generated between "friendly" professionals. Such uninhibited discssion often, im my experience, reveals nuances that often have a major impact on decision making. Physical person to person contact is essential for this.Video conferencing is not a sunstitute and should only be used as a method of very last resort.

61. i need impute from the oncolgy centre
62. i haven't used it and we don't need it so can't comment
63. I feel it makes meetings rather disjointed.
64. hinders development of new working relationships
65. helps the surgeons save time
66. helps if it works (especially with distant surgeon)
67. Help reduce time wasted travelling. Not easy to ensure always works and if it dosent it is a waste of time as csaes cannot be discussed.
68. Haven't tried - from others comments can make a little disjointed
69. haven't seen it in action
70. hasn't been relevant for us so far
71. Enables multisite meeting Relies heavily on equipment and technology
72. Enables members based on different sites to attend
73. enables key members on different sites to discuss cases. To work well it hepls if members already know each other and only 2 sites are involved.
74. enable people travelling some distance to the MDT to attend regularly
75. dont have
76. Don't know. Never used it.
77. DON'T KNOW
78. Do not know - just about to start
79. Distraction and poorer quality involvement/discussion.
80. Cuts down travelling times BUT can be unreliable!
81. CONTRIBUTION
82. Communivation v difficult
83. Communication is far less good whenusing any AV technology
84. Clinical presentation is worth a thousand words. Current technology limits the quality of data displayed
85. Can delay proceedings
86. brings everybody in and may encourage better attendacne - will save time for some of the specialists MDTs
87. always discussion with surgeons every week
88. Allows cross-site conferencing. Prevents wasted time travelling between sites
89. Allows colleagues attendance from outside the Trust Technical problems can be an issue
90. allows all hospitals within the Network to participate in the MDT
91. Allows a broader group of members across a large area. Disseminates good practice to as many participants as possible.
92. all core members can now attend, but is not a substitute to one joint meeting as tecnology fails quite often
93. above it is between always and sometimes 25. the system can be poor or fail altogether
94. A very positive impact

What additional technology do you think could enhance MDT effectiveness?

55 ‘other’ doctors responded to this question.

1. working technology
2. WORKING PACS AND IMAGING EQUIPMENT
3. We need more clinicians, not kit
4. we have a microscope link to demonstrate slides to a remote linked site in real time
5. video conferencing - reliable PACs system
6. video-conferencing
7. The PACS system is essential - yet no system yet devised seems foolproof or 100% reliable

8. The current technology is fine when working (it is not always the case)
9. Technology is a compromise !
10. systems that work all the time rather than sometimes
11. reliabe fast network connectivity.
12. Real time electronic records/data base entry but it would be essential to have adequate secretarial skill available to input the data fast enough to keep pace with the meeting
13. Real time database for recording decisions linked in to electronic patient record to request tests ans referrals immediately.
14. Ready availability of a technician when equipment does not work properly!
15. problems are not technical
16. Probably everything could be solved by a dedicated high-bandwidth line
17. Printers to print out reports for signing at the meeting
18. photos available all the time
19. ours is mostly discussion based
20. Not new, just requires to stop using substandard equipment, less cheap and cheerful.
21. none needed
22. none
23. none
24. More reliable PACS
25. More bandwidth
26. Microphones!
27. Microphones
28. memory sticks for patients
29. Lucada input (possible via LCMS) at the MDT
30. Linking of PACS of different hospital trusts so that an MDT will be able to review imaging in totality
31. link to endoscopy system
32. Large multi-header microspcope
33. laboratory access
34. IT database
35. Improved sound quality and picture quality ie far greater band width
36. Improved clarity of histopathology and radiology images from other teleconferencing hospitals
37. HIGH quality videoconferencing links, not just the basic. without high quality linkage that can accomodate linking up to 4 sites at once, the benefits of the MDT meeting are compromised
38. Good MDT management database.
39. fully supported videoconferencing. real time data and decision recording
40. full access to hospital systems, so that we can all access as much uptoate patient info
41. faster and more pwerful computers that do not crash
42. EPR - if all patient data were available electronically - especially other lab results/reports - would be very useful. Even better if could extend that to ordering/booking further investigation etc
43. Electronic recording of decisions
44. Electronic database?
45. electornic medical records.Allocated preperation time in job plan for members.
46. Easy access to blood test results easy access to endoscopy reports and endoscopic images computerised booking/tracking of investigations inc. radiology, biochemistry, etc
47. DON'T KNOW
48. Don't know
49. digital photograhy
50. Dedicated MDT room where equipment is checked regularly and set up prior to meeting

51. communication to GP. Realtime
52. better audio
53. Availability EPR
54. Ability to book investigations at time of MDT
55. 2 screens, one for pathology/radiology images. Somone who can touch type and record decisions in real time.

Meeting organisation and logistics

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

135 'other' doctors responded to this question.

1. we need a maber of the oncolgy centre to be present
2. updated information on the cases discussing
3. to make sure that I am aware of the patients that are under my care and to make sure that results and clinical photos are available.
4. The physician responsible for the patient should present a clear concise history to allow the MDT to function effectively. This means that doctor must know the case or if they cannot attend, a deputy should familiarise themselves with the case before the meeting. Radiology and histopath must have time to prepare.
5. The MDT co-ordinator needs to make sure all notes and results are available. He/she should meet with the MDT lead prior to the meeting to ensure all that can be organised has been, and so that time is not wasted on discussing patients with results still pending.
6. summary of latest information eg. other MDT decisions, investigation results, social changes
7. Summary of Key data Availability of notes tests etc
8. Summary information needs to be available for each patient including perfomrance status etc. Relevant information including histology slides and results should be available. CTs should be reviewed
9. Suitable room, notes, investigations, pathology and an MDT list
10. slides and images need to be reviewed (should be recognised within job plan). Chair and core members should be familiar with the case summaries prior to meeting and discussion (10-15minutes only)
11. Screen relevant cases. All information to be available. Clinician review of individual cases
12. Review pathology, x-rays, endoscopy Ensure all results available Ensure the clinical question to be answered is defined
13. Review of why the patient is on the list. Are results back?
14. review of radiology, histopathology, clear questions to be asked at the MDT
15. review of notes, data entry onto Cancer Register, review of histology by pathologists, review of imaging by radiology both with access to clinical info and questions being askes. good knowledge of trials available. access to thoracic surgeon for every case discussed
16. review of notes
17. Review of current and previous studies
18. review of cases
19. Review of case to clarify what has been done, discussion with pt & Gp regarding pt preferences, as required, discussing comnplex cases with colleagues not due to be present at the meeting.
20. Review of case notes, imaging, endoscopy, biopsy reports and fitnes for intervention as determined
21. review of case notes and results by clinician. review of diagnostics by relevant specialty. generation of summary of all cases for discussion. Ensure relevant

forms for documentation are dated. info on any targets wrt a case documented as part of discussion

22. review of case histories
23. review information. why is this pt in MDT, what questions need answering, obtain results of PET scan etc before MDT
24. Review clinical reports, review imaging with radiologists and review literature of recent publications appropriate to the MDT
25. Result of all investigations need to be available.
26. Relevant resuts/data to be available for each patient to be discussed.
27. Relevant individuals present who know the patient well. Relevant histology, radiology (inc from other institutions present)
28. Relevant clinical information, availability of all investigation results
29. reciew of case notes/letters/histology reports
30. Recall history and other medical conditions, risk factors
31. Reason for discussion Fillout form MDT clerk to get notes/results Radiologists to preview films Pathologist to preview results
32. Radiology reviewed Histology reviewed Case prepared
33. radiology and pathology review; retrieval of scans and pathology material; clinical summary presented in advance of the meeting; adequate time to discuss each case at the meeting
34. radiogist look at xray - histopath prep.
35. pulling patient notes for meeting and ensuring histologist is aware of patients due to be discussed
36. presenting clinicians to have a structured delivery, histology reviewed before meeting, the majority of radiology reviewed before the meeting
37. Preparation of notes, ensuring resuts are available, chasing letters from tertiary centres
38. Preparation of agenda review of clinical and imaging data by the appropriate clinician, radiologist and pathologist.
39. Preparation of a patient list with important clinical information, results of investigations - so that the MDT chair can run the meeting efficiently without having to resort to searching through case notes etc.
40. patients notes to be seen by their consultants and history summarised. Consultant to look at the treatment options which should be tailored to the patients needs and choice AND MUST BE EVIDENCE BASED prior to presentaing the case in the MDT
41. Patients discussed should have been seen by clinician at the meeting - sometimes not the case
42. Patient notes, investigations,summaries,results should all be prepared in advance. Histologist needs to be advised of patients inplenty of time
43. Patient list Notes and investigations present at meeting Relevant specialists prepared to present information and plan next step for the patient MDT proformas for each patient
44. patient familiarity
45. patient's clinical presentation, dominant symptoms affecting QOL,performance status,patients views and preferences regarding treatment options,pathology and imaging results,ensuring that relevant specialist(s) are actually attending the MDT on that day
46. pateints names collected and cases identified notes collected histology collected other experts contacted if neccessary (radiology etc)
47. Our histopathologist and radiologist will spend some time on preparation. The MDT coordinator obviously spends a large amount of time each preparing for the meeting. The CNS will also be involved. The physicians and surgeons don't tend to do any preparation unless for complex cases.
48. Notify co-ordinatpr, review results etc,
49. NOTES, FILMS, PATHOLOGY SUMMARISING CLINICAL AND RADIOLOGICAL OUTCOMES TO COMPARE WITH HISTOLOGY TRIAL MATERIAL HIGHLIGHTING DISCREPANCIES
50. Notes, agenda, imaging, full clinical assessment of patient

51. notes reviewed and summarised-films reviewed
52. Notes read, missing data obtained, images reviewed on PACS work station, parking God know how many hours I waste, better investment in videoconferencing equipment not the stuff we have at present which is like watching the Woodentops (if you are old enough to remember this programme!)
53. Notes imaging histology
54. Notes available to relevant people, radiology, histolgy, knowledge of names on list
55. Notes and xrays reviewed by clinicians. Pathologist informed of need for results.
56. Notes and results collated and available, including access to imaging
57. Need to summarise clinical data of the cancer + back gound medical state + family and social circumstances + any data on patients wishes
58. need to know pts
59. ned to know cases so if you have no idea about them you can check detainls-mostly this can be done during th emeetgin as you should know th ecase anyway
60. Mostly done by MDT coordinator & pathology - gathering notes & slides
61. MDT coordinator arranges all patient data to be available.
62. Making sure proformas are fully completed and up to date. Reviewing patients only when all results available.
63. Mainly coordinator collating data, histopathology having details to obtain path results and radiologists to prepare imaging
64. location of case notes, extraction of information from case notes
65. List of clinical details. Establishing the clinical question. Ensuring the information needed to answer that question is available.
66. Knowledge of the case (performance, co-morbidity, imaging, bronchoscopy findings, lung function, co-morbidity and other important factors)
67. know patient clinical ans social needs and management reqierements
68. know history anddetails of investigns
69. It woukd be useful to read through the notes and review imaging
70. It will differ for different team members. I need to know the medical details of every patient under my care who will be presented and (usually) to have an outline management plan as a basis for discussion
71. it depends on how effivient you want your mdt to be. often it's actually preferable to go through patients at a relatively relaxed pace, and mdt members looking up patient details allows other mdt members to play mental catch up.
72. INTELLIGENT summary of patient history, investigations, scans, patient preferences.
73. Individual case review
74. In our LMDT I dont think it has been all that useful as we were doing a good job prior to MDTs It would be useful to have dermatoscopic images with the histopath for teaching/learning reasons when reviewing pigmented lesions.
75. In 'skin' it is not really relevant because all the patients, or nearly all, have already been treated.
76. identify patients for MDT at clinnic check list of MDT
77. I read through all case notes and ensure that the corect clinical information is summarised to enhance the MDT discussion. This includes lung function, co-morbidities and performance status. I ensure that if a patient has not had a teat, they it is done.
78. I check patients that need discussion are on the list, and appraise any issues that may not come over simply from investigation results.
79. History, what tests have been done, what question is being asked
80. Histology and imaging reviewed. List of patients for review drawn up. Notes obtained and MDT paper work inserted. Arrangment for patients to attend made. Special problems for discussion considered.
81. Go though the list, identify patients with personal involvement, ensure full knowledge of details for these patients
82. getting notes/radiology and pathology
83. getting everything together and identifying the questions to be asked
84. gathering of casenotes, review of slides, review of history

85. Gathering data for co-ordinators and histopathologists - and loading scans on to the PACS sytem
86. For me this would be ensuring I have a summary of the patient, including relevant results
87. Finding notes, results, appointment details, knowing which investigations have been done, reviewing of pathology slides
88. Familiarity with the case history, patient's knowledge and wishes
89. Ensuring you have a clear recollection of the patient's history and up-to-date laboratory, endoscopic and imaging results, if you are bringing the patient to the MDT for discussion. The notes SHOULD be made available.
90. ensure correct guidlines are available ensure patient details are known
91. Ensure biopsy results and case notes available. ALso tha X-rays available for viewing. Thought about what likley treatment plan is
92. Ensure am familiar with cases. Prepare an MDT proforma for each patient. Have an idea of relevant points for discussion
93. ensure all results are present, if not may need to ring up other hospitals where specialised tests are sent to get results.
94. ensure all notes and results available - presenter prepared to give precise and accurate summary of case
95. Each individual should know the details of the patients they have put on the MDT
96. Do not know as we have not started going to ours yet
97. Determine what the clinical question is and ensure all important clinical data / information is available
98. Depends on who you are talking about, as a clinician knowing your own patients most important.
99. Depends on the specialty: a radiologist needs to looks at he radiology, pathologist at the the pathology etc
100. data collection. results review. This should not be an enviroment where tests etc are reported for the 1st time
101. Cytology, pathology and radiology is most important as these services need to show investigations and need time to prepare. Co-ordinator needs to assemble notes. Physicians, surgeons and oncologists have less pre-meeting organisation that is necessary other than to be conversant with patients to be presented
102. concise history / collation of relevant facts
103. collection of data to be viewed
104. collection of data and notes, done by coordinator. Review of case notes.
105. collecting notes for the meeting
106. collect clinical info
107. collation of relevant scans / records
108. Collation of information
109. Collating the notes, and background information about the patients. As lead I have a discussion/ emails with the MDT co-ordinator about a few patients who are listed where there are queries. The co-ordinator is efficient and conscientious, otherwise my workload would be considerably more.
110. collate and ensure results available, approve appropriateness of patients on list
111. Clinicians need to know their cases! Histology needs to be retrieved
112. Clinician needs to read notes and clarify the facts - should take very little time. Radiologist show review images and prepare staging prior to meeting to save time. Histopathologist should have reviewed slides and come prepared with their opinions.
113. Clearly some MDT members have an important role in the peparation for the MDT and therefore this should be recognised in JPs - but others are not involved in pre-meeting preparation. Case summaries circulated prior to the meeting should not be necessary - just makes more work
114. Ckecking patient notes, adding names to the list, check investigations (histology, radiology...)
115. Check notes present, check own patients' case histories and make sure investigations up to date
116. case summary, knowledge of patient PS, review of X rays and pathology

117. Case summarising Diagnostic results
118. case review, summary and questions to be addressed already identified
119. Case review
120. case notes used to identify important details about the case and ensure that the results of all investigations are available. Imaging and pathology has been reviewed before the meeting so that the pathologist and radiologist have opportunity to give adequate time to review
121. case note review, spirometry, radiology review
122. case note review and collation of investigation results. ideally prepare the key qusetions to be answered at the MDT
123. Case ascertainment - checking pathology database etc Collecting patient data Completing patient summary forms which I do for both my patients and on behalf of others Communicating with histopathology
124. Awareness of what cases are to be discussed. Any rar or nusual presentations?
125. Availability of final histopathology in a timely fashion;currently not so.
126. As patients come to the attention of the meeting a summary of the case with relevant pathology needs to be made
127. As MDT Lead I like to look at patient lists and case summaries before each meeting.
128. As Lead I have to go through the patients to be discussed with the MDT Coordinator clarifying the clinical issues and the information needed. If overbooked then I also have to decide on prioritisation.
129. AnMDT coordinator is very helpful and cuts down on the time the clinician would otherwise spend on preparing for the MDT
130. ALL RESULTS AVAILABLE
131. all patient notes available and xrays/CT scans to have been reviewed by radiologist, pathology reviewed by Histopathologist
132. All patient data to be available for review
133. agenda preparation, collection of notes, results etc, review of images by radiologists
134. accurate history and notes available - this stops people being brought back for discussion because noone can remeber if he had 2 or 3 chemo sessions etc
135. 1All cases should have short clinical summary on proforma 2 concise Question's posed for meeting to discuss/answer 3Clinical notes available,radiology/histology available.4 Proforma's part completed in readiness for meeting and completion at meeting.Radiologists/histologists where possible should have viewed images prior to meeting.5 Patients waiting time in process needs to clear to avoid delays

What makes an MDT meeting run effectively?

111 ‘other’ doctors responded to this question.

1. whan all core requisite data is to hand and can be reviewed by all members of the team
2. timekeeping. familiarity with cases. open discussion, opportunity to challenge and discuss
3. time spent discussing cases that need MDT decision. Otherwise, in dermatology, it is very tedious to go through every single case of skin cancer. I often see members falling asleep in these meetings.
4. TIME KEEPING, GOOD PATIENT SUMMARIES AND HAVING ALL THE PATIENTS INFORMATION TO HAND
5. time keeping
6. time for all members of the core or extended team to give their opinion rather than dominated by one or two individuals
7. This is dependant on all of the organisational factors mentioned above and in addition a good working relationship with all members and that all members feel the can contribute and will be listened to and decisions made on the best case for

individual patient

8. There may not be a need to look at the pathology of every case. Chair needs to move the meeting on
9. The character, personality and knowledge of the chair person
10. Technical facilities, organized administrative work, availability of tests (histology, radiology), good leadership
11. Teamworking and persona;lities involved
12. team working
13. succint presentation, specific questions and decisions made
14. stick to the details. Would run better if we had the time to prepare for the meeting.
15. Somoene who knows the patient being present with all the relevant data and relevant specialists being present
16. set time and clear management of the meeting
17. See above
18. see above
19. results present, representatives from radiology/histopathology/radiation oncology present, concise presentation of patient history with a provisional managment plan.
20. Reliable technology. Firm leadership
21. relevant clinical / other members + effective chair
22. punctuakity familiarity time and knowledge
23. preventing managers adding cases at inappropriate meetings
24. Preparation; the data and images being available at the moment they are wanted; the right staff being there; a robust means of recording the decision of the meeting and of following up any agreed actions to make sure that none slip through the net
25. Preparation.
26. Preparation, time appropriate staff present
27. Preparation, preparation, preparation
28. PREPARATION, organisation, information to make decisions
29. Preparation by co-ordinator, good attendance and good chairmanship.
30. preparation before the meeting and priorisation of cases at the meeting.A good co-ordinator
31. preparation
32. preparation
33. PRECISE SUMMARY OF INFORMATION
34. Pre-meeting preparation People arriving on time
35. Poeple who know the cases well discussing them (and not deputising responosibility to a junior)
36. planning, team work
37. people who know what they are doing
38. people turning up on time
39. patients consultant/team member present all relevant data present
40. our fantastic mdt coordinator
41. organised meeting
42. Organisation. There needs to be an open, helpful attitude between team members, and a desire to achieve the highest standards.
43. ORGANISATION!!
44. Organisation Preparation Attendance of all core members
45. organisation
46. Only discussing patients that need discussion. If patients have been treated according to protocol, they should be listed. This way the MDT time is spent most effectively.
47. notes, investigations and clinician involved in care available. Chair being aware of each case and ensuring that time is not wasted discussing none relevant issues. The chair or other person nominated to obtain information and evidence on management of rare cases before meeting
48. Not having to discuss too many cases

49. Members arriving on time-all modalities being present. People listening instead of eating lunch. effective preparation.
50. MDTs are run in different ways - there is no single way that is the best. Local arrangements are best worked out locally. The role of the chair may vary - there needs to be leadership and someone who can resolve conflict/agree consensus/and sometimes "steer" the meeting - but not to take total control
51. maintain regularity,good interpersonal relationaship
52. keeping to time
53. having everything abailable and all members presetn on time
54. good strong chairman, effective nurses
55. good preparation; good chairperson
56. Good preparation/presentation - so that all the relevant results are available - so a sensible treatment plan can be agreed.
57. good preparation, expert knowlage, good communication
58. Good preparation, a proactive radiologist, stong leadership from the chair.
59. Good preparation by the MDT coordinator, a good chairperson, involvement of all core members, good histological support
60. good preparation and core attendance on time
61. Good organisation. The right people being there. Committment of the team.
62. good leadership from MDT chairman and effcetive preparation from |MDT coordinator
63. GOOD LEADERSHIP GOOD TEAMWORK POLITENESS AND CONSIDERATION THROUGH MEETING
64. good coordinator and chairman
65. Good coordinationation, leadership and effective team working. Respect for other psoples views. Good use of technologigy. Good preparation of case notes so that time is not wasted finding information, or patient being offered a treatment which later is found to be inappropriate because no one knew the case well prior. The time spent per patient will vary by MDT site. Most lung cases are very complex so longer is required compared with other sites.
66. Good coordination and strong clinical leadership
67. Good co-ordination. Protected time for core memebers. Not too long. No undue chatter!
68. Good chairperson; MDT coordiantor
69. Good chairmanship, sticking to agenda.
70. Good chairing and good pre-MDT preparation
71. Good chairing - with rapidly accessible clinical information
72. good chair. Effective radiology/patholgy technology
73. Good Chair + sufficient time to discuss the cases. We have been restricted to a one hour meeting to allow medical staff to fulfill their other clinical committments.
74. good chair conscise information
75. good chair
76. Good availabilityof information
77. Good attendance. Co-operation betwenn everyone involved.
78. Functionning technology
79. Focussed Chairperson, prior preparation
80. Fewer cases to be discussed.
81. Everyone keeping to the point, not chatting and not abusing the meeting by looking at extra Xrays not on the list, for example.
82. everybody turning up on time.
83. Enthusiastic/skilled team making valuable contrubutions to the MDT
84. efficient running through the cases. Everyone there from the beginning of the meeting
85. Efficient organisation, succinct histories, only view relevant histology, avoid chit-chat.
86. Effective organization of MDT meeting with prioritization of agenda
87. Effective leadership from a chair, with adequate pre-meeting preparation. Regular

attendance of the core members.

88. effective coordination and leadership from the MDT chair
89. Effective chairman. Cooperative members.
90. Distributing patients notes to relevant clinician at start of meeting. Keeping order
91. discussion relevant to case only. sticking to agenda. respect for views of all members of mdt
92. Discussing clinically relevant cases, with all the facts and relevant consultants present
93. Data, loud voices, absence of interruptions
94. Crisp presentation Respect for clinical expertise. Lack of complex and ambiguous cases!
95. concise presentation of cases preparation of radilogist and pathologist presence of core members from each disipline
96. concentration on job in hand and not diversions - availability of all information to make decisions - working technology for Xray review
97. Co-operation and preparation and effective IT
98. clear leadership and discussions based on EVIDENCE
99. clear direction, no anecdotes allowed.
100. Clear decision making, clear communication, ensuring that only appropriate cases are discussed
101. clear and relevant information made available in a consistant manner (pro-forma)
102. Avoid time wasting by useless discussion or "chat" about the early patients, leaving a rush to complete the rest. Thus discipline.
103. Available information/notes
104. Availability of histology and good input from members and good chairing
105. Availability of case notes and histology reports of cases to be discussed Availability of clinician/deputy in charge of patient's care to present case to MDT Punctuality of team members Prioritisation of patients to be discussed according to complexity
106. Appropriate time management.
107. an understanding of the purpose of the meeting. In dermatology it is not very clear what this is -it is more of an audit process really
108. Many of the facilites are multiuser rooms simply not fit for purpose yet the NHS just bumbles along.
109. all clinical information on pts summarised all readiology and pathology available for review
110. administartor, community nurses attending and a co ordinator
111. A good organiser; fo us it's our Cnacer Nurse Specialist

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?

63 ‘other’ doctors responded to this question.

1. Written communication between oncology and specialty.
2. With respect to private patients, in my view it is important that clarity regarding liability for decision making and recommendations for treatment needs to be determined before discussion of private patients occurs. In addition, it must be a two way process - the MDT must receive notification that the agreed treatment pathway and care was adopted. MDTs should always receive consultation fees for private patients - this would represent a revenue support for the MDT service. These issues are almost impossible to implement and currently this is an

important grey area that is frequently overlooked.

3. We discuss them all.
4. Treatment pathways agreed for 2nd/ 3rd line chemotherapy
5. treatment as per protocols and patient wishes.
6. TREATING CONSULTANT SHOULD BE ABLE TO DECIDE ON THE APPROPRIATE TREATMENT STRATEGY IN CONSULTAION WITH THE PATIENT
7. to local treatment protocols that have been agreed, with referral to the MDT for the clinical exceptions
8. this can be discussed informally by the clinicians involved then documented at the next MDT
9. They should be siscussed at the MDT
10. they should be
11. They should all be discussed at the MDT, even if retrospectively.
12. these patients, i feel should be discussed at an MDT, if nothing other than to remind us of longer term outcomes
13. there isnt one
14. The problems posed by recurrence or progressive disease can be both simpler and more complex than those posed by a new diagnosis. Within my own specialty of lung cancer, the options for some patients with progressive disease can be very limited, especially if they (as they often do) have severe comorbidity. It is therefore not reasonable to insist that all such patients should be discussed at MDM, as often the experienced clinician and the patient can find the best course of action between them and the MDM should support that rather than interfere with it
15. The majority of patients should be discussed at the MDT. There will be patients where an agreed pathway of care is appropriate and where the MDT is not required. It is impossible to discuss every patient with relapse or recurrence.
16. Talk to colleagues on phone or face to face
17. sub meeting to take place after main MDM as will not involve several core members of meeting
18. standard treatment. Treatment decisions for skin cancers are not usually complicated
19. Standard pathways - to bring back ALL patients is inpractical
20. Specific discussion between oncol/pall care and physician caring for patient
21. Some patients with recurrence are discussed but not all if the appropriate treatment if srraightforward
22. Recurrant disease is usually treated in oncology departments. Traetment could be ratified by meetings within the oncology department and only if there is disagreement need the case be brought back to the full MDT
23. prior agreement what would be done if fails initial treatmenr modality
24. Planned protocols
25. peer review be other senior specialists (eg for oncology - oncology consultants weekly group meeting)
26. Patients are individuals and should be treated as such - treatment tailored to his/her best interests
27. Oncologists should feel free to discuss patients with recurrent disease at their discretion
28. Oncologists discuss the situation between themselves. But increasingly they bring such patients to the MDT
29. NSSG guidelines to be followed exceptions to be reported to MDT
30. not applicable
31. Not all cases require MDT discussion
32. no sensible solution
33. MDTs can only make simple decisions as often no-one present has a detailed first hand clinical knowledge of the patient. Recurrences are clearly complex occurrences and the MDT is not necessarily the best place for a decision about further management
34. MDT of oncologist and palliative care team

35. locally agreed pathways for treatment and assessment
36. Lead consultant refers to specialist of choice.
37. Joint decision between patient and oncologist
38. It is the speciality domain of oncologists who are linked with their research networks to make decision in consultation with pts
39. individual clinicians should take responsibility
40. Ideally discussed at MDT - but not necessary for all in my disease site (lung) and should be in the discretion of the oncologist
41. I think that the primary physician should be following up the patient rather than the oncologist or radiotherapist. If not, the primary physician should still be involved in decisions at this stage.
42. I think all new cases should be discussed but for recurrent disease, there are some circumstances where decisions are blindingly obvious and forcing these though the MDT will increase workload with little benefit.
43. I dont feel qualified to answer that
44. How about asking the patient?
45. guidelines in line with evidence
46. guidelines and standard protocols
47. For thyroid they should be discussed at MDT
48. For lung, progression is the rule and standard therapies are recognised and employed. If complex however, or recurrence after surgery then re-discussion is appropriate.
49. Following protocols
50. DON'T KNOW
51. don't know
52. discussion betwen clinicians more informally
53. Discussed by oncology colleagues-brought to MDM if unduly complex
54. discuss with other team members to ensure that they are in agreement with the treatment plan
55. Discission with the oncologist or surgeons separtely
56. combined clinic between oncologists, surgeons and physicians who together see the patient and also have the opportunity to know the patient choice and idscuss all options with the patient
57. Clinicians looking after the patient make the decision on treatment ie like we use to do before MDT came along.
58. clinical acumen!!
59. clinicain follows agreed guideline
60. BROUGHT TO THE MDTM WHEN A MANAGEMANT CHANGING DECISION NEEDS TO BE MADE
61. Best practice
62. Best discussed in the MDT, that is our practice.
63. A full plan to encompass recurrences/advanced disease should be made prior to starting treatment for advanced disease at the MDT. Retrospective reporting to the MDT of cases that required more urgent intervention is acceptable.

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

89 'other' doctors responded to this question.

1. Wrong or incomplete information in first place .
2. we do not provide treatment
3. Usually due to patient choice or change in performance status
4. Unilateral decision by treating doctor that his/her treatment plan is better for the

patient. Treating doctor does not want to tell patient that an alternative treatment has been suggested. Not the role (currently) of the MDT to check to see if advice has been carried out by initial treating doctor.

5. Unexpected test results,
6. Time, clicical change
7. This is not the function of my MDT (shared care hospital)
8. They aren't very sensible.
9. The MDT meeting doesn't actually look at the patient but makes decisions based on X rays and sample results
10. surgeon prefernece , often MDT is a tick box exercise rather than for making descisions
11. suggested by people thathave not met the patient
12. Refusal by patient / carers
13. Referral outside region or patient declines treatment
14. Recommendation being considered inappropriate on meeting with patient. patient declining recommended treatment
15. Rarely does this happen
16. progressive disease/patient refusal etc.
17. Private patients. Patients referred to MDT should become part of MDT. PP should pay, then could be discussed
18. Patients not agreeing to treatment, patient too infirmed, relatives not agreeing
19. Patient wishes/fitness assessed after the meeting
20. Patient wishes.
21. patient wishes, unexpected disease progression
22. Patient wishes
23. patient wishes
24. patient veto
25. patient refuses
26. patient refusal to accept mdt proposals
27. Patient refusal
28. patient refusal - or change in circumstances of disease staging/patient performance status. MDT's are great - but they often delay decision making - so no surprise if the patient has progressed while we deliberate !
29. Patient preference
30. patient not suitable for therapy suggested due to co morbidity
31. patient does not wish to follow advise
32. patient discussed before being seen in opd and assessed. This is often because of the traditional practice of medicine being interupted by the apparent urgency of stupid time targets
33. patient deterioration.
34. Patient delclines
35. patient declines or deteriorates
36. patient declined treatment or too frail
37. patient complaince
38. patient choosing not to go ahead with the planned porcedure
39. Patient choice; inability to prescribe recommended treatment because of Trust funding decisions.
40. Patient choice/deterioration in clinical condition
41. Patient choice. Rapid onset of terminal disease
42. Patient choice, changed circumstances
43. patient choice, change in patients cicumstances
44. patient choice or patient not fit enough to tolerate high dose chemo
45. patient choice or change in pts condition
46. Patient choice is the most common. Unexpected deterioration also happens
47. Patient choice Patients fitness for treatment as discussed in MDT was better/worse than reality

48. patient choice change in patient'sclinical condition i.e.progressive disease
49. PATIENT CHOICE
50. Patient choice
51. Patient choice
52. Patient choice
53. Patient choice
54. Patient choice
55. Patient choice
56. Patient choice
57. Patient choice
58. Patient choice
59. Patient choice
60. patient choice
61. patient choice
62. patient choice
63. patient choice
64. patient / family wishes; inappropriate for patient; 'committee camel' decisions if relevant clinician not present
65. Patient's wishes Poor performance status
66. pateitn choice, further information coming to light
67. Not known, but lack of peer review of practice of consultant to whom patient is sent?
68. Not being aware of the patient's circumstances or preferences
69. not appropriate for the patient or patient declines
70. No longer appropriate, patient too unwell.
71. Medical problem mitigating against chemo. Patient choice
72. lack of communication
73. Interevntions not being available for terchnical reasons (operating magnet down etc)
74. Individual discision
75. Inadequate clinical information available at the MDT about the patient's co-morbidities and functional status
76. I don't know. NOt really relevant in our specialty
77. I do not know
78. Funding of drugs; patient choice; consultant preference.
79. Dominant clinician at meeting defining treatment or lack of person who knows patient best
80. Clinicians not attending MDT meetings when their patients are discussed anf MDT decision/discussion not communicated adequately to these clinicians. Sometimes MDT discussion is delayed eg due to histo slides not being avaiable and patient receives treatment prior to MDT discussion
81. Clinician decision following discussion with patient
82. clinical state of patients changes
83. Changes in patients condition Patients preference may not be known at the time of decision at MDT
84. change in performance status
85. Change in patient status or staging
86. break in communication, members taking there decisions individually
87. BLOODY MINDEDNESS LACK OF UNDERSTANDING OR CONSIDERSTION IF ANOTHER SPECIALTY VIEW POINT
88. Adequate information
89. Armchair decisions divorced from an intimate knowledge of the patient can be inappropriate.

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

61 ‘other’ doctors responded to this question.

1. You'll never get 100%. You could start by looking at the ones who weren't - but that requires excellent diagnostic data collection and that is tricky
2. Via pathology databases
3. via cordinator
4. TWG support. This is possible in one trust but unless the TWG addresses this it is not possible within a region
5. Tightening up on inclusion criteria
6. They are all referred to the MDT
7. stop all cancer diagnoses and treatment in primary care except by accredited GPs who are MDT members. Use pathology internal hospital databases to identify all individuals in the previous week/two weeks with cancers applicable to that MDT. Automatic referral to the MDT to discuss or MDT chair to sift.
8. Standardising and improving pathology data systems
9. Show how effective they are, and demonstrate improved outcomes.
10. shoot all geriatricians
11. run a search through histopathology on a weekly basis to pick up all new cancers
12. Regular audit of X-Ray report and histological reports to look for cases that have been missed - and then examining the reasons why they were missed - it will vary from organisation to organisation.
13. regular audit and support from none member clinicians such that they will refer cases. governance process used to address clinicians who are not refering patients to the MDT team
14. raise awareness of mdts. adopt systems to highlight cases not brought to mdt- eg by liaison with pathology
15. PCT should not commision non IOG compliant services.
16. not appropriate for pall med mdt
17. Multiple triggers to identify cancer patients
18. Multiple pathways of access and notificatuon
19. MDT members should go and see patients in a timely fashion and make treatment recommendations that make people better. All other staff will then learn that it is beneficial to refer patients to MDTs if they happen to present to other clinicians.
20. Make it mandatory.
21. Make it easy to access and well publicised
22. Job of all team members
23. It should be part of clinical governance and failure to refer treated as a critical incident
24. inform all physicians of your speciality and the cancer group you treat and keep on reminding them
25. Induction program for new staff to explain referral mechanisms.
26. IN BREAST, ALL MALIGNANT PATHOLOGY IS DISCUSSED AT THE MDTM
27. Improving Outcome Guidelines are strictly implemented across all hospitals
28. improve awareness
29. if they are flagged up by the pathology department and automatically added to the relevant MDT
30. I wish I knew - it takes me hours of checking and cross checking
31. I don't know
32. Histopathology codes on diagnosis can speed referral to skin cancer MDT. We review any new skin cancer diagnosis of SCC and Melanoma that is processed by our pathology lab, regardless of the original clinician performing the biposy.
33. having an electronic alert on PAS systems if cancer is mentioned. reminding all clinicians to refer. having a pathway available to view in clinics. having a co-ordinator to check clinics and liaise with the lead nurse in clinic

34. Having an efficient system that picks up all cases and filters them through to the MDT
35. Have system in place to ensure all histology with cancer diagnosis goes to MDT
36. Have MDT Co-ordinator view all new histopathology reports
37. Good communication with other disciplines
38. good cancer coordinator working with the MDT lead or CNS
39. General information to other teams to alert MDT with new cases. Radiology to feed in suspected cancers. Easy unified referral form, ideally online.
40. Formal mechanism for each of pathology/endoscopy/radiology to fax details of EVERY suspected case
41. failsafe systems
42. facilitate communication between cancer referrals office and clinicians
43. Ensure our colleagues are aware of the benefit. Involve the coordinator early in the pathway
44. Ensure everyone knows, that radiology and pathology automatically copy positive reports to MDT
45. education to clinicians not involved with cancer care
46. Education that therapy cannot be recommended in the absence of this
47. Education of colleagues and effective referral process and patient pathways.
48. education of colleagues
49. Education and advertisement to raise the profile of the MDT in the hospital
50. Don't know
51. Do all new BCCs need to be discussed????
52. Core MDT members include radiologists and pathologists as well as clinicicians - so all ports of entry are covered. the culture now is that everyone knows that every patient with cancer needs at least 1 discussion at MDT. The trouble is that patients have recurring appearances at MDT after every scan and biopsy - which is a waste of time as they should have already had their pathway agreed in advance.
53. continual education to the outside trust
54. Communication within the Trust. Specific codes for patients to be identified and tracked
55. by informing all consultants who might see or suspect cancer. Managerial audit of ICD 10 data
56. Automatic from pathology or radiology or bronchoscopy
57. automatic addition to meeting
58. automate cancer pathology result refrral to MDT
59. Audit against diagnostic databases.
60. all diagnostic streams feed in
61. A system that picks up relevant histology - then MDT coordinator puts on MDT for discussion

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

65 ‘other’ doctors responded to this question. 1 ‘other doctor’ replied ‘Yes’ to this question, appearing to agree that it should happen, but not stating how it should happen.

1. written down I suppose
2. Writing it down in English
3. Within the records of the patient
4. What should be recorded is the treatment recommendation. What treatment is delivered is between the patient and the responsible clinician. Disagreements

should only be recorded if all clinicians involved have seen the patient

5. We don't get this so hesitate to say. If there are a number of reasonable treatment options which have support by various different members of the MDM, it is not unreasonable to put these to the patient and allow them to make a guided choice
6. Treatment options to be discussed with the patient
7. Treatment options should be recorded on the pro-forma.
8. The MDT is impersonal and does not make the clinical decision; the clinician does - and is accountable in his/her own right but not to the MDT.
9. The clinician responsible should have the final decision. Other options should be recorded as discussed but not adopted.
10. Responsible clinician and chair. Final responsibility is the treating clinician
11. One to one discussion outside the MDT in the first instance. If this fails, than a faciliated meeting should be convened
12. on the proforma, then discuss with the patient and record outcome
13. On pro-forma used to record decisions
14. on outcome sheet and in notes and conveyed to GP
15. on MDT decison proforma - indicating possible treatments
16. Noted in MDT minutes
17. noted down
18. majority view has always been accepted at our mdt.
19. majority view
20. Majority decision; MDT chair should have casting vote
21. It should be explained to the patient and recorded in the clinical record.
22. In the notes and the minutes of the MDT
23. In the minutes of the meeting and in patient notes
24. In the free text of the proforma
25. In teh minutes of the meeting
26. In summary, but this is very very rare
27. In standard MDT record
28. IN NOTES, INCIDENT FORMS, ANY LOCAL QUERY PATHWAY
29. In minutes?
30. In minutes taken at meeting
31. In MDT recorded electronic decision given to GP and/or treating doctor and hospital notes.
32. in MDT record and in patient notes. Decision can be discussed with patients for their own input
33. in detail with supporting evedence for each decision
34. In detail with information given to patient
35. in detail and explained to the patient
36. If members are able to discuss freely without inhibition it is usually possible to reach consensus
37. If both treatments are equal let the patient decide
38. I think a consensus needs to be reached - if it cannot be agreed generally around the table the case should be referred for second opinion elsewhere
39. i have no experience of this
40. Honestly
41. Factually
42. factual account in pt notes
43. DON'T HAPPEN
44. Documented in the MDT record, discussed with the patient
45. Documented in patient case notes
46. dk
47. discussion with patient re different opinions/options
48. Clearly, but with explicit statement that the primary clinician looking after the patient will make the final decision following discussion with the patient. The MDT is there to advise, not tell the patient what to do. It is perfectly acceptable,

particularly where level one evidence is not present for there to be disagreement between consultants about the best management for an indvidual case. as long as the situation is presented carefully and clearly to the patient, this will allow for an informed decision.

49. clearly in the notes with the proportions clearly documented together with reasons for disagreement
50. clearly and why there is a split decision
51. carefully worded phrases.
52. by writing them down in the notes
53. Both treatment options views should be clearly stated with reasons for which was chosen
54. both opnions shoudl be recorded as as the decision of the majority
55. At the end, it is the primary clinician to decide. Disagreements do not need to be recorded.
56. As they happen, and then if appropriate, communicated to the patient
57. As such
58. as split decisions / disagreements
59. As it is eg ranking treatment recommendations 1,2,3
60. As disagreements/split decisions.
61. As any other
62. As a disagreement with explanations
63. As a conclusion then discussed with the patient and represented
64. All options outlined and final decision left to treating clinician and patient
65. Accurately to reflect discussion

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

114 'other' doctors responded to this question.

1. Whoever knows them best
2. Whoever knows the patient best - in my case it is likleuy to be myself b-in some instances it may be the Skin CNS
3. who ever has had most contact with the patient
4. Variable, dependant on idividual who knows the case the best
5. usually doctor as the nurses unlikely to have seen them
6. usually a nurse specialist who knows patient best
7. treating physician on specialist nurse who has met the patient
8. treating doctor
9. thier clinician
10. there is no best person. nurses frequenlty believe they are the patients advocates but often advocate palliative care rather than treatment to patients without explaining that if the patient declines surgery / chemo that the life expectancy will be reduced
11. Their specialist
12. Their doctor
13. Their consultant in conjunction with our Breast Care nurses
14. their consultant
15. their clinician
16. their clinican
17. the worker who knows them best
18. The physician presenting the case
19. the physician looking after the patient (who has met the pt)
20. THe person who knows the patient the best and has discused treatment options with them
21. The patient is in no position to give an objective, unbiased and professional opinion about their case. It is not as if one is discussing whether or how to mend your car - the discussions should be dispassionate and include all the facts, unpleasant of otherwise, in order not to restrict either thinking or inhibit frank discussion. A clinician must represent the patient and his/her views
22. The patient
23. The patient
24. The patient
25. The one who knows them best
26. the members
27. The key worker
28. The healthcare professional who knows them best
29. The doctor who has met the patient and discussed their wishes with them
30. the doctor
31. The coordinator/Nurse specilaist.
32. The consultant who is primarily looking after the patient
33. The consultant and breast care nurse together
34. The clinician who saw them
35. The clinician who has sought to find out what their views are
36. the clinician who has seen the patient
37. The clinician who has met the patient
38. The clinician who first assessed the patient.
39. The clinician that has seen them - ideally they should have seen the same person on more than one occasion
40. The clinician involved in their care. Not practical to have patients present

41. The clinician in charge of the patient's case.
42. The clinicain who has seen the patient - whether doctor or nurse
43. Supervising physian or cancer nurse specialist
44. specialist nurse
45. specialist nurse
46. Someone who has seen the patient!
47. responsible clinician / pall med nurse/doc at our mdt
48. Referring clinician or Cancer nurse Specialist
49. The options should be discussed and then discussed with the patient. This avoids both false hope and premature gloom.
50. Probably the doctor who has seen the patient.
51. Physician who saw patient or the specialist nurse
52. Physician who has seen the patient, taken a history, examined them properly and has they full previous records.
53. Physician who asks for patient to be presented to meeting
54. Physician or specialist nurse
55. physician or other specialist who has seen the patient
56. person treating them or cancer nurse specialist
57. Patients consultant with help from nurse specialist
58. PAtients Consultant
59. Patient's lead physician
60. Patient's clinician or nurse.
61. often if clinical nurse specialist has seen the patient
62. nurses
63. nurse specialist
64. nurse specialist
65. nurse
66. No patient should be discussed unless known to soemone at the MDT. The decision is then to "offer" treatment to the patient, not to impose it on them after.
67. MDT coordinator
68. lung cancer specialist nurse
69. Key worker
70. key worker
71. key worker
72. key worker
73. Key Named Worker
74. Key clinician involved
75. Ideally the physician with responsibility for their care.
76. His/her initial treating doctor
77. health care worker who has discussed patient views with patient
78. experienced clinician who has met the patient and family
79. Dr directly dealing with the patient or specialist nurse
80. Doctor who cares for patient
81. consultant who looks after the patient and clinical nurse specialist
82. Consultant responsible who has met the patient previously.
83. consultant or team mmeber
84. Consultant or Clinical Nurse Specialist
85. consultant looking after patient
86. CNS or consultant patient is under
87. CNS / Consultant
88. CNS
89. CNS
90. CLINICIAN(DOCTOR OR NURSE)
91. Clinician who has met the patient and the specialist nurse
92. clinician who assessed patient

93. Clinician seeing or key worker (nurse)
94. clinician responsible
95. clinician or specialist nurse that has met the patient
96. Clinician or nurse involved in case.
97. clinician incharge at the point of discussion is pts best advocate
98. clinician in charge of their case
99. Clinician directly involved in patient care
100. clinician and nurse specialist looking after the patient
101. Clinician and cancer nurse specialist
102. clinical nurse specialists
103. Clinicain in charge of case
104. CLIN NURSE SPECIALIST
105. Cancer Nurse specialist, or doctor managing the case.
106. Cancer nurse specialist (key worker)
107. Cancer Nurse specialist
108. Cancer nurse specialist
109. BREAST CARE NURSES
110. Attending Physician/MDT coordinator
111. Any who knows patient
112. all those that have met the patient or the patient themself
113. a team member who has seen them
114. a clinician who has met the patient and is aware of their views - in practice often a CNS

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

110 'other' doctors responded to this question. 9 'other doctors' referred to the answer they had given to the previous open question (Q32).

1. Whichever medical member of the team meets the patient next after the meeting.
2. Usually either the consultant physician or th enurse specialist if pre-agreed with the patient.
3. Usually a doctor or clinical nurse specialist
4. Treating Dr or Cancer Nurse specialist
5. treating doctor
6. This could be a nurse specialist or their consultant.
7. Their doctor
8. their consultant
9. their clinician
10. their clinician
11. The responsible clinician
12. The primary clnician or specailsits nurse
13. the physician who knows the patient
14. The person who sees them next in cliic - in my case it is likely to be me
15. The person delivering the treatment - sometimes the one referring patient to the MDT
16. The MDT coordinator should inform the GP and the patient should be seen again in clinic
17. the key worker is ideal
18. The Healthcare professinal who is able to fully answer any questions the patient has
19. The doctor.
20. The Doctor

21. The doctor
22. the doctor
23. the doctor
24. The diagnostician or the clinician initiating treatment
25. the core team member who has contact
26. The consultant and nurse specialist
27. the consultant
28. The clinician who knows them best and can best answer relevant questions about the recommendations
29. the clinician under who's care they are
30. The clinician that has seen them
31. the clinician responsible for the patient's care
32. the clinician primarily involved in his care
33. The clinician in charge of that particular treatment plan
34. The clinician in charge of care
35. the clinician
36. specialist nurse/consultant in charge of case
37. Specialist nurse or consultant
38. someone who has met the patient previously and is able to discus fully the recommended treatment - usually the consultant or associate specialist
39. Referring clinician or Cancer nurse Specialist
40. pts clinician
41. Physician incharge
42. physician in clinic
43. Physician
44. Patients Consultant
45. Patient's lead physician
46. Patient's clinician or nurse.
47. nurses or key clinician
48. nurse specialist or consultant
49. nurse specialist
50. nurse specialist
51. nurse
52. no recomendations its an information sharing excersize
53. MDT coordinator AND Clinican who assessed the patient and made the MDT referral
54. managing medical team
55. lung cancer specialist nurse
56. local consultant/cancer nurse specialist
57. key worker usually clinical nurse specialist
58. Key worker
59. Key worker
60. Key worker
61. key worker
62. key nworker
63. Key Named Worker
64. key clinican involved
65. ideally the clinician who has seen the patient- otherwise the lead clinician
66. Ideally a core MDT member or the physician with responsibility for their care.
67. his/her initial treating doctor
68. From a legal perspective the buck stops with the consultant, until this changes it reamins so!
69. dr responsible for their care
70. Doctor who has cared for patient

71. Doctor managing the case
72. discussed at next patient contact
73. Depends what the decision is. Mainly CNS
74. Consultant responsible.
75. consultant or representative
76. Consultant of the patient
77. consultant is responsible, but can deligate to nurse SpR
78. CONSULTANT IN CHARGE OF CASE/BREAST CARE NURSE
79. Consultant and breast care nurse
80. CONSULTANT
81. Consultant
82. Consultant
83. Consultant
84. Consultant
85. consultant
86. consultant
87. CNS or doctor
88. CNS / Consultant
89. CNS
90. Clinicians responsible for their care
91. Clinician who has met the patient
92. clinician responsible
93. clinician or specialist nurse that has met the patient
94. Clinician or nurse involved in case
95. Clinician or deputy
96. clinician or cancer nurse specialist
97. clinician in charge of their case
98. Clinician directly concerned in patient care
99. clinician and or specialist nurse
100. Clinician and cancer nurse specialist
101. clinician / CNS who knows patient
102. CLINICIAN
103. clicnician in charge of case or spec. nurse
104. cancer nurse specialist
105. Attending Physician
106. As above [answer given to Q32]. If not, clinical nurse specialist
107. Any professional, suitably trained.
108. Always the doctor, unless patient has a very good relationship with nurse specialist.
109. a senior doctor
110. A relevant clinician

Measuring MDT effectiveness/performance

What other measures could be used to evaluate MDT performance?

32 'other' doctors responded to this question.

1. We do not need more measures
2. Usefulness
3. treatment plan clearly defined for every patient
4. Thyroid deaths are low at 1-5 years so not good FOR THAT CANCER. Patient satisfaction is very important, however a patient could be very satisfied with trreatment that was not good in the long term, therefore not useful here
5. The only performance indicators that matter are clinical outcomes and patient satisfaction. Everything else just adds to administrative burden and is likely to result in adverse effects of performance monitoring (gaming, fruitless controversy and the like)
6. the idea is to facilitate the most appropriate treatment for each patient. we are not here to facilitate time trials and political success
7. Reduction in the time of the patient journey
8. Quality of information recieved by the patients,their GP and the referring clinician.
9. QUALITY OF DOCUMENTATION QUALITY OF COMMUNICATION OF OUTCOMES TO STAFF AND PATIENTS
10. quality of communication about treatment plans to none core members. Reduced treatment morbidity
11. outcomes
12. numbers of patients rediscussed over time following first treatment decision
13. Not relavent to thyroid cancer
14. No comment
15. N/A for pall med
16. MDT Membership satisfaction survey
17. Length of time discussiong patient cases
18. It will depend on the individual tumour type
19. It is not possible to generalise here - for thyroid cancer for example the use of 1 7 5 year survival times as an outcome emasure is inappropriate - this question is difficult to answer therefore and the results should be treated with due caution
20. It's very hard; probably the best way to do this is to encourage self assessment based on comprehensive staging and outcome data, supported by periodic external review. There wishes of the patient are ultimately paramount and an MDM where patients are treated with dignity and respect and achieving good clinical outcomes when benchmarked against similar MDMs is likely to be doing well
21. Inervention rates probably the most dynamic surrogate marker
22. improved survival presupposespoor performance pre mdt we provided good care pre mdt
23. don't know its difficult to measure. I don't think an MDT should be measured by improvements in survival rates because that is not its remit
24. don't know
25. dk
26. completion of national audits
27. Auditted pick-up and discussion of all relevant cases
28. Audit data
29. Audit changes in clinical decisions made by the MDT. Satisfaction surveys of MDT users.
30. attendence of core members. number of clinical incidents related to disrupted patient pathway involoving MDT. Audits and audit outcomes completed.
31. an honest acknowledgement of the cost

32. adheranc eto local protocols

Supporting MDTs to work effectively

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

71 'other' doctors responded to this question.

1. We need a co-ordinator and a specialist nurse
2. Very effective at present. Presence of MDT co-ordinator is crucial, therefore periods of annual leave, etc. need to be covered.
3. true acceptance that the responsibilites continue outside of the meeting
4. Train the chair
5. Timely final histopathology reports; clinically relevant and flexible targets
6. TIME TO DEAL WITH CASES (AVG 50-60/MEETING)
7. Time availability
8. Time
9. Team meeting every year/other year
10. surgeon present every week
11. Surgeon present at all meetings.
12. support and recognition from management
13. start on time
14. Short case summaries circulated before meeting to allow MDT members to prepare for case discussion
15. Senior members should not abuse more junior attendees. Maintanance of professionalism
16. secretarial support
17. relax the beaurocracy, tracking and continual professional checking that team members are obeying directives
18. Refreshments, tea coffee!
19. reduced waiting time for complex to investigations
20. provide more clinical staff time - so that there is time to prepare and present cases properly.
21. Protected time so that not rushing to finish to start a clinic
22. PCT and medical director vocalising their clinical support of the MDT and its decisions
23. Pay MDT coordinator more to get high calibre individual capable of excellent job
24. one site joint MDT
25. NO it FAILURE
26. More time.
27. more time per case
28. More time for the chair to ensure he/she (as they are usually surgeons) is reliably available for the task
29. More time
30. More time
31. More time
32. More resources and managerial support.
33. More effective leadership
34. More clinical staff to do the work of looking after patients
35. making sure decisions on proformas at MDT meetings get into the patient notes for next consultation
36. Make sure that adequate time is allowed in job planning
37. make everyone listen and stick to point
38. Its timing in relation to clinics (in the morning with clinics in the afternoon rather than occuring in the afternoon after the clinics)

39. IT database
40. is fine frm my point of view
41. Incentivise people to turn up. Sticky buns? Free tea and coffee?
42. Imrove teleconferencing qulity particularly audio quality
43. improved documentation of discussion and outcome
44. improve videoconferencing links
45. improve video-conferencing facilities, improve email communications of the case summaries
46. If the SHA stopped messing around and sorted thoracic surgery. More resource from off site specialists
47. If ALL core members all the time
48. I'd get one or two colleagues to retire...or be given more time to manage the difficult personalities within the team
49. have time for feedback of decisions made at previous meeting
50. Have dedicated time not holding it in lunch time thus sqeezing it between clinics which means members arrive late and the MDT doesnt run to time
51. guaranteeing that the meeting room would be available when we arrive. the meeting before always runs over.
52. good data; summary before, good summary, good database
53. good communication to relevant doctor following discussion of their patients, often it is difficult to track down the doctor in charge
54. epr available
55. Ensure regular attendance by some core members
56. Ensure better attendance of extended and some core members
57. ensure all are prepared in advance and know patients
58. Encourage surgical attendance for the whole meeting
59. Don't know yet
60. core member's attitude
61. Consistent treatment descisions - get rid of pp
62. case preparation
63. Better preparation and presentation of cases
64. Better organisational support
65. Better attendance from radiology
66. Aquire better access to the MDT room. Improve on existing teleconferencing facilities, and aquire a data analyst to input data according to protocols so we can make realistic conclusions about outcomes.
67. Amicable environment where it is readily accepted that members ofthe MDT may have differing views
68. agreed protocols
69. Access to IT
70. A committed coordinator
71. a better database to enable us to input the data live during the MDT

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

58 'other' doctor responded to this question.

1. What you put in=what you get out
2. Time. I don't think induction is much use - yet another bit of mandatory training to cram into a working week that is already too short
3. Time!
4. TIME TO RUN IT EFFECTIVELY AND CONSISTENT ATTENDANCE
5. time to reflect!
6. Time in job plan for preparation.
7. time in job plan for meeting
8. Time
9. Time
10. time
11. Start a short educational talk session before the meeting,
12. ongoing chronic pain cover during my absences
13. nothing
14. Needs protected time for MDT in Job plan.
15. na
16. More time to visit GPs and other specialists and present what we do.
17. More time to prepare for meeting
18. more time to prepare cases, and record outcomes. clinicians are generally becoming drowned in bureaucracy - a bit like the time it is taking to fill in this blessed survey.
19. more time to discuss patients
20. More time to develop it
21. more time to demonstrate slides of cases
22. More time per case.
23. more time in the day
24. More time for preparation
25. More time and support.
26. More time and assistance to prepare cases
27. more time
28. more time
29. More protected time
30. More effective MDT coordinator
31. More colleagues to help with the work load. Less pressure. Fewer targets. Fewer crass and elongated questionnaires to fill out.
32. more admin support/time to prepare
33. maintaining knowledge, particularly new developments
34. Leadership training
35. leadership training
36. Leadership and communication skills
37. imporved planning and role demarcation
38. I am not sure. More time, less rushed.
39. help from other collegaues
40. Having more time to keep up to date with developments/ evidence based recommendations in cancer care
41. having more time
42. having more allocated time rather than yet another add-on duty
43. given time to prepare and review decisions
44. given more time for this.
45. Fewer cases to discuss so ability to contribute to other discussions. Chair not also having to present cases

46. expertise
47. efficiency
48. Dont Know
49. Don't know yet
50. CPD directed at some of the techniques and treatments that lie outside my specialist sphere but are part of the treatment options that patients could be offered.
51. better videoconferencing links
52. Better resources
53. Being able to finish my clinic in time to get there.
54. An MDT is just a clinical meeting so all professionals should be well used to operating in this way. It is like an expanded ward round -and no more training for this should be needed.....
55. All my MDT meetings are outside working ours and contracted hours. Provision for these meetings should be made in working hours.
56. adequate time
57. Academic meetings of the MDT team members for case presentations so each member could understand better the treatments provided by team members from different specialities
58. ability in job plan to attend MDT occasionally

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

22 'other' doctors responded to this question

1. What we need is the time to discuss patients and the staff and technology to prepare for the meeting and to record the discussion and decisions. We need staff withsufficient time to look at our decisions and to compare them with the actual treatment received, the survival outcomes and to see how we compare with other hospitals. We do not have personality problems with our MDT. There is much enthusiasm and expertise, what we lack is time for us and the data collectors.
2. visits form tratment centres to input into cases live and inform us how we are dovetailing in with thier side of treatment
3. the team working and this being built into the team struture would be useful
4. Seeing how other MDTs function.
5. Observe model MDTs in operation not on away days but in real time
6. Nothing else. MDTs are an interim tool to aid the patient pathway and change the culture from an individual to a team. Their decision is a collective opinion, not always in the presence of the full facts of the case, so it cannot be binding. Like other 'committees' in medicine (Case conferences, patients managed in ITU), the MDT is an adjunct to good practice but there must always be individual accountability to the patient, even if that changes frequently throughout the course of diagnosis and therapy
7. Not sure
8. none we are all trained professionals
9. None
10. none
11. No comment
12. Need more availablity of information from other areas as to how they run MDTs
13. National standards of care
14. Meeting of MDTs form a network to share good practice
15. Forum for anonymous discussion and review of cases would be useful.
16. external review
17. dunno. I doubt very much anybody would be that interested to be honest

18. dk
19. Discussion with other MDTs about how their MDT is run and possibly attending someone elses MDT
20. direct participation
21. CPD, as already happens. Training for use of improved videoconferencing, if installed
22. ATTENDING OTHER MDT/M'S

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

21 'other' doctors responded to this question.

1. personal and team psychometric tesing and analysis v useful
2. not aware of any
3. NONE!
4. None known.
5. None
6. None
7. None
8. none
9. none
10. none
11. we do not need courses . we need managerial commitment and support.
12. Nil
13. nil
14. i do not know of any
15. Don't know
16. dk
17. communication skills national
18. Away days every 3 months seem to be the mainstay
19. Advanced communication workshop,
20. The colorectal MDT "training course" held at another trust and apparently compulsory was shocking. Completely surgically driven and a waste of everyone's time. It was a woefully wasted opportunity. The idea is a good one but needs to be multi-disciplinary
21. Advanced communication skills course

Final comments

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

37 'other' doctors responded to this question

1. Whilst we have good MDTs wit excellent functioning, I am not sure they have produced better outcomes for our patients. At least in the cancer centre where I work we have always been at the forefront of good management and a lot of the work of the MDT is unnecessarily bureaucratic and time-consuming and we cannot properly analsye the data to look at outcomes.
2. we need a reliable way of recording changes in opinion regards imaging and pathology that result from MDT review. This is a particular problem where initial reporting occurs at a different trust from the MDT host. Waits for discussion at MDT can significantly prolong patient pathway especially when further investigations are ordered. There should be some work on how best to refer patients on to a different MDT when indicated.
3. Three is a danger that MDTs are becoming a way of abdicating responsibility. MDT to MDT referrals happen without anyone seeing the patient. Patients can wait 7 days for an obvious decision because no-one will take responsiblility outside an MDT
4. This seems to be about proving to yourself that MDT are essential . I know of no published data in lung cancer that shows any benefit
5. The focus on cancer which tends to be realtivley straightforward to manage ahs been to the huge detriment of those with benign disease who are no longer discussed in any meaningful forum. We are simply overwhelmed with MDT's taking up more than 3 hours weekly to have time for other patient focussed meetings such as histology and Xray meetings which have simply ceased to happen. I find our MDTs which cover more than one site's activity extremely dull and I have ceased attending unless there are good reasons to go.
6. there are no data for the cost-benefit ratio or of the long-term consequences of a huge burden on overworked health care professionals
7. The LMDT in skin cancer is a lot of time and effort for the gains we make - we were actually dong quite well before MDTs. I really feel that is a rubber stamping exercise with little management diffrences for the time and effort we put in. The questionairre is really more suited to SMDTs and other cancers rather than skin LMDTs
8. the concept of MDT has been enacted for years, long before they were formalised and politicised. Let the medicine flourish and stop all of this superfical admin, audit and time keeping
9. The best MDTs I have ever attended have been well organised and have had a dedicated team to discuss the cases. The chairmanship did not seem to impact highly as this was shared.
10. Systems where npatients are discussed nsequentially at multiple MDTs are not good for patiebts or MDT members
11. Preparation is the main issue, with poor preparation, wrong information emerges and the MDT stalls.
12. Multi-disciplinary attendance. Audit of decision changes made by MDT. Number of cases discussed. User satisfaction surveys.
13. More support staff required for adequate data collection. Good MDT's have sufficient staff
14. mdts with well planned patient lists and all information can wotrk well
15. MDTs should facilitate clinical practice with minimum disruption to clinical practice and the aim should be to reduce the burden of uneccessary bureaucarcy for clinicians whilst provided auditable data and clear benefit for patient care

16. MDTs are very important, there is no formal training , members learn on the job, there should be a national recommendation that they are important and there should

be formal training

17. MDTs are in different stages of development - some will be well developed others not. But would avoid overly rigid guidance - one -size does not fit all because of the differences and complexities between tumour sites
18. MDT's are most stronly influenced by their strongest members. MDT's with poor leadership or conflict between core members do not work as well. Improved IT and imaging speed up the process. MDT's should be held during office hours and not over breakfast or lunchtime.
19. I would be very interested to know if MDTs have ever been demonstrated to be useful, because sometimes I wonder. But maybe I'm just ignorant
20. I think patient prescence during the MDT would hinder the decision making process, and there would be serious issues with respect to patient confidenctiality for other patient son the list., If every patient attended the meedting could last all day - when would we actually do ANY work?
21. I find the two week wait detrimental to patient care. Prior to the two week wait patients waited two days, now they wait two weeks. I think that priority should be given to local referral, and that one clinician should be involved from first visit to treatment.
22. I believe our MDT functions very well and have had feedbcak from other MDT attenders to support this view. I believe this is because it is well organised, led and prepared for in advance and because of the culture in the group, we work well as a team
23. An MDT is a very useful way of incorporating different specialist knowldege and views, facilitating discussions and ultimately a group decision with regard to complex cases (not just cancer). Nothing more, nothing less.
24. High performing MDTs are well organised with committed professionals
25. Good efficient team work with same focus in improvement of patient's care
26. good atmosphere excellent feedback from all team members few adjustments to treatment as reasonable baseline practice amicable resolution of differences with difficult cases represnted for learning with benefit if hind sight
27. Effective leadership Evident expertise Reliable IT
28. each member of mdt should identify his /her role,and limitations ,punctuality,responsibility
29. Currently I find the MDT process prolongs the patient journey; increases the chance of clerical error and is plagued with inflexible irrelevant clerical targets and lack of essential final histopatholgy reporting in a reasonable time frame.
30. commitment professionalism punctuality managerial support
31. THERE IS A DIFFERENCE BETWEEN THE MDT MEETING AND THE MD TEAM; THIS QUESTIONNAIRE SEEMS TO BE ADDRESSING BOTH AT THE SAME TIME.
32. Chairman and relationship between members is crucial
33. cancer standards can be counter productive when used rigidly.
34. As indicated, MDTs have achieved a terrific change in the culture even though the patient experience has not always improved with this. Ease of referring and an agreed approach to specific cancers are major advantages of the MDT culture - but it is ultimately a committee with no direct accountability to the patient - or indeed the organisation - so needs to be regarded as a change agent rather than an end in itself. After all, 90% of decisions are straightforward and not requiring expensive peoples' time to nod through. But the concept of MDT has worked and the culture has changed - so now is the time to move on.
35. Appropriate funding has not followed this process: MDT members time has been taken out of other activities (the Trust restrict the time for MDT's to prevent MDT

members being taken away from clinical work) or added to an already over full job plan (to MDT member suffers); managers do not understand what the MDT process is all about and use the personnel to chase/track targets (my MDT coordinator spends the majority of her time chasing targets rather than run and MDT). I see below that this will lead to a workshop: firstly there needs to be local managerial involvement/support and secondly this is an additional study leave day and study leave is severely restricted for clinicians. As MDT lead I am required and encouraged to go to a number of meetings and they have to be taken out of my annual study leave allowance.

36. allowing time in the job plan for the meetings and good efficient leadership is essential
37. a representative of each specialty should attend MDM with a nominated deputy to attend during holidays/sickness etc