

Multidisciplinary team members views about MDT working:

**Results from a survey commissioned by
the National Cancer Action Team**

Open question responses: Palliative care specialists

November 2009

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Introduction

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

Method

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

- a. Where respondents did not provide an answer to a question but instead used a symbol (e.g. /) to indicate that they wanted to miss out the question. Such responses have not been included.
- b. Where respondents used free-text questions to simply refer to the previous (multiple choice) question (e.g. 'see above' or 'as above'). Such responses are removed due to the lack of context provided by including these in this report but a total count of such responses is provided in the summary at the start of each question.
- c. Where respondents have named an organisation or Trust or potentially identified themselves. Their responses have been anonymised.
- d. Where respondents used potentially offensive language. Any such words have been replaced with xxxx.
- e. If respondents have given comments that are not relevant to the question. Such comments have been removed from the response.

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

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

Contents

DOMAINS THAT ARE IMPORTANT FOR EFFECTIVE MDT FUNCTIONING	7
What do you think constitutes an effective MDT?	7
THE TEAM	10
What qualities make a good MDT chair/leader?	10
What types of training do MDT leaders require?	11
What makes an MDT work well together?	12
INFRASTRUCTURE FOR MEETINGS	13
What is the key physical barrier to an MDT working effectively?	13
What impact (positive or negative) does teleconferencing/video-conferencing have on an MDT meeting?	14
What additional technology do you think could enhance MDT effectiveness?	15
MEETING ORGANISATION AND LOGISTICS	16
What preparation needs to take place in advance for the MDT meeting to run effectively?	16
What makes an MDT meeting run effectively?	18
CLINICAL DECISION-MAKING	19
What model of decision-making could be used for patients with recurrence/advanced disease if these patients are not discussed at MDT?	19
What are the main reasons for MDT treatment recommendations not being implemented?	22
How can we best ensure that all new cancer cases are referred to an MDT?	23
How should disagreements/split decisions over treatment recommendations be recorded?	24
Who is the best person to represent the patient's view at an MDT meeting?	25
Who should be responsible for communicating the treatment recommendations to the patient?	26
MEASURING MDT EFFECTIVENESS/PERFORMANCE	28
What other measures could be used to evaluate MDT performance?	28

SUPPORTING MDTs TO WORK EFFECTIVELY.....29

What one thing would you change to make your MDT more effective?.....29

What would help you to improve your personal contribution to the MDT?29

What other types of training or tools would you find useful as an individual or team to support effective MDT working?30

Please provide details of training courses or tools you are aware of that support MDT development31

FINAL COMMENTS32

Please insert any final comments or observations on the characteristics or indicators of high-performing MDTs and appropriate measures of performance.....32

Domains that are important for effective MDT functioning

What do you think constitutes an effective MDT?

56 palliative care specialists responded to this question.

1. Willingness of participants to participate Proper management support, need to be careful easy to say you have things and then just call my secretary an MDT coordinator
2. Well organised. Mutual respect of participants, presentations from people who know the patients and are able to present them concisely highlighting the key issues
3. The presence of a coordinator as well as regular attendance, well run etc
4. The answering of a specific question by the appropriate group of experts who have all the relevant information to hand and knowledge of the specific patient discussed
5. structured agenda
6. Right people in right place with right information, willing to present patients concisely and effectively, contribute to discussion openly and reach consensus
7. Representatives from all involved disciplines - doctors, specialist nurses & others plus co-ordinator. The doctors should include Pall Care, Pathology & Radiology
8. Representation from all disciplines, Good leadership, commitment and time.
9. Regular meetings of an effective team (shared purpose, respect for and knowledge of each others' roles, mix of skills and teamworker types) with good leadership. Clear sense of purpose and sense that discussions and decisions will have a directly beneficial impact on patient care. Discussions are at their most successful when more than one person in the MDT knows the patient, their symptoms and performance status etc. and their perspective on treatment decisions. Effective facilitation is key. Our MDTs are embedded within a very high standard electronic patient record so all discussions are accessible immediately by relevant health professionals within the Trust and in primary care.
10. Regular access to committed members of different disciplines, not just in the context of a weekly meeting
11. Presence of all key members. Clear aims. Good communication.
12. Preparation, consistent attendance well chaired
13. Preparation so that all investigation results are available and everyone knows which patients are being discussed. I think site specific tumour MDT's only focus on treatment decisions and therefore are ineffective as a means of picking up palliative care referrals. Surgeons and histopathologists etc not willing to discuss 'care' issues since MDT's are just too long.
14. organisation and the opportunity for each member of the MDT to discuss pts and be involved in discussions.
15. Opportunity for open discussion, all MDT members' opinions given equal weight
16. Opportunity for everyone to contribute. One participant needs to know each patient
17. One that reviews all patients efficiently makes a sensible plan and communicates its decisions quickly to patients and professionals involved. It also needs regular business/development meetings to ensure it develops and improves
18. One that makes an efficient difference to patient care through considering and utilising a broad spectrum of professional knowledge and expertise
19. one in which all members are able to contribute their skills and experience to inform the management of individual patients. An effective MDT functions beyond the formal meeting, in terms of referral pathways, audit, quality standards.
20. Needs to be organised effectively with clinical info available. Members need to contribute and there needs to be adequate time for discussion. Needs effective chairing and note taking.
21. multidisciplinary. well organised and structured. able to freely discuss and come

- up with action plan.
22. Multi-disciplinary members who communicate patients' concerns and discuss actions communicating to all parties.
 23. Management of patient care Communication Development of action plan for patients Sharing information Resolving/sharing complicated issues/difficult situations MDT Discussion
 24. I think that effective MDT should provide the opportunity for every member to make a positive contribution with the understanding of the patient discussed condition, prognosis and appropriate therapeutic intervention. It should also give every member of the team the opportunity to make a contribution in the training of the other members of the team through their clinical experience. Since this is a learning opportunity we also have frequent attendance by medical students, trainee AHP and one or two non training grade doctors from the local Hospice. We should also have relevant contribution from all members of the MDT and not only from medical staff.
 25. having the right people, (this varies from patient to patient) good teamwork and effective communication, enough admin support would be a great gift.
 26. Having the necessary people present to make decisions. An organised structure and a good chair.
 27. Having someone who knows the patient present.
 28. Good multiprofessional working and decision making, not just box ticking exercise
 29. Good communication, liaison between members of the Team and informative documentation recorded.
 30. good communication, commitment
 31. full complement of professional responsible for making treatment decisions All up to date investigations
 32. First you need to consider what an MDT is actually for - I think all it can achieve is to select treatment options, it cannot make a decision on what treatment a particular patient will receive as the responsibility for that decision lies between 1 clinician and the patient. I am not convinced that MDTs are very effective and they are very resource intensive. They certainly need to be well-chaired to avoid waste of time. I am not convinced that they are effective or cost-effective, and they can have adverse outcomes as there is little or no clarity on who holds responsibility for the decision they reach.
 33. established membership set date time to ensure diary planning An administrator team members feel equal and valued safe confidential non judgemental environment time to prepare and follow up actions/documentation All share the philosophy of MDT working Measurable outcomes/effectiveness
 34. Efficient data collection to enable complete decision-making at first presentation of the case. Minimal need to 'bring the case back next week'. Respect for the knowledge and expertise of all other professionals. Firm and efficient chair person. Feedback demonstrating that the time invested by so many clinicians improves patient care and outcomes.
 35. Effective chairman, working video links, the right people being present and committed to making it work
 36. dr nurse social worker physio ot at least plus spiritual provider
 37. Core members who drive it and others who can input as relevant
 38. Comprehensive patient assessment before meeting Complete patient data available at MDT Patient-centred approach, avoiding tick box mentality Ensure MDT members present with 1st hand contact with the patient Dedicated support to manage MDT; MDT Co-ordinator / data collector Clear MDT remit and role demarcation Mutual respect across MDT Fair chairing of meeting; involving all members Joint OPD clinics feeding into MDT Protected time for MDT to ensure attendance and allow education MDT training Feedback to MDT on outcomes of decisions made Appropriate membership of MDT Appropriate dissemination of MDT findings
 39. Comprehensive membership and effective chairmanship to allow range of discussion and views to be given appropriate weight
 40. Communication, Listening skills of all participants, location, timing, access, respecting everyone's views who attends. Clear concise presentation of the case

- by the person who knows the patient best
41. Committed proactive members. The full MDT Core membership needs to be funded
 42. commitment to attend Open discussion decision making efficiently organised
 43. Commitment of all core members to attend.
 44. cOMMITMENT & COMMUNICATION
 45. Clearly defined and agreed remit (Terms of Reference) managed by a trained and skilled chairperson with equal contributions from all the disciplines represented in order to maximise individualised patient care.
 46. Chair that controls meeting. All participants views respected. Contributions from all. Discussion about patient and people that know the patient present. Clear decision at the end of the meeting. All relevant parties present.Meeting not too long and focused on issues relevant to those present. Good administration and functioning IT.
 47. Balance of all relevant specialities. Agreement on running of MDT. Respect for all opinions.
 48. appropriate membership provide an effective information cascade to appropriate peoples. Continuity - feedback effective data collection
 49. An effective MDT happens when all results are available and the correct people are present to facilitate a decision.
 50. All the necessary people there. Efficient communication All the information required available - eg scans, bloods, etc Good record keeping Information projected
 51. A wide group of professionals with an equal voice from the most senior to the most junior
 52. A team of health professionals that improves and makes most efficient the planned care of a defined population of patients
 53. A structured, inclusive, involving and valuing multi-professional culture which reviews & assesses each patient on a weekly basis using a recognised assessment tool to ensure assessment and review across all domains
 54. A co-ordinator who communicate effectively to all members Each member to have an opportunity to in put into the meeting members to be respected by all Understanding of roles and responsibilities within that role Meeting to be kept to time and no one person dominating the meeting
 55. A clinician who knows the patient presenting the clinical issues to appropriate specialists to who can advise on their area of expertise with administrative support to organise, record and communicate as appropriate
 56. 1)A robust, supportive infrastucture with real time data entry - this facilitates engagement 2) Enthusiastic leadership 3) Well-chaired, time managed meetings valuing all contributors

The team

What qualities make a good MDT chair/leader?

39 palliative care specialists responded to this question.

1. understanding of subject and roles of individuals. good Leadership qualities
2. Understanding of different roles. Good time management. Patience
3. The qualities of a good MDT Chair is that they have a good understanding of the processes being discussed, have good time keeping skills and are respected by all members of the MDT. In order for all members of the MDT to respect the role of the Chair they should be given the opportunity to Chair the meeting so that all members understand the functioning of the MDT team.
4. Taking authority, clear voice, clear decision making, involving all
5. someone who openly encourages participation in discussion and who can see beyond their own specialty and what their discipline has to offer
6. Self-awareness in avoiding bias Willingness to learn and keep up the skills of chairmanship Being able to recognise when the remit is being strayed from and bring things back on track.
7. Respected clinician who is good at directing and reaching decisions
8. previous experience in chairing wide knowledge of speciality time management keeping focus facilitating agreed outcome
9. nb 'evidence' includes patient factors such as comorbidities, stated goals, expectations, choices. Clarity, inclusiveness, challenge, respect for different disciplines, accommodation for uncertainty and clearly articulated decision-making.
10. listening, time management, ability to summarise, appreciation of others
11. listening
12. Lack of bias towards one particular treatment modality
13. Knowledge, communication skills, personality
14. Keeps meeting moving
15. Involving, valuing, respectful, excellent communication skills (verbal and non), a good teamworker
16. Inclusive, good communicator, able to negotiate tough decisions, time management
17. good timing, fair, knowledgeable re disease processes and other professionals' roles, good facilitator
18. Good time management skills, ensure all the MDT members are given an opportunity to contribute.
19. Good team worker Good communication skills Good clinical skills
20. good organisation promote good communications promote fairness and ensure inclusion of all members. Able to summarise and agree plans for each case
21. Good management and has effective people skills
22. Good listener. Able to encourage all.
23. Good communicator, organised, time management, polite, respectful, summariser, strong leader, diplomat and able to move the meeting along.
24. good communication skills, approachable, good chair person
25. GOOD COMMUNICATION AND MANAGEMENT, PARTICULARLY TIME MANAGEMENT.
26. Focussed, clarity of thought, assertiveness.
27. focussed
28. Focused. Liked/ respected within the MDT.
29. Firmness, a critical mind so that they understand the limitations of MDTs, willingness to engage in trying to resolve dysfunctional MDTs because of differences of values between members. They have to believe in MDTs, which in itself is difficult.
30. Excellent communicator Organised, clear vision of what they are trying to

- achieve, patient champion
- 31. Confidence. Organisation.
- 32. Clinical experience; excellent communication skills; true commitment to MP working and to patient centred management
- 33. clear vision and time keeping
- 34. Clarity of thought, good communication skills and a good clinical knowledge
- 35. Being able to chair the meeting and keep things going and under control. Weak leadership means the meeting functions less well and usually takes longer
- 36. Able to facilitate all the above
- 37. Ability to keep to time and to facilitate discussion and participation of all members
- 38. ability to encourage discussion, but also reach a timely conclusion
- 39. A good effective communicator, good team player and leader, not easily manipulated

What types of training do MDT leaders require?

31 palliative care specialists responded to this question. In addition, 1 palliative care specialist responded 'as above'.

1. Very brief if doctor, more would be required for non-medical staff regarding differing disciplines and treatment modalities
2. Unsure
3. Training on....Leading a team, assertiveness, time management
4. Training on Chairing a meeting, time management, good communication and negotiating skills
5. The training for MDT leaders should include experience of taking part in MDT meetings, training in diversity, ability to listen and summarise when difficult decisions have to be taken. MDT leaders may also benefit from Communication Skills training, assertiveness training and research training.
6. Some - very little. Others may need direction on how to chair, value all contributions and multitask + what other specialities do!
7. People and communication skills. Ability to time manage and chair a meeting
8. Part of professional leadership and management training rather than specific
9. meeting management
10. managing people communication skills clinical credibility teamworking
11. Leadership, time management, awareness of role of members of MDT
12. Leadership training , it doesn't need to be specific to MDT chairing. How to chair a succesful meeting.
13. leadership course/chairing course
14. leadership and communication and conflict management (eg managing egos!)
15. Leadership
16. Impossible to be prescriptive, should be based on individual need
17. How to chair meetings effectively.
18. Gaining concensus; How to accurately summarise; Conflict resolution
19. Facilitation skills
20. Don't know
21. Communication. Management. Technology
22. COMMUNICATION, TIME MANAGEMNT AND PEOPLE SKILLS
23. Communication training and in some cases asseriveness training. An opportunity to share challenges and methods of dealing with them with one another
24. communication skills, cahirig meetings
25. communication skills and something specific about chairing meetings - eg time and agenda management, facilitating discussion and allowing contrary points of view
26. chairmanship
27. Chairing, leadership and diplomacy skills
28. Chairing meetings Lean training

29. Chairing meetings
30. Basic principles of chairmanship and MDT dynamics
31. ?

What makes an MDT work well together?

37 palliative care specialists responded to this question.

1. Time management. Making members feel valued. Humour
2. That all Team members work together and not independently
3. shared vision and values keeping the patient at the centre commitment to making it work good communication including recognising and discussing conflict rather than avoiding it basic rules around respectful communication and behaviour shared objectives that are objective and transcend ego games professional approach
4. shared philosophy of approach
5. shared philosophy/goals mutual respect non judgemental culture feeling valued
6. Shared objective
7. Respect, communication, strong chair, mature members
8. respect, clear objectives
9. Respect for others, good communication and organisational skills.
10. Respect for individual points of view. A shared understanding of whatever it is that MDTs are supposed to achieve
11. Respect for each others views
12. Respect for each others' views and those of the individual patients
13. Respect for all members of the MDT and their opinions
14. RESPECT FOR ALL CONTRIBUTORS AND EXCELLENT COMMUNICATION SKILLS
15. Respect
16. respect for each others roles and knowledge and valuing all members of the wider team
17. Professional respect, integrity and putting patient care at the heart of the MDT
18. Patience and the ability to listen and respect other opinions
19. Organised meeting with all views heard and respected
20. mutual respect ie drs for nurses views
21. MDT work well together when everyone is aware of each others role and respects them in their experience and contribution. Employers should welcome meeting of MDT members on a social basis.
22. leadership good communication humour
23. Knowing and respecting each other
24. Identify and agree the common task Keep focused Recognise each others skills
25. Good relationships and understanding of each others roles
26. good leader, shared values / goals
27. good communication effective leadership good organisation
28. Genuine respect for others contributions, good chair, good organisation
29. Focus on patient outcomes. Leadership which manages interpersonal conflict effectively
30. feeling like part of a team
31. Everyone feeling as though they have an role and are valued
32. Common goals
33. Commitment. Good leader
34. coherent leadership and mutual respect
35. close clinical working relationships
36. Clear protocols/terms of reference. Shared aims
37. behaving professionally and remembering why they are there, for patients

Infrastructure for meetings

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

45 palliative care specialists responded to this question.

1. Uncomfortable surrounding with senior staff in front row talking inaudibly and excluding others!
2. Unable to see/hear id behind the core members
3. unable to see screen
4. Too cold/too hot. Unable to see other participants. Lack of tea and coffee.
5. time
6. Theatre style, chairs in rows Darkened room for projectors Distance; needed for number of attendees, some just making up numbers!
7. the seating layout eg theatre style or where core members are the only ones who can sit at the table
8. The key physical barrier to a MDT working effectively is when people cannot see one another and diagnostic results are not visible for those who are participating.
9. Switching venue at the last minute
10. Specialist hospital palliative care teams are not resourced to attend the number of MDT's we are core members of let alone the MDT's where we are extended members.
11. Space in the room and ability to see the monitors
12. space
13. Seating arrangements
14. Poor or slow IT
15. Poor IT links to remote units
16. Poor communication
17. poor acoustics
18. poor acoustics
19. People not thinking it is a worthwhile use of their time, feeling we are doing it for the DOH and not the patients
20. People not being able to see or hear key discussions
21. people not attending
22. one person dominating the meeting
23. Number of people attending and the space they are in
24. not good enough view diagnostics, people having separate conversations, just front row speaking
25. Not exactly 'physical' but clinicians mumbling into their microscopes!
26. Not enough space in the room for all members to even sit down!
27. not being given a room to meet in
28. Not being able to see radiology and pathology.
29. Not being able to see or hear
30. Not being able to view data / CT,s.
31. no imaging
32. Need to get everybody together at same time can be difficult with clinical workload.
33. members of MDT with their backs to each other
34. Members feeling they are not heard or valued, not enough time allowed
35. Looking at people's backs. Not sure its a physical barrier as main obstacle. Often that people don;t know each other and don't feel free to discuss, aware of pressures of time etc.
36. Layout of room. Poor (or failure of) technology - especially where MDT tele-linked
37. Layout of accommodation and poor quality/reliability of video links are blocks

38. Layout is important.
39. lack of a dedicated space
40. Invisible/unheard participants
41. Bleeps and interruptions, lack of availability of notes
42. All members of the MDT should have a comfortable environment with refreshments and all should sit around the table on an equal footing now in hierarchial rows
43. all core memebtrs able to see each other and key information
44. accessible venue time?
45. Access to notes/XRs and Path

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

41 palliative care specialists responded to this question.

1. video-Neg- cant always hear everyone if people talk at the same time, sometimes technology fails so MDT cannot go ahead.
2. Very time-consuming if equipment not working efficiently
3. Useful when core members are off site.
4. unsure
5. Teleconferencing and video conferencing would not have a place in palliative care MDT meeting as these apply to locality and human interaction is preferable.
6. Teleconferencing and videoconferencing are good time saving models but reduce the potential for members to get to know each other. Relationship building is key to a good team.
7. Technical failures currently very common and extremely distracting. relay of images and path often unsatisfactory.
8. Stilted, unnatural communication
9. Saving of travel time making more frequent meetings possible. Requires more skillful management on the part of the chairperson
10. Provides a speedy and effective decision making process. Also provides a face to face communication between the disciplines.
11. positive- allows opinions from distnat tertiary sites. negative- sound delay difficult
12. POOR IMAGE AND SOUND QUALITY, AND FREQUENT BREAKDOWN IN SYSTEM
13. Our MDT co-ordinator ensures that the latest results of ivestigations are available, in advance
14. only access to above is by leaving meeting
15. Never been involved in it
16. Never been in a meeting where it is used, but I should imagine that lack of engagement by team with the person on the video and vice versa would be problematic. Also difficulty knowing when to speak, and being interrupted!
17. Negative - the communication with the other site tends to dominate the meeting
18. My opinion on this area is really of no value as I work in a unit where all mebers of the MDT are available and on site
19. more timely
20. Lack of eye contact would be negative.
21. It may just be our poor facilities but the satellite unit cannot see the images properly and end up just chatting - coming in to conversation just to present their patients and log decisions. I cannot see the point of just having people on the phone.
22. It is better than not having an oncologist but not as easy for a good discussion as having the oncologist in the same room
23. It gets everyone to the meeting, this is good if the system works
24. irrelevant

25. Insufficient experience to be sure
26. Improves communication with regional colleagues and broaden support for difficult decision -making
27. I find it difficult to concentrate when links are of poor quality. Also people regard a different geographical site as "not their problem"
28. I have worked with it in previous roles and found it invaluable in ensuring involvement of the full MDT
29. Feels a bit unreal and I'm not sure communication is great
30. Excellent when the technology works
31. enables wider membership requires careful co-ordination/chairing images are often of poor quality
32. Directs meeting time wise. Can feel like an intrusion on the 'main meeting'.
33. difficult to view imaging from other site, so scans from other sites not meaningfully reviewed; radiologists from other site talk through the scans which is helpful but no opportunity for "second opinion" from local radiologists. Good sound quality important. Can mean quieter members do not participate so fully - more difficult for chair to involve them in discussion if done over teleconference link.
34. Cuts down travelling time and allows more opinions to be heard
35. can increase attendance technical problems can disrupt meeting negative - cannot always see all the people. Can inhibit interaction between members.
36. Can be difficult to hear, discussion can be stilted
37. can't respond as no experience but can see its potential
38. At previous meetings when video-conferencing has been used, poor connections has meant stilted discussions, and difficulty for all members to fully participate in meetings. Also recurrent technological failures result in delays and interruptions to the meetings. However when it works well it can reduce travelling time etc for core members etc.
39. Allows all core members of MDT to be present. must allow different communication style over video-link
40. A virtual team virtually never works together!
41. We are a palliative care MDT so the above are less important

What additional technology do you think could enhance MDT effectiveness?

18 palliative care specialists responded to this question.

1. Voice recognition software (ie dictation turned into notes)
2. the stuff we have working reliably
3. The addition of electronic recording of consultation and MDT discussion would enhance communication with community services and local Hospices. This would require electronic linking with local Hospices and palliative care community team. The connection with the general practice record would also enhance communication with GPs.
4. Systems that work, everyone in the Network using compatible systems, having more than one room per trust to avoid agitation when meetings run over etc
5. Recording on laptop.
6. Real time updating of decisions
7. Proper data base so we can record activity, just do it on a piece of paper currently
8. PACS ,PATHOLOGY
9. Not sure what more could be done time effectively.
10. Not required for our team
11. None if all the above in place
12. nil
13. Mute button for the surgeons so they might listen occasionally (sorry, couldn't resist it!)

14. Laptop computer allowing electronic access to patient information systems.
15. Fault free video conference connected to remote PACS and path projection. Clear sound projection.
16. Being able to see what is written by the co-ordinator on the database
17. Being able to see good quality images wherever you are.
18. Access to images and pathology results taken anywhere in the network not just the host hospital

Meeting organisation and logistics

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

48 palliative care specialists responded to this question. In addition, 2 palliative care specialists referred to the previous multiple-choice question (Q13) stating 'as above'.

1. Thought about who needs to be discussed and, specifically, what the particular dilemmas with each patient are
2. The MDT need to have agreed in their unit the process for that unit and follow it, however flexibility may be needed in some meetings
3. summary of case, collection of results etc, radiology and pathology assessments
4. Some knowledge of patients to be discussed Forms and patients lists available before the meeting.
5. Seems to work best if the presenting clinician remembers their patients well and the imaging is available and has been reviewed
6. Room booked. List prepared and circulated. Patient assessment documents prepared and other information prepared in advance
7. review notes of patients on list, check results
8. Review lists, Collect information. Sending info to MDT coordinator.
9. Referring clinicians must be clear of the reason for referral to the MDT and those attending should have time to read through the list of cases and consider some of the issues likely to be raised/discussed
10. Recording of patients seen. Patient summaries
11. Reading through the circulated lists of patients. Compiling list for our own MDT
12. Radiology and notes made available. One participant needs to know patient
13. Not much, just preparing patients to be discussed
14. Need to be familiar with patient history and also current performance status. Need to be sure that all relevant information has been obtained before initiating discussion

15. MDT navigator to collate the list and get the notes ready. Pathologist and radiologist probably need most preparation time, the core members already know the majority of patients as they are current clinically, as the palliative care rep I just look through the list and see which patients if any are known to us.
16. Leads being fully prepared extended team members being available when core team member not
17. Knowledge of history, current clinical status and specific information relevant to each members speciality.
18. It is very important that someone who knows the patient is at the MDT and that radiology and pathology have had a chance to review the case before the meeting.
19. Individual clinicians need to prepare the presentation of their patients, Xrays, Histology needs to be available. List of patients to be discussed including information on targets

20. In our situation it includes forward planning booking of rooms ensuring meeting starts and finishes on time every member aware of any changes
21. Identifying patients and communicating with meeting organisers. Reviewing the clinical information
22. i don't tend to add patients to the mdt lists but those who do need to identify the question they want answered and make sure all the relevant information is there and available beforehand to appropriate people
23. I believe that good note keeping at the time of assessment of the patient should make preparation for the MDT meeting small if not necessary for me. However preparation by the MDT co-ordinator is required in order to make sure that the agenda is properly prepared and all information is available for discussion. Case already discussed previously should have summary available on the agenda in order to minimise repeated information which takes longer than reading the previous notes.
24. I am not convinced of their effectiveness so cannot really answer this. Someone needs to know something about the patient and what question the MDT is being asked to consider.
25. Good clinical summary of patients, including recognised/anticipated physical, psychological, social and spiritual needs alongside relevant investigations
26. From a palliative care perspective, someone needs to be able to communicate the patient's expectations, wishes and goals - this is usually the site specific CNS
27. Ensure results of investigations are available. Ensure list of patients to be discussed circulated to all members prior to meeting.
28. Effective assessment of levels of need across all domains. Designation of effective and efficient chair. Prioritisation of patients to be discussed using assessment scores. Leadership & development of multi-prof teamworking
29. Depends on role in the meeting. The leader, radiologist and co-ordinator are likely to need to do the most
30. Demographics of patient to be discussed. Latest information available.
31. Comprehensive up-to-date patient assessment Complete patient data available at MDT Each discipline to bring their view / consensus of clinical situation and specific questions to ask other disciplines present Arranging for representative for each discipline attending MDT to be familiar with patient
32. Complete availability of ALL information on every patient to be discussed. Full review of all radiological and pathological results Clinical summaries to be accurate and clearly presented by a designated clinician. Chairman to be aware of number of cases for discussion and to allocate time according to complexity of each case.
33. Collation of information available so far. Formation of a clear question.
34. Collation of all results to allow full discussion and identification of issues to ensure relevant people are there/or have been consulted if they cannot be there
35. Collating results of tests and relevant patient information
36. CO ORDINATION OF CARE/SERVICES. DOCUMENTATION FOR THE MDT
CO ORDINATOR TO COLLATE/PREPARE pLANNING TIME INTO WORKING DAY TO ATTEND
37. Clinicians to think through clinical summary of cases and what questions they have and for whom
38. clear objectives
39. case history.
40. Awareness of patients to be discussed Current conditions Results of recent tests/investigations Patients perception,family perception time/venue established
41. As a clinician, it is checking over the clinical history, investigations, and status of the patients I am presenting
42. All scans, equipment need to be functioning. Lists need to be circulated for those who need to review scans, slides. Personnel need to arrive on time. Those that have to present reports on imaging or histology need to have time to prepare. How to chair, for some of the chairs, would be helpful.
43. All information (notes, results, scans) to be available. Agenda for MDT set and circulated. At least one member of MDT should have met patient.

44. all done by co-ordinator here
45. agenda prior to MDM Case summaries nominated chair staff apologies/representatives
46. Agenda preparation and circulation patient summary prepared Meeting room set up
47. Admin, prepare the list of names to be discussed, ensure notes available and MDT outcome is documented and placed in notes
48. accurate list of patients, data collected on symptoms and performance status, imaging, histology

What makes an MDT meeting run effectively?

47 palliative care specialists responded to this question. In addition, 1 palliative care specialist responded 'all of the above' referring to Q16.

1. Well prepared, key clinicians present, technology working well +all of the above aspects
2. Well chaired
3. The chair needs to time manage the process very efficiently
4. Strong leadership, clear ground rules and creating an open forum where staff can ask questions, clarify and make suggestions
5. Robust, good quality coordinator support and good chairmanship to ensure time is allocated appropriately - plus enthusiasm of at least some team members - and the chair
6. Punctuality. No interruptions
7. Prior preparation and good chairing plus having all relevant results available PLUS having the pall/site specialist nurse who knows the patient there
8. Preparation. Good chairmanship. Comprehensive presentation and review of all relevant information. Clear decision/outcome at end of discussion.Circulation of minutes with action plan
9. Preparation, availability of data and presence of required staff to aid decision making for a particular patient or complex case
10. Preparation, Appropriate members of the team present A decision at the end of the day!
11. Preparation and effective leadership and people turning up on time
12. Not waffling on, and all members engages, everyone arriving on time
13. mDT COORDINATOR AND A STRONG CHAIR TO LEAD
14. Leadership/time management Preparation by all
15. Leadership by the chair to ensure all views heard and a clear plan agreed
16. Leadership and the presence of clinicians who know the patients
17. Keeping to the point
18. It is possible to get through a lot of cases quickly when the presenting clinician has prepared. After about 1.5 hours everyone gets tired and slower and the discussions are less productive. Some of our clinicians are well prepared and succinct which keeps everyone concentrating and some are ill prepared, flick through notes, are unsure what they are presenting the patients for and this leads to everyone getting disinterested and slows the process down. So well motivated and prepared clinicians!
19. Information readily available and good chairperson
20. info before meeting. good coordinator. good chair. effective technology
21. I think I have now been asked this question several times.
22. good team work and leadership
23. Good planning and preparation. good leadership of meeting, cooperative relationships between different clinicians involved. Good IT
24. Good organisation, strong chair
25. Good leadership clear objectives, good team working and not being used as an

- opportunity for 'point scoring' or venting of political frustrations
26. good leadership and facilitation.
 27. Good co-ordinator and good communication from each member without the group going off at a tangent, even if it is interesting
 28. Good chair. Focussed members. Patient summaries. Correct people there when required.
 29. Good chair, relevant personnel, good administration, time for discussion when case is difficult, someone to have seen patient, all views respected, time for education, IT functioning, refreshments if meeting is long.
 30. Good chair, organisation before hand of the meeting, starts on time.
 31. Good availability of information. Punctuality of memebers
 32. Good agenda, all information available and majority MDT present
 33. Enough information, skilled administrative support, shared sense of focus
 34. Efficient coordinator. Effective chairman Clinicians who already work well together Respect accorded to all professionals and their expertise
 35. Effective chair Precise handovers
 36. Effective and efficient meeting structure, full multi-prof attendance and an involving, valuing and effective chair
 37. Depends on how you define effectively. Decisions can be made that are not patient-centred, but can still be made efficiently and communicated to the GP. What are your goals of MDTs? I'm not sure I know.
 38. Comprehensive patient assessment before meeting Complete patient data available at MDT Patient-centred approach, avoiding tick box mentality Ensure MDT members present with 1st hand contact with the patient Dedicated support to manage MDT; MDT Co-ordinator / data collector Clear MDT remit and role demarcation Mutual respect across MDT Fair chairing of meeting; involving all members Joint OPD clinics feeding into MDT Protected time for MDT to ensure attendance and allow education MDT training Feedback to MDT on outcomes of decisions made Appropriate membership of MDT Appropriate dissemination of MDT findings
 39. commitment
 40. Clear presentation of summary of case and present issue/ decision to be made. Discussion to be kept relevant to case.
 41. Clear goals, leadership and management of meetings with monitoring and review
 42. chaired effectively agenda prepared availability of patient info core members present
 43. All members arriving on time
 44. All core and extended members attend start and end on time record/minute taker all feel involved and able to contribute good chair skills-promoting and facilitating holistic approach no interruptions good timekeeping
 45. A MDT meeting runs effectively if we have a good Chair. We usually rotate the Chair so that everybody has got the opportunity to have insight into the role so they can be there for a good participant. We should also have relevant contribution from all members of the MDT and not only from medical staff.
 46. A list of pts so everyone can follow the format and one person to chair the meeting with appropriate attendance
 47. a good chairperson

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?

32 palliative care specialists responded to this question.

1. Treatment decisions should be discussed at the MDT for relapsed and palliative patients otherwise the MDT turns into a which operation will I do session. However decisions will need to be made outwith the MDT but from an education point of view the case should be brought back. There is a problem in hospital with an attitude that once I have have done my bit it is nothing to do with me - so having the case brought back to the MDT helps clinicians to see patients in context of things like how much benefit or not they have had from their treatment. If you never hear about the problems of patients with early relapse it exacerbates this problem.
2. They should be discussed at the MDT as others may have things to offer eg palliative care. This wont happen if we dont know about them and they are not referred by other means
3. There simply is not the time to discuss all recurrence and new diagnosis. As a palliative care specilaist we would do nothing but cover MDT's all week. Decision making should be patient centred, between consultant,patient & CNS and could be communicated to MDT in a short precis each week.
4. The Cancer site specific nurses usually refer patients to the SPCT after the MDT. The SPCT attends MDT's when we need to discuss a patient we are involved with.
5. Standard protocols - but these patients need the role of the MDT as much as patients presenting initially - and then palliative care input is essential. A decision not to treat is more likely with pall care involved. Pall care involvement is impossible in my Trust but I am told I always make a difference when I can go - and not always to the patient that the team thought I was there to talk about.
6. Specilist may wish to discuss with selsted mdt members a mopre informal basis
7. Should not be an option (cf NCEPOD)
8. Should be discussed with specialist nurses and palliative care specialists if necessary, a lot of patients are being offered unrealistic hope
9. one of the biggest problems with cancer MDTs is they meet 1/week or less, and the patient is excluded. They may meet many hours or miles from the patients base hospital. This risks making them slow, inflexible and impersonal.
10. Need to ensure that all those involved in the care of the patient are able to put forward their views on te appropriateness of further treatment and to ensure GP is aware
11. minimum of 2 senior drs and patient/family
12. MDT discussion best option

13. Locally agreed treatment guidelines (audited) based on national outlines,with patients presented at MDT if the planned treatment is unclear or falls outwith local guidelines. To be supported by annual audit of death within 30 days of treatment, and regular morbidity and mortality meetings. This is where specialist palliative care can play, arguably, their most useful role.
14. joint oncology/ Palliative Care Clinic
15. Joint clinics with pall care. I would much rather invest time in a joint clinic that in attending an MDT
16. Involve key professionals eg palliative care team
17. Intradepartment discussion should be sufficient except in complex cases
18. Ideally to discuss at MDT but his would be a big increase in work load. May be better to have a seperate Oncology MDT
19. I think they should be discussed at MDT
20. i have concerns that clinicans are no longer able to make decisions without MDT support, the best person to make the decision in this situation is the clinican with the patient, using the mdt time to discuss patients with complex issues
21. I dont know but it shouldnt be left to one specialty to decide what is best in case there are alternative options

22. evidence that discussion has taken place with other (not necessarily core) members of the MDT - may be specialist nurse and palliative care reps
23. Don't know of any
24. Don't know
25. discussion with relevant people
26. Discussion with palliative care team reviewing patient
27. Discussion with appropriate colleagues, patient and carers
28. Depends if a general plan has been decided i.e. not for further surgery consider chemo if future recurrence vs no plan at all
29. Decisions could be made in the joint oncology clinic.
30. Decision making for patients with recurrent and advanced disease should be done at MDT meeting that is attended by a member of the palliative care team so that we have the assurance that all treatment options have been considered and prognostication is included in the decision making process.
31. An MDT does not make any decision: all it can do is make recommendations regarding treatment options to be offered to the patient. Even then its decision may be wrong. The clinician who actually sees the patient and understands the clinical problem and the patient's priorities is the only person who can make a decision with the patient anyway. So lack of involvement of the MDT is only a minimal, if any, disadvantage. There is no legal or moral mechanism by which a MD team can 'take a decision' as there is no way of attributing responsibility to a 'team'.
32. all major changes should be discussed at mdt reported back by CNS

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

30 palliative care specialists responded to this question.

1. turn out to be inappropriate
2. Treatment being considered inappropriate on re-assessing patient or patient declining treatment
3. This data is not fully collected. Plans to do this in place
4. The main reason for the MDT recommendation not to be implemented is that patients condition can change as patients are reviewed but the existing recommendation are usually beneficial for the care of patients as they represent a starting point for joint thinking. Changes in MDT treatment recommendation should be brought back to the next MDT meeting for information and subsequent approval.
5. Specialist pall care is an advisory service
6. Rarely happens but if it does, poor communication
7. pt choice
8. Primary care reluctance or patient/carers refusal
9. poor initial information
10. Patient wishes Patient deterioration
11. patient unfit/ patient choice
12. patient situation changes
13. Patient not fit when seen
14. Patient has deteriorated/changed clinically without the MDT being aware. Also, patient may not agree with MDT decision
15. Patient factors eg ill health or unwilling
16. Patient's performance status was not considered in the initial discussion
17. Patient's clinical picture changes
18. One reason is that sometimes treatment decisions are made without anyone knowing the patient and their wishes
19. not enough staff
20. New information may become available after the meeting. The patient may present to clinic one week later and their performance status may have changed
21. I would guess it is because the MDT recommendation is clearly wrong when one actually meets the patient.
22. I think it is patient choice - although when the clinicians who present the patient's have met them we can have a more sensible discussion because the patients views can have been elicited.
23. I should imagine it is patient choice
24. DISAGREEMENT BETWEEN PROFESSIONALS
25. Change in the patients condition
26. Change in patients condition
27. Change in clinical circumstances/condition
28. Change in circumstances, or patient not agreeable
29. 2 main categories: patient rejection of recommendation. Process; eg no ITU bed available
30. ?

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

25 palliative care specialists responded to this question.

1. Teaching + local flowchart guidelines and acute oncology service
2. safety net systems within imaging and pathology
3. Robust communication systems within the Cancer Unit and the whole Hospital
4. repeated emails to consultants/CNSs
5. Only can collect data if given resources to do so
6. Not sure.
7. Not sure this is entirely appropriate. We discuss patients who are not well enough to receive treatment or for whom their cancer is an almost co-incidental finding. The latter is more understandable, but the former is a waste of time
8. Multisource referral to MDT, i.e. direct from radiology/histopath as well as clinical teams
9. Multiple 'sites' of entry to cross check. eg Path; radiol;. Coding.
10. **MADATORY DIRECTIVES AND TARGETS**
11. It seems to me that the statements above merge Cancer MDT and morbidity and mortality meetings.
12. Improve awareness and access to MDT
13. I do not have an opinion on this.
14. I am not convinced there really is a benefit in ensuring that all new cancer cases are referred to an MDT - some patients are clearly dying at diagnosis and the MDT achieves nothing.
15. Electronic register of all new cases
16. Education
17. Education
18. education
19. don't know
20. Disseminate information to primary care and have clear referral pathways
21. culture change over time
22. better IT resources
23. Better education of junior clinical staff with more readily available information on criteria and methods of referral and times of meetings
24. Availability of resources and an effective process ie MDT for new cancers to be discussed
25. Almost all are - you need to consider how cancer cases with no known primary cancer are managed within the MDT system.

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

31 palliative care specialists responded to this question. In addition, 1 palliative care specialist responded 'yes definitely' appearing to agree that this should happen but not stating how it should happen.

1. Usually obtain a consensus
2. These are rare but should be recorded as a majority decision
3. The rationale for treatment decisions and options for treatment should be documented
4. Recorded, but it is the chair's role to sort this
5. Recorded reasons for disagreement. Present options to pt.
6. put to the patient to make an informed choice. Or request 2nd opinion from cancer centre
7. paper here and then reflection session if serious
8. Opinion of role rather than name.
9. on MDT record
10. On current format for MDT decisions
11. Literally record which clinician recommends what.
12. IN THE PTS NOTES
13. In the normal manner that all MDT decisions are recorded
14. IN THE MDT MINUTES AND THE PATIENTS MEDICAL NOTES
15. in the case record - with note of treatment plan adopted
16. I do not have any specific answer to this as we aim to reach consensus of treatment recommendations within the team.
17. Enter details on proforma
18. Could be reviewed bi-monthly perhaps, with outcome data
19. Contemporaneous documentation with Chairman's decision of next steps.
20. Clearly. (In our MDTs it doesn't happen - a consensus is reached).
21. clearly
22. Clarify multiple possible treatment options raised by MDT, with favoured option and possible triggers to adjust plan
23. carefully!
24. carefully
25. Both views should be presented to the patient
26. Both possible decisions should be recorded and it should be ensured that the decision is patient centred and that patient consent is fully informed
27. As they are stated in the meeting
28. As such
29. As options depending on particular reason for split decision
30. As decisions by the meeting. Individuals only to be named if relevant/clinician choice.
31. ?

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

47 palliative care specialists responded to this question.

1. You cannot represent the patient's views at an MDT and attempting to do so would risk misrepresentation which would be worse than no representation.
2. Whoever knows them best
3. Whichever professional has the most knowledge of that individual's values/preferences ?should generally be the site-specific nurse
4. varies
5. Usually specialist nurse
6. This will depend on the patient and the MDT
7. The person whop knows the patient best. This is not necessarily the key worker who may be allocated to ensure certain functions are completed.
8. The person who knows them and the case
9. The person who knows their views best-this is not role specific.
10. The person who knows the patient best and who has told the patient they will be contacting them afterwards
11. The person who has assessed them
12. THE person who broght the case to the meeting
13. The person in the team who has met the patient. This is often the Clinical Nurse Specialist
14. The patient, but not practical, so specialist nurse
15. THE PATIENT OR PROXY (AGREED BY PATIENT) MDT MEMBER WHO KNOWS THEM BEST
16. the most senior clinician with sufficient first hand contact to be patient's advocate
17. The key worker although this changes
18. The Key Worker
19. The key worker
20. the healthcare professional who knows them best or has had most input into their care
21. the clinician/ specialist nurse who knows the patient best
22. THE CLINICAL NURSE SPECIALIST WHO LOOKS AT THE PATIENT NEEDS HOLISTICLY
23. The best person to represent the patient view at MDT meeting is the person who has had the opportunity to discuss their views and it could be any member of the team as long as they can represent these effectively without bias.
24. Specialist nurse who has seen the patient in clinic
25. specialist nurse
26. Someone who has met the patient and knows them best- often falls to the CNS
27. Someone who has met the patient and discussed the patient's feelings about possible treatment options. Needs to be a senior professional with good communication skills and the time to spend with the patient
28. Someone who has met the patient
29. Site specialist CNS or doctor who has met the patient and completed an holistic needs assessment
30. patient's key worker patient themselves
31. Patient or someone who has met the patient and asked them their views who has sufficient experience to have been able to discuss options
32. Pall care nurse or site specialist nurse
33. often specialist nurses, in combination with senior clinician
34. keyworker
35. Key worker may be of any professional group
36. Key worker
37. Key worker - usually a Clinical nurse specialist

38. It depends on the patients needs at the time. Patients should attend case conferences but not MDT's
39. if not the patient, then probably a specialist nurse although anyone can act as an advocate - depends on patient and circumstances
40. either the named dr or nurse
41. CNSs are usually not able to confront the surgeon/physician with whom they have to maintain a working relationship in my experience, so I really don't know. I think we should be training all of our medical colleagues to ask the patient how much they want to be involved in the decision-making
42. CNS or soemone who has met the patient
43. CNS
44. Clinical nurse specialist
45. Any one who has had a discussion with them about possible treatment options and has some understanding of their views, however this cannot be a substitute for the MDT decisions being discussed in full with the patient and their agreement sought
46. A member of the MDT that knows the patient well and has a good relationship with them. Could be any member of the team
47. A clinician who knows them.

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

45 palliative care specialists responded to this question. In addition, 3 palliative care specialists referred to their answer to the previous open question (Q32).

1. will vary depending on the patient, the team, the decision, the pathology
2. Whoever will see the patient next as decided in the MDT. They might choose to delegate this to one of their team.
3. Whoever is deemed most appropriate at the meeting
4. Wherever possible, a senior doctor who can communicate the reasons for the decision making and give accurate and informed responses to questions or queries.
5. Their key worker (see above)
6. The same clinician
7. The responsible consultant and specialist nurse
8. THE person who broght the case to the meeting
9. The person who knows the patient best and who has told the patient they will be contacting them
10. the most senior clinicain with sufficient rapport with patient
11. The Key worker, this is often the CNS
12. The Key worker or the MDT member who has been involved the most
13. The clinician who is actually treating the patient will bear in mind the treatment recommendations, but should not be bound by them when they are inappropriate.
14. The best person to communicate the treatment recommendation is the one responsible for providing the treatment but this should be done with another health care professional present who may be able to further discuss the issues raised subsequently.
15. Specialsist nurse/ senior doctor
16. specialist nurse or consultant
17. specialist nurse
18. someone who has previously met the patient. Ideally the diagnosing consultant
19. Probably the key worker or a doctor

20. patients key worker
21. One who will see him/her quickest
22. KEYWORKER
23. keyworker
24. Key worker or site specific CNS or patient's consultant depending on the situation
25. Key worker or his/her representative/deputy
26. Key worker
27. Doctor
28. doctor
29. Depends on recommendations - usually should be the main consultant managing their case initially
30. depends - sometimes CNS, sometimes consultant or SpR
31. Consulting Member of the Team
32. consultant treating
33. Consultant in charge (although this can be delegated
34. CONSULTANT AND /OR CLINICAL NURSE SPECIALIST
35. Consultant
36. consultant
37. clinician who knows them
38. Clinician who has seen the patient
39. clinician responsible
40. Clinician in charge of patient care.
41. Clinician identified at MDT
42. clinician caring for the patient
43. As above or the person identified by the MDT best placed to do so
44. Agreed by the MDT team at the time and dependant on the decision
45. A clinician they have met -or the clinician they meet at next appointment. But the clinician must have the knowledge and expertise to explain the treatment recommendations

Measuring MDT effectiveness/performance

What other measures could be used to evaluate MDT performance?

14 palliative care specialists responded to this question.

1. Unsure
2. trickier in pall care but ?higer rates of ppc
3. there needs to be some quality marker regarding the issues raised in discussion - otherwise an MDT slavishly follows protocols to achieve ratings as listed
4. The above depend on which MDt you are part of - palliative care MDT couldn't be measured by improved survival, although it would be interesting.....
5. None of above apply to palliative care MDT
6. Most of the measures above don't relative to palliative care. We are currently over monitored and I have grave concerns about the administration of more satisfaction surveys and benchmarking. It distracts from the key task!
7. It is difficult to evaluate the performance of a MDT in palliative care as the treatment outcomes are not measured in survival rates. However patient surveys and attendance of non core members may give some measure of the effectiveness of the MDT meetings and of MDT working. Palliative care is involved in some other MDT meetings and I have overall been disappointed with the inability of some of the physicians to take into account psycho-social dimension in the decision process but it has been difficult to influence changes as we are not core members and do not have the resources to attend those MDT meetings regularly.
8. I don't think these outcomes are applicable to palliative medicine MDT's
9. Don't know as I think there is severe lack of clarity regarding what the MDT is meant to achieve, so don't really know what it is that you would be trying to evaluate.
10. Can;t think of any others
11. Audit of adherence to Terms of Reference
12. 360 questionnaires for the chair?
13. 30 day mortality. Symptom management
14. ?

Supporting MDTs to work effectively

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

33 palliative care specialists responded to this question.

1. Training of ALL participants
2. The venue
3. Team working skills of some more senior members
4. Surgeons attending promptly
5. Stronger chair (two of the MDTs i attend have strong chairs and are highly effective. one doesn't and is dysfunctional).
6. some management support, less emphasis on what DOH tells us to discuss and we discuss those patients that need discussing
7. Pass - I don't think they can be very effective in that there is a completely unrealistic notion of what they can achieve i.e. what their 'effect' is meant to be.
8. only discuss relevant cases
9. more time for the number of patients
10. More time
11. More frequent business/development meetings looking at the functioning of the MDT, audits, patient views etc
12. more effective time - keeping
13. More data before More feedback afterwards
14. MDT working would be more effective if there was enough staff to allow involvement in teaching as a team. Therefore staff levels improvement would make the MDT more effective.
15. Location
16. LESS WAFFLE AND MORE SPECIFIC COMMUNICARION/DISCUSSION
17. Less people going in & out with less pressure on them to move on to other tasks.....time time time
18. Improve pre maating availability of data; MDM Coordinator's time is spent inefficiently chasing around network for 'lost' items
19. I attend a variety of MDTs which vary in their effectiveness - the best have good leaders, doctors who know their patients and a good approach to team working. for the others i think strong leadership can help to address all the problems
20. Half the length and run it twice each week to cover the same amount of patients
21. funding of full MDT
22. Formally summarise plan before moving on to next pt.
23. ensuring regular attendance all members. Better allocation of time to discussion - do all patients need to be discussed in full?
24. enough administrative support
25. coordinator
26. Clear records of decision making process, so that patients are not rediscussed at length or inappropriately.
27. Clarify leader
28. Change lengthy documentation
29. better organisation pre meeting
30. better administrative support to fully document and communicate decisions
31. Become an Integrated Directorate
32. Attitudes
33. an administrator

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

26 palliative care specialists responded to this question.

1. Time to fully attend always
2. time
3. time
4. Proper time allocation for one of the MDTs I attend - it is squashed into lunch time and has to be because it is so resource intensive. A bad arrangement all round, although clinicians do their best to mitigate the obvious problems.
5. nothing feel fully confident as a member of the MDT
6. More time!!
7. More time to prepare
8. MORE TIME TO ATTEND WITHOUT OTHER PRESSURES
9. More time
10. MDTs do educate but time constraints of visiting consultants make this difficult
11. MDT's in cancer are not usually true teams. They are people who come together for a specific purpose and usually sit within other teams as well. Whilst I agree with many of the statements above I do not believe we need specific training to be an MDT member, we need it as part of our core pre and post graduate training across all professional groups and disciplines.
12. Less emphasis on attendance at meetings, more emphasis on my palliative care contribution to quality markers, audit, teaching - far more efficient use of limited time resource
13. Just being involved with cases in which palliative care has a role. Although educational very few of the site specific MDTs include patients where palliative care is either needed or wanted
14. increased attendance
15. if I had more medical support
16. I get fed up when patients who are clearly in the last phase of their illness are still referred to the oncologist and my expertise is not recognised. The assumptions that 1. I only see the imminently dying and 2. that if I do see someone they will be dead within days, limits my ability to offer support to patients and their families since it is often received in horror or with the words "they're not dying yet!"
17. I do not have enough session in my job plan for clinical work in the hospital where I am core member of the MDT. Currently working with 3 different teams makes my personal contribution to all 3 very uneven.
18. I'm currently happy with my contribution
19. Good facilitation
20. Clear agreement on Terms of Reference of the MDTM followed up by consistent chairmanship
21. Better organisation Fewer patients on MDT, so each was given enough time...discussing every new patient in palliative care leads to huge overload, such that the discussions that are had are sometimes meaningless.
22. being there for site specific MDTs! Only able to attend own (palliative care) MDT
23. Being encouraged to contribute
24. Attend an appropriate leadership course
25. Admin support
26. Active support from employer organisation and valuation of MDT time & contribution - attendance and contribution perhaps should be considered in CEA assessment and other appraisal/performance assessments/rewards

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

10 palliative care specialists responded to this question

1. Unsure
2. To attend MDT meetings in other hospitals in order to learn from others
3. team training most useful
4. Fully support the aspect of workshops with other teams
5. Pass
6. None
7. Mortality and morbidity meetings
8. Communication skills, negotiation training, managing conflict
9. ?preprinted MDS for pall care mdts with ?preprinted MDT outcome communication sheet
10. ?

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

13 palliative care specialists responded to this question.

1. Went to study day 2 weeks ago on improving team performance
2. Unaware
3. NOT aware of any
4. None that I am aware of
5. nil
6. Leslie Fallowfield
7. Irene Higginsons - Support Team Assessment Schedule (STAS)
8. I know that the core members of the colorectal team attended a two day workshop which was away from their usual site and was independently facilitated - this sounded helpful
9. Don't know any
10. Communication skills workshop are a good way of developing MDT working. It should therefore be offered to all core members of MDTs.
11. Chairing meetings effectively
12. Away days
13. away day

Final comments

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

17 palliative care specialists responded to this question

1. you shouldn't make palliative care MDTs try and be like other cancer MDTs it stifles the way we work to try and do the best for patients, it is not at all transferrable to SPC
2. While cancer MDTs work well, the site specific model doesn't fit the needs of hospital palliative care team MDT (where management plans vary day-to-day i.e. little / no over-arching long-term plans are put in place and most attendees don't know patient while the key professionals i.e. ward doctors / nurses leading the patient's care never attend!) Palliative care input to cancer site specific MDT has great benefit in networking, prompting of referrals and educational value, but limited direct clinical value at time for many / most patients discussed, despite palliative intent warranting subsequent input
3. Traing early on in the evolution of MDTMs rather than just get on with it
4. The questionnaire is based on the assumption that MDTs are good for all patients - but it would be interesting to consider what benefits are derived and adjust MDT working accordingly - some take a very long time!
5. The MDT's vary considerably. Some have good, clear leadership, presence of various players who can all contribute and definite decisions that are arrived at in a timely way by consensus.
6. The idea is good. Often the numbers of patients to discuss and people attending is too high to make an effective MDT possible.
7. SPC MDTs very difficult to measure, but does not mean they should not be measured
8. Should be looking at outcomes. There should be some reflection of the patient experience.
9. Plea for palliative care involvement at MDTs as core, but resources do not allow
10. Palliative care does not fit into the Cancer MDT model and needs it's own model. We rarely pick up referrals from cancer specific MDT's and wouldn't wish for staff to wait a week before referring to us.
11. Most hospital SPCT's are small and are not resourced to attend all the cancer MDT's. The majority of MDT's discuss diagnostics and treatment.
12. MDTs are very variable. Some specialities eg radiology and specialist palliative care are required to attend many. The meetings need to work well. I think it essential that patients with recurrent disease are considered at these meetings but have no solution as to how to do this without need for many extra staff.
13. In terms of specialist palliative care there needs to be much emphasis on efficient use of available time/expertise rather than tick box attendance at meetings. 'Core' membership and attendance at weekly meetings encourages 'SPC failure' at Peer review rather than showcasing excellence in practice regarding referral pathways, audit, teaching, sharing good practice, quality markers etc.
14. I think that you need to know what your goals are. If patient-centred decisions are one of them, then I cannot see this being achieved unless the hierarchy issue is resolved. If you want quick-ish decisions and cancer waiting times monitored, then we are all probably on track.
15. I may have mixed my opinions in this questionnaire: I have referred mainly to the upper GI meeting that I attend, but 'my own' MDT is palliative care and fewer resources are needed for this. I do not think that this questionnaire is really applicable to Palliative Care MDT
16. I do think someone needs to look carefully at palliative care MDTs. They are quite different in nature to site specific MDTs, and have quite different goals. The demands currently placed upon us mean that the MDT is completely unmanageable

due to such huge numbers of patients receiving quite basic palliative care, that still have to be discussed, leaving insufficient time for the more complex patients to be discussed. This is frustrating for everyone - I think someone needs to realise that palliative care MDTs have a completely different role and character, and need different performance indicators/standards from site-specific MDTs.

17. Good organisation - dedicated MDT coordinator and enthusiastic chair.