Multidisciplinary team members views about MDT working:

Results from a survey commissioned by the National Cancer Action Team

Open question responses: Haematologists

November 2009

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

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

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

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

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

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

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

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

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

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

Method

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

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

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

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

Contents

Domains that are important for effective MDT functioning

What do you think constitutes an effective MDT?

83 haematologists responded to this question.

1. where members feel free to discuss cases and exchange views on any given case in a nonjudgemental manner, without humiliating or degrading a member of staff as cases are brought there with a view to the patients best interest and free exchange the most current knowledge, where members experiences can provide expertise the bringing together of PROFESSIONAL opinions from across disciplines ie radiology radiotherapy etc. Keeping the representative nos. not too large so that timely opinions on matteres can be exchanged.
2. Where diagnosis of patient can be reviewed and appropriate management stratergy planned. It is not a forum to discuss detail of patrient management. This remains the responsibility of the local clinical teams.
3. Well organised, data managers, effective collection of data, timely and regular meetings to discuss patient management, consistent attendance by different specialties
4. Well organised in terms of data available and use of IT system such as Somerset
5. Well chaired, all relevant data ready and accessible for all cases, pithy presentations, a mixture of hawks and doves, documentation of agreed management plan, research support for clinical trials.
6. Well chaired productive discussion that influences and assures best practice and patient centred care with good documentation
7. timely histopathological diagnosis and interactive discussion about management plan
8. Time and colleagues that work together well and are functional. We have a highly functional team so the MDT works very well
9. The relevant people get on well together and trust each other.
10. The principal problem with HaemOnc is the requirement for a population of 500,000 which means a cross-Trust MDT; operationally this is difficult to deliver effectively as each constituent Trust has different procedures.
11. Team of specialists reviewing the morphology, histology, cytogenetics and molecular results for individual patients and then devise a strategy for individualised treatment
12. Supports clinical teams in making appropriate diagnosis and treatment decisions.
13. submitting requests/data in time, efficient data cllectors/organisers
14. Staff knowledge and experience from the bottom up, avoiding frequent staff changes.
15. Regular meetings, with robust administrative support and appropriate and regular core specialist attendance
16. Regular meetings, effective communication eg videoconferencing, good MDT coordinator to provide all necessary data, commitment from core members, effective chair, brief discussions on straightforward cases so more time for complex cases
17. Rapid effective decision making facilitated by good chair, full attendence of relevant parties and availability of material. Shouldn't be a rubber stamping exercise but to focus on the difficult cases
18. Preparation in advance, face to face discussion, good IT
19. Patient list and purpose of referral to MDT Notes present, results available, real time documentation and some implementationof outcome
20. Organisation, appropriate attendance, clear remit and time
21. Open forum for debate with input from all relevant professional groups. Discuss all patients and ensure excellent quality of care for all patients within a region
22. One which functions efficiently to enhance patient care, rather than to tick boxes that fulfil medico-political dogma.
23. One that communicates well, has mutual respect and works as a team, not a group of individual special interests.

24. One that allows time for discussion of difficult or contentious issues but does not dwell too long on 'straight forward' cases. One that has reliable and consistent radioloigcal and histopathological input.
25. One in which difficult diagnoses or treatment decisions are made
26. needs to be well organised with high level of effective communication between participating units.easy transfer of data. good communication,understanding and sympathy between clinicians. time to prepare.effective feedback which is acted on .good vcr links.good behaiviour amongst participants.
27. Multidisciplinary Structured Information Focussed discussion
28. More than a tick box exercise. Need adequate resources and time to ensure all relevant information available and reviewed. Need decent radiology viewing, good support staff to get notes and collect data and protected time
29. MdT's have just been added to the weekly workload with no reduction elsewhere.
30. locally based clinicians making decisions with full knowledge of the patient's clinical condition. All necessary information and WRITTEN reports available of all relevant materia to ensure accuracy. There must be adequate staffing and time to make informed decisions and record these accurately
31. knowledgable clinicians (haematologists oncologists, radiologists CNS's)
32. knowing the other core members
33. Information available. All members present. Decisons made at the time
34. Ineffective model for haematology.
35. Individuals with time to prepare before coming to the MDT to ensure that all the relevant information is available to the MDT. Some one who has met the patient and can give an opinion of which treatment modalities a patient may be suitable for and what the patient's views are. A co-ordinator who can ensure that the cases are collected, the notes and histology, staging investigations are present. Someone who can collate the MDT's data and allow the MDT to audit its performance. A system for assessing response to treatment and outcomes. A research interest in the diseases being treated with an assurance that the MDT keeps up to date with treatment modalities
36. I have doubts about the real value of the MDT in cancer management.
37. I don't think they are that effective because they take up to much time and change little
38. Having the time, technology, resources and personnel to establish, maintain and develop propoer case discussions. This needs to be a continual process with a proper data-base and data manager that can be updated at any time by any apporved individual. Not a one off episode hurriedly compiled by overstretched staff
39. good organisation and effectiveness - this does not necessarily mean that all members of the "core" as specified by IOG should be a part of the haematology MDT - members can take part is other meetings which are more effective for patient care (e.g. palliative care).
40. good organisation - MDT co-ordinator essential radiology/histopath preparation time mutual respect and listening
41. Good IT backup to enable teleconferencing. Secertarial support. Engaging members during meetings. Good turnouts. Consultants responsible for a patient's care being present. Familiarity with all patients discussed.
42. Good clinical & diagnostic service interface. Good data collection & trials coordination. Documentation & standardised approache wherever possible.
43. good chaimanship, cover for absentee members, accurate minutes
44. Good attendance by all core members. Good admin support, good data support
45. GOOD ACCESS TO RADIOLOGY AND PATHOLOGY OPINION, PLUS INPUT FROM WELL INFORMED RESPECTED COLLEAGUES WHO ARE THOROUGHLY CONVERSANT WITH THE MEDICAL FIELD
46. Full review of investigations and diagnosis and discussion on management. This all requires adequate support
47. Full membership: our 'M'DT is plagued by absences possibly because, by geography, it serves too small a population
48. focussed discussion, up to date knowledge, availability of key specialists, correct MDT preparation and agreed documentation of outcome. A good chair is essential

as well as availability of clinical trials co-ordinators to ensure consideration of all pts for potential studies. video-conferencing at present is still inadequate for haemato-oncology MDT's where resolution of images and slow data transfer due to banwith issues remains problematic.

49. Focus on cases that are difficult, note cases that are straightforward, good chairing, better video-conferencing equipment than we have, true team rather than cancer centre telling unit what to do!
50. face to face meeting on one site good preparation good professional relationships
51. Evidence based decision making Effective secretarial support (MDT co ordinator & data collector) Effective decision making
52. equal participation in discussions rather than dominant opinions from teaching hospitals, listenning to all patients being discussed across the region rather than just ours, good quality images etc
53. EFFICIENT COORDINATOR REAL TIME DATA INPUT GOOD CHAIR
54. Effective Leadership & Teamwork Adequate staff and time resources
55. effective IT for teleconference. standardised case presentation. concise presentations and consistency of decision making
56. Effective and committed people. Data support
57. discussion that contrubutes to or supports treatment decision making
58. Discussion of cases where there are issues that are difficult/important to discuss. Not fruitless discussion of cases for the sake of inclusivity.
59. Discusses all the patients, at diagnosis and at relapse/rogression All the relevant professionals present Agreed diagnosis and treatment plan recorded Data collected so that audit and research can be carried out Possible trial entry dicussed ADEQUATE time for dicussion
60. core' memberships so that diagnosis and management can be discussed; availability of results necessary to reach decisions
61. Consulants with time in their job plans to prepare and attend MDT meetings. A good coordinator with skills and time to do the job properly.
62. Committment, agenda, direction, well chaired
63. Commitment to the process. Good communication and listening skills. Availability of notes and results
64. Co-ordinator support, attendance of team members, multi-disciplinary approach, time in job plan to attend
65. Clinical discussion time ie evidence base etc. encouraging participation of all
66. clear roles- diagnostic and treatment planning separated from the extended care delivery team
67. clear comprehensive policy, well organised in advance, chaired, good projection facilities, outcome typed up real time, actions and person responsible for them from MDT clearly identified
68. buy in from all concerned
69. Buy-in from all those involved Building on the best of current practice and not inventing something new and unwieldy Talking to the professionals involved and trying to get a model that fits into the local situation Not having a tick box mentality Being flexible about the 500,000 population requirement so as not to force awkward mergers Having effective co-ordinators Not trying to do it without any resource Good IT support Understanding things such as the difficulty of having CNS input at the time of diagnosis when they may not have met or formed a real knowledge of the patient, yet insisting that they attend the whole meeting Understanding the impact on radiology and pathology resources
70. Approriate core members with wide knowledge base, an ability to discuss dificult cases sensibly and amicably. A good system for making sure all patients that ned to be discussed are and that accurate records of the MDT and decisions are kept and can be accessed by all members of the MDT.
71. appropriate membership, suport and good team working with videoconferencing round region
72. an effective chairperson, all members being present, up to date technology to display slides, radiology, text etc
73. All notes available Precise presentations with a specific question healthy debate

74. all material available for discussion
75. All diagnostic data discussed on all new and relapsed patients. All disciplines regularly attending and participating in all cases. Cases discussed in terms of network agreed guidelines Careful documentation of all decisions Audit etc etc Sorry this is a ridiculous question
76. Adequate time from histologists, radiologists & the physicians Adequate data collection personnel
77. active and effective discussion and review of each patient's case
78. Able to discuss cases in an evidence based way and resolve conflicts without predjudice.
79. a well run meeting with contributions from pathology, radiology, clinical teams including clinical oncology and haematology. Good IT support and clear projection from both microscopy and radiology.
80. A team that is able to review the management of all patients with a haematological malignancy at the time of their first presentation and any subsequent relapse. The discussion needs to be brief and focussed. The patient's clinical and other problems need to be familiar to at least one of the medical staff attending the MDT meeting.
81. A skilled co-ordinator familiar with terminology and therefore able to make the MDT run rather than simply collect data. Team members that understand the intention is for the care plan to be discussed rather than simply agreed.
82. a group of clinicans (doctors,nurses,diagnostic laboratory staff)sharing by regular discussion diagostic and treatment decisions based on guidelines agreed by the MDT. The participants must be committed to regular attendance and comfortable to debate and if necessary challenge in a constructive way patient management proposals. Decisions must be acurately minuted and those minutes distributed in a timely way. There must be the means to record the decsions in the case record in order that they inform the next consultation with the patient.
83. 1. Qualified MDT co-ordinator with specified duties 2. Data collection 3. As many members of the MDT directly involved with the care of patients being discussed. 4. Investmnet in IT in a more effective way. 5. Flexibility. The national cut off of 500,000 population is far too big for some diseases and doesn't nescessarily address my point 3 above.

The team

What qualities make a good MDT chair/leader?

51 haematologists responded to this question.

1. Well organised. Knows all the pros and cons of treatment options
2. Well organised, open to views of others, promotes full discussion
3. well informed, respectful of colleagues
4. we rotate (between the core medical members but not histo or radiology) and i feel this is important - we have a policy which include the responsibilities clearly defined - keeping the mdt moving and getting clear decisions or deferring discussion
5. We don't formaise a leader/chair. Maybe we are more democratic and happen to work well together. We always arrive at an agreed group decision and no one would need to overrule it.
6. To have the confidence of his/her colleagues
7. Time management, clarity or purpose
8. Time management
9. Succinct - listens to others
10. Standard leadership stuff
11. see above.plus msut be able to multitask or have good support from trust for time, administrative.

12. Respected, sense of humour
13. Respected as clinician by colleagues
14. respect; formal structure to meeting, a bit bossy
15. Respect of MDT group Commitment to MDT process General chair skills: control of meeting, timekeeping
16. Our usual chair facilitates thorough but not necessarily lengthy discussion, ensures decisions are made and repeats these to check there is consensus.
17. organised, firm but with a sense of humour
18. Organised, clinical skills in the area of the MDT
19. Leadership, respect and a high level of medical and emotional competance
20. Leadership qualities
21. Keep the meeting moving, allow all to have an input
22. Keep discussion focussed. Aim for unanimous decision on treatment to be adopted. Able to summarise discussion succinctly, accurately and unambiguously.
23. Insight into the specialty. Able to cooperate with others including those outside own field. Open mindedness.
24. I think it should be a clinician who is a recognised expert in the field who can lead the discussion
25. Good overall knowledge of the diseases and their treatment Time and people manangement skills Ability to listen to and respect opinions but to identify consensus Good relationship with co-ordinator
26. Good organisational & commuication skills, up to date knowledge in the field.
27. Good organisation and communication skills
28. Good communicator, able to listen also
29. General qualities of anyone chairing a meeting (have you seen the John Clees video?) timekeeping, including relevent members in decision making, ensuring accurate documentation of decisions etc etc
30. Firm, fair, respected by the team, genuinely caring.
31. FAIR, INCLUSIVE, GOOD TIME MANAGEMENT
32. Expert knowledge
33. Experience in the field.A good listener. An inclusive style.
34. experience
35. Effective governance, communications, time keeping & democratic
36. direct and to the point, good time-keeper, very good at politely shutting up people who get off track
37. Decisiveness. Time keeping. Involving relevant players eg CNS. Routine flow from Hx > imaging > Histo> Decision. Leaping all over the place or making a decision without all the facts is foolish. Shouldn't be the pt's own doctor and probably not the lymphoma expert chairing the lymphoma MDM - encourages random digression and showing off
38. Communication skills
39. Comes to the meetings Prepares for the meeting Promotes discussion Ensures surgeonslisten to others
40. Clinically experienced, respected, sensible and flexible.
41. clarity, excellent time keeping, good humour
42. Ckear organised thinker. Leadership qualities
43. being concise & clear
44. Awareness of how to create discussion, when to conclude discussion how to avoid discussion of issues completely unrelated to the MDT!
45. Attendance, encouragement of team member roles, clear vision of what can and can't be achieved in time available
46. Ability to summarise and invite all opinions
47. Ability to manage MDT meetings well with clear direction, keeping to time, ensuring members come to the meeting prepared in advance, ensuring support mechanisms are in place, identifying audits are carried out, ability to ensure all members communicate well with each other. Identifying new treatment modalities and preparing business cases for high cost or new therapies which the MDT have identified as being necessary. Working with Trust management to ensure that the

resources are in place to support the MDT. Ensuring the MDT is working to Peer Review standards and auditing the MDT against the standards regularly and not just pre visits.

48. Ability to maintain an orderly and timely approach to MDT meeting with adequate preparation
49. Ability to direct the discussion to keep it on track. Encouraging contributions. Efficiency of agenda and treatment decision dissemination. GSOH.
50. a multi-tasker who is approachable and reliable
51. 1. Experienced physician 2. Experience in chairing meetings 3. Experience in setting up and period of participation in an MDT. 4. Commitment

What types of training do MDT leaders require?

41 haematologists responded to this question.

1. Training in running meetings
2. Training in chairing meetings - in our case by video-conference
3. Time to do the job properly!
4. time management, conflict resolution training, recognition of personality types, IT training,
5. Time and people managemennt
6. stamina
7. specific training in person managemet. vcr training.
8. Purely facilitatory to the professionals gathered.
9. not sure if its defined in policy may not be necessary - its just keeping a meeting going with outcomes documented
10. none
11. No specific training required except seeing it done well may be helpful.
12. no special training if they have experience of managing teams and chairing meetings. If not will need training in these two areas
13. never had any and I chair 2 MDTs
14. Medical.
15. May not need any
16. learnt by attending meetings for some time before becoming chair
17. Leadership and chairing training
18. I believe you've got it or you haven't and training does little
19. How to chair/run a meeting (on time!). How to promote team working. Understadning the IOG agenda.
20. You can't teach the above [*referring to Q35*].
21. Group work, assertiveness, public communication, timekeeping
22. Good question - what is available??
23. generic chair skills
24. General leadership training
25. Experience is best
26. experience
27. Effective management skills
28. Doubt training really helps
29. Don't know
30. Diplomacy! Expertise in the field. Communication skills
31. Depends on the individual
32. Consultants should have acquired these skills in their training already which is why a doctor is probably an ideal person to lead the MDT
33. Who has the time to undertake them & who is qualified to give the training?
34. Communication skills. Possibly negotiating skills.Regular updates on their disease area.
35. Communication skills.

36. Communication skills
37. We already have too much training in everything we do. Please realise that we are all working under consdierable pressure to provide a clinical service in an increasingly regulated environment. I could spend all my time having mandatory training! keep it simple and practical
38. Communication
39. chairmanship techniques, presentation skills,
40. Chairing is a particular skill. It requires someone to be clear thinking, able to elicit information/views from others and able to help the group reach consensus. It requires an awareness of medical concepts, but does not necessarily have to be a medic.
41. 1. Arbitration 2. MDT work

What makes an MDT work well together?

46 haematologists responded to this question.

1. Willingness/desire of all participants to make it work.
2. willingness to listen to other views
3. Time for everyone invloved to have their say
4. The Health Service is very bad at dealing with interpersonal problems which do have an influence on good clinical practice. We do not have any issues but I know of MDTs that do.
5. Team working
6. team members listen to other opinions and take them on board, and members are committed to mDT working
7. Shared vision for effective good clinical management
8. Shared values and approaches to treatment. Good interpersonal relationships.
9. shared objectives and working e.g. protocol development days
10. See previous comments
11. Respect, excellent quality staff, good communication, confidence in other team members ability, dedication to the MDT by each member, good information availability
12. Respect for each others views and recognition that an individual may select the wrong treatment on occasion.
13. Respect
14. MDTs may well work for some disease sites. But not all haematology!
15. Patient focussed working.
16. Need to shut thebullies up
17. Mutual respect.
18. mutual respect.
19. mutual respect, clear goals, support for MDT working
20. Mutual respect
21. Mutual respect
22. members knowing each other well.Meeting face to face from time to time.Members valuing one another and having an understanding of the local problems that individuals may have to deal with9 eg differences in availablity of funding of treatment)
23. member communication
24. Keep all discussions patient centred Allocate tasks (documentation, presenting cases, diplaying results etc). Agreement on protocols/pathways
25. having a common understanding of the issues.
26. Good understanding of conditions discussed i.e.small number of conditions and good working relationships within team
27. Good team working, IT that works and people having the time available.
28. good communication

29. good chair, regular attendance and timeliness, respect for other members
30. good chair and professional respect and co -operation
31. Feeling that something definite has been achieved.
32. Excellent team functionality with everyone naturally appreciative of each other
33. Everyone having time to doing their role properly and being personally committed to the MDT process
34. effective communication and treating all with dignity and respect
35. Contributions from all members of the MDT
36. common goals mutual respect
37. common goal, engagement and committment to the process
38. common commitment to MDT process good interpersonal relationships good communication and delivery of agreed actions
39. clearly defined aims and goals and inter respect of the members
40. clear SOP
41. Chairing. Realisation as a group that it is a hugely expensive and time consuming exercise 18 consultants, 4 SpRs, 6 CNS etc for 3 hours. Must be slick and focussed - if it isn't relevant, shut up.
42. Agree the objectives of your MDT. Freely discuss opinions and hear opinions. Use the time to listen and learn.
43. A level playing field
44. A common ethos and acceptance of diversity.
45. 2-3 members see discussion has helpful rather than the MDT as a rubber stamping exercise
46. 1. Willingness of members to devote time to MDT. 2. Willingness or employers (and government) to invest in appropriate resources such as training and facilities and facilitators

Infrastructure for meetings

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

67 haematologists responded to this question.

1. Wasting the time of MDT member experts by spending time on matters irrelevant to them. They will soon fail to attend.
2. videoconferencing
3. Video conferencing or PACS not working
4. Video-conferencing (which we do) - a definite barrier to effective communication
5. Verbosity of contributors. A failure to reach clear management decisions.
6. too small a venuu and poor IT so cannot view xray and pathology images, poor temparature control
7. Too many people talking at once
8. time to discuss complex cases
9. time constraints.
10. Time and conflicting committments
11. Time
12. The lack of good Case conferencing facilities due to underspecified systems and a total lack of appropriate training
13. teleconferencing problems lack of preparation
14. teleconferencing - would be much better if we were all in the same room
15. technology not working
16. Technology failure
17. technology
18. support staff
19. Sub-optimal technology, especially in video-linking

20. THE ROOM NEEDS TO BE BIG ENOUGH TO HOUSE EVERYONE AND MUST BE WELCOMING TO THE MORE TIMID SPEAKERS
21. Room layout is less important than the team working issues. If the Chair ensures that all members are equally valued and their opinions sought then the team will wowrk more effectively
22. Reliability of videoconferencing faclities
23. Quality of video conferencing Availability of video conferencing
24. porr performance of technology eg video conferencing
25. Poor visibility of diagnostics and key members
26. poor visibility of diagnostics
27. Poor videoconference functionality - currently limited by triple ISDN connection
28. Poor venue or visual aids (computers/microscope/projection)
29. poor technology
30. Poor quality audiovisual equipment.
31. poor projection facilities, poor microscope, room not set up in advance
32. Poor or unreliable, poorly maintained VC facilites
33. Poor IT e.g. diffficulties with teleconferencing
34. poor IT and poor videoconferencing technology
35. Poor images, unable to hear what is being said
36. poor audiovisual equipment
37. poor acoustics, extraneous noise, mobile phones and blackberries.
38. Not having video links Poor projection facilities Poor sound system
39. Not being able to see the screen clearly
40. Not being able to hear or see what colleagues are saying or showing.
41. Not being able to hear (muttering on front row etc)
42. non-engagement of clinicians feeling that decisions do not take account of individual patient's condition and choices
43. Noise poor projection
44. No coordinator
45. MDT co-ordinator away
46. Lack of working equipment
47. LACK OF VIDEO-CONFERENCING
48. lack of technical support. lack of help with information retreval Inability of key members to attend
49. Lack of space
50. Lack of seats, poor view of radiology,poor ventilation.
51. Lack of IT to project proformas, radiology, histology (if shown, need for this is questionable but valsued by some attendees)
52. lACK OF A GOOD CHAIR
53. IT
54. IT
55. IT - ability to link across sites
56. interruptions e.g. mobile phones and poor IT
57. Insisting they cross disparate Trusts.
58. ineffective vcr, poor sound quality ,poor visual qulity.inexperience of players not aware of impact of secondary conversations
59. Having to travel to another geographical site to meet.
60. Good communications link
61. failure of video links (5 way video conference is our norm)
62. Failure of technology. Need for dedicated technical support
63. Failure of technology - eg can't see CT scans
64. Ensuring involvement of all by physical position
65. Crowded place Unreliable technology Uneccessary disruption and irrelevant discussion
66. Audiovisual equipment leads to a delay between sites making interaction difficult
67. access to room with appropriate facilities and iT issues for video-conferenced

MDTs; we do two V/conf MDTs/week and often have problems with the technology and there is no "help line" facility if there is a problem which wastes time for mDt members at both ends and potentially delays patients' treatment

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

66 haematologists responded to this question.

1. Would be good if we could get it to work effectively. Currently pixelated images and poor audio prevail despite all attempts to rectify
2. Working in a DGH with time constraints it is essential. No meeting takes place when the equipment fails which is not infrequenst
3. We use a webex system to connect with other hospitals not a video-conferencing system. Seeing our colleagues faces is not essential but hearing their views is. An added advantage is that they can use a PC/Microscope in their offices to share images with us. In my view this system is far superior to any video-conferencing facility i have ever seen demonstrated. The quality of the histopathology images is very good.
4. We have to have it as we have two sites - it is crucial
5. We have not adopted teleconferencing, but travel from our Trust to host Trust to attend meetings.
6. We are linked to an adjacent Trust and it is essential. We use it every time.
7. Very positive in enabling participation over a wide geographical area and therefore large population base. Some of the visual cues that are used in a face to face meeting are lost(eg expressions of disagreement, confusion, frustration).It seems to work well if participants do meet together from time to time and know each other quite well and understand the different personalities.
8. The communication at a distance tends to disenfranchise some members and demeans their contribution. It is harder to ensure that the members present at the other sites have equal opportunity to voice their views. They tend to stay for their own patients and then go.The technology is still too basic to make it an effective working pattern
9. Tends to inhibit proper discussion. Atmosphere is quite different when clinicians meet face-to-face
10. teleconferencing not good cos can't see other members or path/rad v/conferencing effective. easier if all members know each other and helpful if members visit the opposite end to understand any potential limitations/problems. needs a dedicated "help line" or IT support for technological problems
11. Teleconferencing is hard for us as we'd need 3 screens using current system (radiology/path and teleconference)
12. Teleconferencing has become a nescessary evil. Ideally smaller groups should meet for near-patient care and only cases requiring specialist input (such as stem cell transplants in haematology, relapses or complex rare cases) should be teleconferenced. Teleconferencing leads to lack of direct relation of decisions to individual patients. Moreover there is difficulty in participation of non-medical carers, such as nurses in teleconferenced MDTs for a number of reasons. This is something that needs to be addressed
13. Stifles discussion, images are not as good
14. Sometimes disrupts meeting
15. Slows it up substantially
16. Significantly cuts (wasted) travelling time. Rather less personal but worth it
17. saves HUGe amount of time- it would take us 2 hours each way to cambridge!!!
18. Quality of images hinders
19. Providing it is high quality and state of the art. Unfortunately ours is not with very good quality and we are applying for state of the art video teleconferencing
20. Prevents travelling but otherwise is only to ensure IOG compliance in terms of

population. Does not add anything additional for the patient in my view.

21. Positive: it allows for very good attendance and contributions from a large number of members Negative: it can stultify discussion
22. Positive: ease of attending Negative: difficult to communicate with someone you can only half see. Poor sound systems mean you cannot hear properly. people talking together, no real personal interaction
23. Positive impact
24. Positive
25. Positive - easier to attend. Negative - lose nuances, relationships harder to forge.
26. positive- regular attendance negative- poor quality images, barriers for long discussions
27. People JUST dial in for their own patients and there is never a true across Trust discussions. It also leads to fragmented discussions and ends up being a "tick box" exercise with little educational value.
28. People at remote sites do not fully participate in MDT discussions
29. Our MDT involves 2 Trusts some distance apart, videoconferencing allows the MDT to meet weekly, with efficient use of all members time
30. Only used to agree care pathways/protocols etc, otherwise time consuming
31. Not relevant for our location. XR conferences held seperately as XR doctors are not available at the time of the MDT (not because they cannot come to the room)
32. not good for teamworking where social interaction can be very fruitful in bringing teams together. allows people to switch on or off more and can make discussion very fragmented. technology is not robust with links often going down.
33. No experience but imagine they would slow it down and inhibit free flow of discussion
34. Never works do to IT failures at the Cancer centre
35. Negative - a barrier to good communication
36. MORE CUMBERSOME, SLOWER
37. Might improve attendance by clinical oncology
38. Meetings can be tedious when videoconferencing equipment malfunctions, which, in the several units I have worked, is a recurrent problem.Visual and sound interfernece/delay is common.
39. Makes "team" interaction even less real-world.
40. Less travel
41. Lack of reliability of system has negative impact. Poor interaction because of time delay. poor quality of televised histology
42. key to the whole thing - our videoconferencing is so bad we now travel to other hospitals rather than use it
43. Its very poor quality and often fails
44. it regulary fails! very negative
45. it means i can attend
46. It is more effective to have everyone in same room but this is far outweighed by advantages of ability to participate regulary. With practice and committment MDT members soon learn VC etiquette
47. It is a poor substitute foreveryonerbeinginthe same room
48. it allows all to be present but I prefer to see people so video-conferencing better. overall i prefer to have people in same room if at all possible
49. It's dreadful. You can't see the scans/histology at the other sites well enough to make a decision on anything. You can't see who wants to speak next so either everyone speaks at once or there are long silences. The link often shuts down in the middle of the meeting or the sound quality is not adequate. Once there are more than 2 centres linked, each site gets a small corner of the TV screen to show their cases - can't see a thing without going and standing close to the TV. We have had to put our MDT back on to single sites due to failure of the technology, which means that each site only gets an MDT alternate weeks.
50. I have no practical experience of this.
51. Hopeless delays in transmission of radiology/pathology images. Speech clipping
52. Harder to keep to ime priorities alter (those linking in get priority)

53. Group etiquette across cyberspace, awareness of non-verbal communication need to be considered - can be negative features.
54. formalises discussions and promotes clear decision making longwinded histology and radiology reviews can be very boring and divert from clinical decisions
55. excellent to allow all to participate when working well but often does not have appropriate support - then risks wasting man manhours trying to fix problems
56. enables widespread teams to participate without travel
57. enables cross trust MDT , as needed for Haem MDT numbers, without travel. Far more time efficient. Allows weekly MDTs.
58. Disruptive, breaks flow of conversation
59. Delays, difficult to have discussions, failure of equipment, but no other practical way to attend
60. Clinicians' time saving
61. can become undisciplined
62. Can't see all members at the same time so don't know who is speaking, sound quality poor especially if >1 person talking
63. brings people together
64. allows members from different hospitals to participate but can delay things when there are technical hitches
65. aids attendance -positive cuts travel time - positive different quality of interaction with colleagues - negative regular technology problems - negative
66. Affects interaction adversely

What additional technology do you think could enhance MDT effectiveness?

49 haematologists responded to this question.

1. where EPR, simulataneous access for MDT members
2. webex
3. We have the facility but have been unable to make it happen
4. video-conferencing may help attendance
5. unsure
6. Teleport
7. State of the art reliable VC
8. State of the art equipment, dedicated technical support.
9. Standards for videoconferencingto be as good as they arefor network television
10. Something that works better
11. SOmeone to manage and maintain the VC facilities across several sites
12. Skype and a web-cam from our desks
13. robust database
14. Radilogy/pathology links across hospital sites
15. Quality links and adequate technical support
16. printers and scanners
17. Potentially individual computer points so that videoing is on the computer monitor and not projected giving better definition of images. Improvements in technology will probably address the down sides
18. on tap coffee and buns
19. newer broad band facility
20. N3
21. Just everything state of the art. As there are so many high expectations of the mdt nothing less will suffice
22. it support to get the most out of it. training to use it.
23. IT support staff present
24. Improved videoconferencing equipment - the best available, with available knowledgeable techincal help immediately available.
25. Improved video-conferencing
26. Improved resolution across all sites
27. Improved histology image projection
28. iF RADIOLOGY IMAGES COULD BE PROJECTED ONTO A SCREEN
29. Good interface
30. good backup from IT staff and up to date equipment that works
31. Getting systems in place that actually work and can have more than one Trust "live" at a time.
32. Faster IT (radiology PACS)
33. Electronic MDT system that could be used across trusts to build MDT lists and record decisions
34. easy tertiary centre links by videoconferencing
35. Dual screens
36. Digital camera on haematologists mciroscopes to capture images for presentation at MDT
37. Dedicated technical support. Training in the use of VC. A combined MDT and Electronic Cancer Data-base
38. clerical support
39. Better VC link, ability to focus in on different individuals while they are talking
40. Better quality of what there is.
41. Better quality kit and attention to fire walls and other obstructions
42. Better projection for the video conferencing. Direct Radiology link between sites so

we can project the scans directly rather than look at scans on the other site by the TV link. Reliable video conferencing that doesn't shut down after an hour because the people that run it have decided that our two hour booked meeting must have finished by now. Need I continue?

43. Better database to enable audit / outcomes searches etc
44. better and more immedite back up for when things go wrong
45. Acess radiology etc from all hospitals in the MDR network.
46. Abolish time delay between sites
47. Ability to project pathology with sufficient definition to make it worthwhile
48. A better database for storing data and MDT decisions.
49. ???

Meeting organisation and logistics

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

77 haematologists responded to this question.

1. WRITING PATIENT PROFORMA RESEARCHING TREATMETN OPTIONS
2. Write up of patient history, collation of investigations, digital images of blood and marrow slides where relevant
3. Wherever possible all patients must have a completed minimal data set for their particular condition. A list of patients needs to be compiled under headings new patient, follow up patient, hot cases (urgent review of histology to guide futher investigation etc) The list needs to be shared with all participants. Ideally the radiologist and Histopathologist need time prior to the meeting to review scans, histology etc. A completed histology report needs to be available before any definitive treatment is decided on. Update of an electronic data set by a data manager in agreement with clinican in charge. Technology (videoconferencing etc needs to be checked prior to the meeting by someone with responsibility for the tecnology) All too often the technology is poorly understood and fails.
4. Understanding precise clinical scenario for each patient; checking whether pathology & imaging tests have been sent to Trust which hosts our Network MDM; reviewing BM aspirate slides / results & checking immunophenotyping / cytogenetics results prior to attending.
5. time to refresh memory of patient and disease. all results and questions needed to be asked
6. the case historys should be known and all histology and scans available
7. Summary of clinical case; photographs of histology slides and key x-rays into powerpoint; partial completion of MDT proforma;notification of cases to histology and radiology and mdt co-ordinator; initial identification of cases is important and one of the most difiicult aspects of haematology mdt due to acute nature of many cases and varied routes of referrals.
8. Summary of case,consideration of treatment options-may need to look uo local or national guidelines for the rarer cases. Our MDT coordinator prepares a powerpoint presentation of all the case summaries which is projected via video-conferencing.
9. Summary of case by presenting physician. Collation of results, ensuring test required have been performed
10. someone needs to be fully informed about the patient's situation, co-morbidities which may affect the decision making process and alter the treatment modalities which should be offered. All the staging needs to be in place, the potential for inclusion in trials identified, the patients own views about their disease and any views about treatment strategies if at all possible
11. review results, review possible treatment options etc
12. review of notes / results / scans / histology so that the case can be effectively

presented and a decision made

13. Rehearsing histories, checking which patients have had which tests, reviewing X-rays / histology. In some cases, reviewing literature to help decide treatment for rare situations
14. Referrer needs to identify decisions to be made by MDT. MDT coordinator needs to find notes and provide access to results/radiology etc. MDT has agreed patient pathways
15. Read through case summaries of each other's patients prior to meeting. If necessary, check on available clinical trials or up-to-date literature which may be suitable for patients discussed.
16. Radiology Histopathology / haematology
17. proper case presentation with the question being asked clearly defined. Haem-oncology MDTs differ from solid tumours where majority of the discussion is around the diagnosis. In haemato-oncology most cases are relapsed or suspected relapsed cases and patients are brought back on multiple occassions for discussion. It is important therfore to have a proper case history of the patient with the reason for discussion at MDT being highlighted. All investigations should be performed and results available at the time of MDT. Physicians who request pts to be listed for MDT discussion should be at the MDT unless there are exceptional reasons why not.
18. Preparing case summaries and collating results
19. preparation proformas for referral, finding results, liaising with co-ordinator
20. Preparation of SMDT referral documents, review of notes and results.
21. Preparation of patient presentation to MDT, completion of MDT forms
22. preparation of case summary - this may sometimes cover up to 20 years
23. Preparation is very important but need support to achieve this and currently not possible
24. preparation & circulation of agenda, finding casenotes, imaging & relevant results: synopsis of case prepared by responsible clinician
25. pepare case histories, check minutes of previous meetings
26. patinet identifaction clincal summary notes finding ct reviews and finding pathology reveiws and sample finding meeting arrangem,ents/IT links
27. patient information, histology reveiw, prior x ray reveiw.
28. organisation and input of data into MDT proforma, diagnostic meeting with input into MDT proformas, review of case notes, literature review if applicable.
29. Needs to be good documentation of consultation in clinic setting (not necessarily by myself) and comprehensive gathering of results. Images are reviewed in advance, and all pathology is reviewed in a timely manner. The reports resulting from these separate reviews need to be available.
30. Needs to be a list of patients Relevant info needs to be prepared A clinician who will be at the meeting needs to know they are responsible for presenting the patient
31. More time to report marrows and fil lout the numerous forms
32. MDT barely recognised in job plan never mind preparation, checking of minutes etc. ideally need to prepare better so that we can concentrate on relavent questions and not be side-tracked by things that don't need discussion
33. making sure correct patients on list, collection of all important information, preparation of room, all members informed
34. Lead clinical consultant or SpR to summarise case on meeting proforma. Diagnostics to have been reviewed by radiology/pathology. Minimum dataset collection to be underway. Research nurses aware.
35. Knowledge of the exact clinical question that you wish to put to your colleagues in order to reach a decision for the patient's care.
36. Individual doctors have to be fully conversant with the details of their case. The MDT coordinator needs to be fully prepared - notes, venue etc..
37. I need to produce a concise case history and re-review all diagnostic material
38. Histology preparation and case presentation preparation.
39. Greatest burden falls on Radiologists looking at cross-sectoinal images. Clinical preparation has often been doen at recent clinic visits or ward-rounds/ward

referrals. Secondary reporting of difficult lymphomas needs to be collated if possible before the meeting.

40. good knolwegde of case to be presented all available results that may be relevant to descion making available some prlimainary idea of patients feelings about treament options
41. Getting case histories, results of tests, imaging, filling out forms etc
42. For medical staff: review of cases to ensure familiarity when it comes to discussing patients. For MDT co-ordinator: collation of notes, x-rays, radiology and pre-completion of data items on database.
43. Filling in referral forms. Ensuring images are being burnt to disc and sent to the meeting. Ensuring biopsy samples are available. Ensuring clinical data is readily available
44. Filling in of the parts of the forms that are possible pre-meeting. Availability of relevant pathology, imaging etc.
45. Familiarity with case notes, invests
46. Ensuring that all information is available for review. Time for radiology and histopathology to review case materila in advance.
47. Ensuring information required is available. Ensuring it is clear what question is to be adressed regarding each patient
48. Each patient case is "presented" by someone who prepares the electronic proforma. This requires review of the history, clinical findings, social situation and investigations. We perform a separte diagnostic meeting (could be considered a form of MDT?). A meting list ned to be circulated at least 24-36hrs in advance of the meeting to allow time for radiologists to review imaging.
49. Draw up agenda of cases. Email agenda to attendees. Core members to prepare for meeting. E.g. radiologist reviews imaging, histopathologist reviews slides, haematologist reviews notes and prepares written case summary for MDT registration form. MDT co-ordinator makes sure room is available and functional
50. Completion of data proforma, blood tests, print out, send away test results, histology sent for review, scans sent to radiology for review
51. COMPLETE THE MDT FORM WHICH SUMMARISES THE PATIENT'S DETAILS AND READ THE PATIENTS' SUMMARIES BEING SUBMITTED BY OTHER CONSULTANTS
52. Communication with MDT co-ordinator to list patients for discussion. Filling in MDT proforma from case notes and x-ray reports. Some thought about which aspects of case need to be discussed. Time to look at cases for other colleagues who cannot be present, so that their cases may be discussed.
53. Collection of information, adequacy of staging, scheduling
54. Collection and distribution of cases and all available diagnostic materials scans/pathology in particular
55. collation of results, previous correspondence , gathering of results from regional centres where apropriateMDT form compilation. Projection of histological /morphological material Radiological material . Insufficient time to collate data unless weekend hours set aside . usually the no of cases in a large trust do not allow all concerns top be addressed.
56. Collation of list Review by radiologist and pathologist prior to meeting Each patient presentation should be prepared in advance and green form completed or someone nominated to present if A/L
57. Collation of history and patient information to complete proforma prior to meeting, and time to liase with coordinator
58. Collation of clinical history, histology, imaging etc. Preparation of presentation of cases.
59. collating tests doen on patients looking for best evidence to manage patients
60. Collating patient information and submitting to the MDT co-ordinator Because haematologists are also pathologists we are involved in making the diagnosis on each patient by looking at blood films, bone marrows and trephines, and interpreting FACS, cytogenetics and molecular diagnostics to provide a diagnostic report so you can add 30 minutes at least for each patient
61. Collating all diagnostics
62. clinicians familiar with patient and history/performance status etc and for

subsequent treatments, prior treatments given radiol and histopath review
63. clinical summary, collation of notes, reports, images, pathology
64. Clinical summary All tests reported & results available
65. Clinical knowledge of the cases. I would spend longer if it was avaialble but too busy to do so at present
66. Clerical- collection of notes and ensuring all relevant letters and results are present. printing off results of all path and radiology, haematology and biochemistry results to be discussed. Radiology and path to ensure final written report of material to be presented is done before meeting. NO on the hoof reporting at the MDT. If central review of any imaging or path this must be sent in befire and not presetned until written reports are done. list preparation, correlation of referrals and circulation to those that need to present. No discussion without full details of pt and results known.
67. Checking which results are available. Insertion of appropriate clinical details and results onto MDT proforma
68. Cases prepared and appropriate material sought. I also prepare powerpoint slides for my cases
69. Case notes, Xrays and pathology slides made available, list of patients to be discussed circulated, summary of case prepared, confirmationof time and place of meeting
70. case note review form filling collating results
71. Case note review
72. Assessement of the case notes to ensure slick presentation. My job plan is so full i never have the time to prepare before the MDT. However i do know the patients well and i know 2 days before who is on the mdt list
73. clinic letters, notes, investigation results including radiology, histopathology reports, blood results & clinical status with a completed MDT template
74. All results to be available
75. Again, presumes MDTs are effective for haematology. They are not, and I know this to be an almost universal view amongst haematologists. Selected lymphoma patients would be a different matter.
76. Accurate and complete MDM form completion, ensure all pts listed, review of literature for complex patients,
77. 1. Submitting cases to the MDT 2. Perusing MDT list in order to find out whether any particular problems can be researched before discussion

What makes an MDT meeting run effectively?

67 haematologists responded to this question.

1. when the it systems work (which they never seen to do)
2. Well organised, good preparation of cases for presentation, not too many cases to allow time for discussion, all core staff present throughout meeting
3. well chaired, all info available, members disciplined
4. We have video-conferenced MDT - we don't have time in job plans to sit through all 20-30 cases being discussed across network, so need realistic time slots to discuss our patients. VC links need to be vastly improved and only ONE person should speak at any one time - this is VERY difficult to achieve by video-link. There should be a summary of decisions made on each case at the end of discussion before moving on to the next case
5. We have insufficient IT support and the system can cause problems. PACS in our hospital is slow and of late frequently crashes making review of images difficult and sometimes impossible. Needs a good chair to summarise/ focus the group on reaching a concensus
6. Timekeeping & Chairing skills
7. Time management / chairing effectively, having key memebers present
8. The relationships between the participants.

9. The notion (Q18) that 15 or more patients are assumed to be discussed appropraitely in this time frame is nonsense. Routine cases can be left to normal data collection mechanisms. The MDT is for discussion!
10. Strong leadership of the meeting Organisation of the meeting beforehand
11. strong chair. good time keeping with prompt start and finish. not allowing discussions to go off track. avoid multiple local conversations . ensure that question being asked is addressed and that everyone is happy with the documented outcome.
12. Strong chair. Sticking to relevant information. Having all informationeasily available. only discussing cases where information is available.
13. Starting on time with all core members present and functioning technology. All aspects of cases avaialble for discussion - notes, radiology and histology and someone at the meeting that knows the patient
14. Speedy decisions, less pontificating, active chairmanship, not discussing pts when info not available, repeated listings week after week, batching easy cases eg CLL stage 0/1, MGUS into preMDM session and signed off by chair to free time for proper stuff.
15. slick presentations and good chair
16. Ruthless chairmanship A clinician who has actually met the patient... Quick access to data
17. Preparation, preparation, preparation. Consultants being present when their patients are discussed.
18. Preparation, effective coordianation, reliable VC facilities
19. Preparation by all involved
20. Preparation beforehand Good relationship between attendees Good IT Effective chair
21. Preparation Discipline Reliable technology
22. People turning up on time - difficult in busy schedules. We have an agreement to turn our DECT phones off otherwise there is constant disturbance. Attention by all is very important hence once a meeting goes over about 90min it becomes very hard to concentrate
23. Notes & machinery all working properly; people turn up on time; more time from histologists so we can discuss patients case by case rather than do histology list then start the list again with radiology
24. Not too many cases. Snacks and beverages. IT support readily available.
25. Needs to be well chaired; relies on all those bringing cases having prepared things beforehand; need enough core members to reach right decision(s); clear post-MDM recording & feedback processes to support feedback / discussion with patients of MDM outcomes.
26. IT facilities, access to notes and results. members of MDT present to consider treatment options
27. in our model we link with tertiary center to discuss the histopath and scans for the treatment plan and then take that to the extended team to discuss delivery- this makes best use of everyone's time as histopath don't want to discuss stairlifts and nurses are not too interested in the detailed marker studies
28. If it involves videoconferencing then the equipment has to be adequate I dislike the meetings mainly because of the inadequacies of the equipment
29. I feel that many straight forward cases which meet agreed minimal data criteria should be flagged up at the meeting and not discussed in detail. E.G. CLL MGUS ET LEAVING TIME FOR THE MORE COMPLEX CASES. In many ways the new cases are more straight forward than the relapsed ones but are usually given more prominance.
30. Good preparation. Reliable functioning of IT and videoconferencing equipment. Good discipline amongst team members. Good videoconferencing etiquette.
31. good preparation and IT
32. Good preparation and good chairing.
33. good preparation good working relationships between core members
34. good participation of all converned adherance to basic rules of behaviour during teleconferencing lack of technology failures/gremlins

35. Good organisation and presence of all team members
36. good organisation and a good chair.
37. good MDT etiquette. All imaging and histology available. Good chairmanship. Functioning equipment. Good representation from core members. Preferbly physical attendance rather than video
38. Good IT support. Good working relationship with colleagues especailly those in the other disciplines.
39. Good communication and listening. Availability of all information
40. good chairmanship, concise presentation of cases
41. good chairmanship + video link working well
42. Good Chairman - succinct contributions
43. Good chair, all data available, succint presentations
44. good chair - good IT - good mdt co-ordinator - minimized bureacracy - avoiding discussion of uncontroversial and simple cases
45. Focused discussions
46. Ensuring that the person requesting MDT discussion is present at the meeting and/or that the MDT is clear on the question that it is being asked to decide upon. Having a database that is suited to its purpose. The Chairperson takes control of the meeting and is good at summarising the discussion succinctly, accurately and unambigously.
47. Efficient knowledgable chairman. Short clear presentations from pathology and radiology
48. Effective time managment & data collection
49. Effective chairing, full participation by all full members, availability of all required notes etc. presence of co-ordinator.
50. effective chair and good preparation and time for the meeting
51. Effcetive chairing to keep the discussion relevant. Avoiding cases brought for review of imaging - as in a traditional "X-ray meeting", but time is needed for this function elsewhere.
52. Don't think they are
53. congenialty between members and lack of intimidation for free participation
54. Concise presentaion and all notes and results being available
55. Clear agenda, with clear reasons for why a patient is being discussed. What question is hte MDT being asked to address. Is is primary treatment, failure to respond to treatment and potential for second line treatment, intolerance requiring transfer to an alternative treatment, a decision to withdraw treatment because of failure to respond or just informing the MDT or completion of treatment and most recent staging results. What makes it run poorly is when no one knows the patient being discussed, someone reads the notes aloud trying to ascertain the patients situation and a decision is sought on the basis of what is gleaned from the notes which are often incomplete and sometimes inaccurate
56. Chairing, not too long a list.
57. Cases notified to meeting in good time. Notes available to refresh memory. Clinical staff who have seen patient are present
58. Being prepared. Concise summaries. ready access to imaging / results etc
59. Avoid over-long agendas. Focus on decision- making rather than "interest" factors. Adequate support staff & facilities.
60. Availability of results, attendance of core members and presence of individual that has seen and assessed the patient, for a patient-orientated decision
61. as previous the committment and engagement of all members of the team and good organisational and chairmanship skills.
62. having all information available - written reports. Technology that works. Clerical support
63. ABILITY TO DIRECT THE DISCUSSION TO REACH A CONCLUSION AND TO LIMIT CHIT-CHAT. ABILITY TO SUMMARIES SUCCINCTLY THE OUTCOME OF THE DISCUSSION. GOOD TIME MANAGEMENT.
64. A suitable disease site e.g. breast/colon/lung where different specialties need to make joint plans on management.

65. A good chairman
66. A competent chairman. Concise contributions by core members.
67. 1. Preparation by all individuals including succinct clinical summaries and minimal datasets 2. Discussion by disease

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?

51 haematologists responded to this question.

1. We talk to each other in the clinic
2. we cannot cope with multiply relapsed myeloma pts. The workload is too high
3. Ward round or pre-clinic meeting
4. variable depending on disease & comorbidities
5. Urgent treatment decisions should not be delayed.However all patients should be eventually presented to MDT
6. They should be discussed at an MDT
7. these patients will always be discussed but do not have to wait for MDT agreement if that would slow the process to treatment
8. These are the most important patients to bring to a proper "discussion MDT", not the new cases where pathways are clear.
9. Standar agreed protoccols if available with difficult patients brought back to the MDT, or where MDT agreement on certain therapy is required
10. Sometimes timing will make it impractical for such patients to be discussed prior to decisions about management. In these situations then experts will need to discuss the case outside of an MDT, but seeking similar consensus and multidisciplinary support.
11. Some will be suitable for discussion at MDT, others not - I would have thought that's obvious.
12. Small group dicussions outsde the MDT.
13. Should go thro MDT but potentially this should be a different MDT from the diagnostic/first treatment MDT and should ideally include pall care medical and clinical oncology
14. Should be discussed in some format
15. should always be discussed at MDT
16. Recurrence options can be discussed at intial MDT. Multi-relapsed patient would paralyse the MDT meetings.
17. previous MDT could make provisional plans in event of further disease
18. Peer to peer discussion
19. Patients with relapse/refractory high grade lymphoma or leukaemia need immediate treatment and cannot wait for MDT discussion. Treatment protocols for these patients should be in place and one might consider contacting the lead in the MDT for the tumour type to discuss management.
20. Patient treatment choices should be determined by the medical staff seeing them in clinic or on the ward. "MDT"s could have a role in discussing difficult or multidisciplinary issues. Patients do not want to be managed by faceless "teams" with no trusted individual responsible for those decisions.
21. Only other way is informal 'in the corridor' discussions between specialists/CNS's
22. None. These are the very patients where discussion in MDT is needed.
23. MDT is not appropriate for simply discussing palliation - this needs to be local MDT discussion
24. Local meeting, e.g. ward meeting

25. local mdts may be more effective, more patient involvement together with the cns
26. Local discussion between consultants who know the pt with involvement of local CNS. DGH consultants usually have little to add to decisions made by teaching hospital consultants. Trials should be advertised through MDM but not feasible to discuss every pt at every stage and nonproductive if the MDM very rarely changes the preMDM plan.
27. Local care teams should look after these pts according to agreed treatment guidlines
28. Individual doctor decides (thisis what happens in practice)
29. ideally shoud be through MDT but needs to be individualised and encourage pier review
30. I think they should be discussed at MDT - they are often more difficult decisions than at presentation
31. i think there is room to respect professional discretion about whether there is benefit to discussion of cases ahead of making decisions - it is valuable to note such discussions at MDT to identify any patterns / variations in approach between members and to help develop agreed second and third line management protocols
32. Following agreed treatment protocols/algorithms.
33. Follow protocols / enter into trials
34. Experience and informal discussion with colleagues if required is more than adequate.MDTs would be completely overrrun if all releases were to be discussed. We bring more difficult ones back to the MDT for discussion already.
35. Engagement of key clinicians and their advice
36. dont know - in context of lymphoma these decisions really shd be made by the MDT- often more difficult than at presentation
37. Discussion with colleagues, clinical nurse specialist, GP, palliative care ie MDT members even if not brought to full MDT
38. Discussion with colleagues in the clinical team managing the patient +/- palliative care help.
39. discussion with clinician. It is not feasible - or usually necessary - to discuss every relapse in diseases prone to multiple relapses
40. Difficult. In practice there is insufficient time and resources to include all cases both new and relapsed and hot cases, which may or may not turn out to be cancer in every MDT. We would have an all day MDT every week with our colleagues in the adjacent trust. We need an on-going MDT/CANCER data-base with agreed treatment guidelines and documented discussions outside the actual MDT meeting. I have always been engaged in MDT discussions throughout my career and often consult many experts in a number of centres about particular cases. The MDT may not have the expertise to decide on a particular case and a national or international opinion may have to be sought. The current system is trying to be too restrictive. I can show that in everyone of my patients MDT decisions have been made but not necessary in one sitting! That is the other problem, not all test results are available at the MDT and the patient may have to be discussed at 2 or more MDTs and elsewhere.
41. descision process should be identical to new cases - ie through MDT
42. Depends on the nature of the case - further intensive chemotherapy options or a decision to convert to palliative treatment may need to be discussed, but often the original MDT decision includes consideration of what to do if disease progresses/ relapses
43. departmental meetings
44. Consultants should be able to make these decisions
45. consultant can speak informally to other colleagues if appropriate
46. clear protocols with only those patients who do not follow pathway or who are to receive high cost drugs are discussed
47. Based on experienced specialist relationship with patient. We must be trusted to make some decisions!
48. At least discussion with another colleague on the mdt
49. Agreed patient pathway, agreed by all members of MDT

50. Adeherence to an established and agreed network protocol. For instance relapse or progression of acute leukaemia results in patient entry onto a national protocol, first progression of myeloma is the only situation in which velcade can be obtained so the network policy is to apply at that time
51. Accepted 'protcols' within department and lead clinician for individual disease entities in case of difficulties. It is more important that individuals are dealt with in a timely manner and that MDT time is focussed on new diagnoses and 'problem cases'.

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

61 haematologists responded to this question.

1. Treatment already started before listing (a once week meeting adds delay which is not always possible for aggressive tumours) and without all info. Consultant disregard for MDM decision because relevant parties absent. Pt condition changes to where intial decision inappropriate. Pt decides on alternative.
2. They are impractical, ill-informed, not based on an in-depth view of the patient's circumstances, or not made with the patient's involvement and agreement.
3. The patient declines (ie prefers some other viable strategy)
4. some members not abiding by decision. patient declining therapy advised. PCT failing to fund
5. So called expert has recommended treatment not funded by NHS/PCT & funding not available
6. PCT will not fund the drugs. Patient choice.
7. PAtinet wishes new information not present at mdt clinica changes between mdt and treatment
8. patients assessed by the clinician not to be suitable for the regimen chosen
9. patient wishes
10. Patient preference.
11. patient preference or change in performance status of pt
12. patient preference
13. patient not fit for recommendation, patient refuses recommendation,
14. Patient had comorbidities which made the original decision inappropriate. a patient declines admission to a trial recommended by the MDT. The patient has read up about the treatments on the internet and has their own views about the treatment they wish to pursue. The staging or advanced stage of the disease precludes the original decision from being offered. The Consultant was not happy with the decision and ignored it and they felt it was inappropriate
15. Patient factors
16. Patient declines.Further investigation (eg cardiac echo) may indicate patient not fit for treatment. Patients condition may deteriorate rapidly making treatment recommended inappropriate.
17. patient comorbidities, unexpected events, early death, rarely choice to go to another centre
18. Patient choice, situation changes
19. Patient choice, rapid change in clinical situation, patient's own consultant (with better knowledge of patient's fitness / social situation etc) not at MDT when discussed
20. Patient choice, physician not being at the MDT when discussion occured
21. Patient choice, changed clinical circumstances, PCT will not fund MDT approvedtreatment
22. patient choice when treatment discussed in detail
23. Patient choice or patient unfit for planned therapy
24. patient choice or change in performance status.

25. Patient choice
26. Patient choice
27. Patient choice
28. Patient choice
29. patient choice
30. patient choice
31. Patient chioce
32. New information from outstanding investigations- usually to check fitness for chemo- eg an ECHO that shows poor cardiac function, which means you can't use certain forms of chemotherapy
33. New information becomes avaibable after MDT or patient declines MDT decision
34. new clinical information regarding pts suitability or patient choice
35. mostly taken up. Patient choice.
36. MDTs do not have the pt present nor can they make remote clinicial descisions regarding pts suitability or desire to have suggested therapies
37. lack of precise information at the MDT leading to a revised decision when seeing patient in clinic
38. It is too simplistic to think that complex decisions can be made on all occasions in the setting of an MDT
39. Impractical - patient too sick/declines treatment/drug treatment not funded
40. Good question and very simple to answer and amazing you had to ask it. Very few of the MDT members have actually seen and examined that patient! Worse...there are cases that are "referred to the MDT" usually from an outside place where noone has seen the patient. My view is that this is very dangerous medicine.
41. Further clinical information at next consultation. Discussion with patient
42. funding
43. failure to take into account comorbidy, patient choice.
44. Elements of the patient's tumour (e.g. site of involvement) or co-morbidity not appreciated at the time of MDT discussion.
45. drug availability - differs between trusts and patient preference
46. don't know
47. Disease progression and/or death Death before treatment Patient refusal Information coming available after MDT
48. Disagreement by clinical or patient with recommendations, or patient circumstances change
49. Difficulty getting everyone top agree to network guidelines. Much easier if MDT covers 500K pop'n. Ours covers 1.6million!
50. Difficult to say how often this happens, let alone reasons for it.
51. Difficult cases may not have clear recommendations, the treatment chosen will depend on doctor/patient discussion
52. Deterioration in condition of patient prior to starting treatment. Pateint choice.
53. Communications failure, change of clinical status
54. Clician seeing patient in clinic disagrees with the majority view and still does his own opinion; sometimes clinical scenario has changed
55. Change in the patient's clinical state.
56. Change in the clinical situation.
57. change in patient circumstances
58. Change in clinical state of patient Patient choice Further clinical information
59. Altered patient circumstances
60. A clinician who is not a team player
61. 1. Lack of funding for certain treatments. 2. Disagreement between MDT and treating physicians as to the suitability of a certain treatment for an individual patient. 3. Patient choice.

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

47 haematologists responded to this question.

1. Why would you want to ensure this? This isn't the clinical priority. Again pre-supposes that the MDT is a good model for haematology.
2. Very difficult.
3. Very difficult for haematology where diagnosis often not made histologically
4. Using hospital data banks and histology notifications
5. This just about works - via histolpathology Ifthere isonly a clnicaldiagnosis then you have to rely on the clinician - this doesntalways happen
6. This is a very difficult issue for Haemato-Oncology MDTs as patients may have their diagnoses made via any one of a number of different laboratories. MDT co-ordinator needs to trawl histopathology and haematology labs as well as out-patient departments to ensure that no patients are missed - most do not have the time or inclination to do this.
7. the co-ordinators help and staff committment
8. Some means of immediate electronic notification when the diagnosis first comes to the clinical team
9. Robust clinician-led navigation
10. Relies on individual doctors
11. provide the support ot make it happen
12. Properly staffed haematology departments ie YOU make it compulsory for data staff to be appointed (if you don't, they won't)
13. Proactive data collection and MDT coordinator tracing all new cases in department.
14. patient tracking lists and cross checking with pathology diagnostic lists
15. patient tracking
16. MDT need moor resources if they are to fulfill roles of audit, data collection and analysis etc. At present their role is confined to organising the meetings
17. Make the referral and listing process as easy as poss and not just a doctor's job. Departmental data manager's list them.
18. Make sure all involved in cancer treatment are members of an MDT Audit processes to find out if all new cancer cases have been reviewed at a relevant MDT
19. Increased admin support An NHS IT system that includes the diagnosis for out-patients On-line submission of new cases that could be completed by a competent admministrator
20. I don't really agree with this premise - eg. it feels like a waste of time discussing all new Stage A CLLs or MGUS
21. I do not believe that all new haematological cancer cases (eg chronic lympholytic leukaemia satage A) should be "referred to an MDT". Indeed the whole concept of referring a patient to an MDT in absentia is wrong and potentially dangerous. A clinician who has seen and examined the patient should bring that case to a therapeutic MDT only if there are issues to discuss. Diagnostic MDT's are different. We have an inclusive all patient diagnostic MDT and the diagnostic decision is communicated and data collected at that time.
22. Having the necessary suopport staff and mechanisms in place
23. good question
24. Give us more admin and data managing support
25. Electronic pick up of new cases. Sanctions for medical staff who fail to refer patients
26. difficult - could try to match histology with mdt data
27. data systems linked to histopath reporting
28. Continue to maximise their effectiveness. Include case ascertainment independent of the medical staff
29. Consultant responsible for patient should ensure this

30. co-ordination from pathology/haematolgy/radiology/cancer registries
31. Clinician awareness or via histologist
32. Cancer networks like the Haematological Malignancy Research Network in Yorkshire are the ideal way to enable this. Otherwise cases are very easily missed.
33. By making them cover less hospitals so that the sheer number of patients can be discussed
34. By making sure whole department is vigilant and checks new people they see are listed for discussion
35. better it systems and processes
36. Automatic sending of pathology reports to a designated lead in each MDT
37. Audit to check for 'missing' cases. Publish and discuss resultsat MDT
38. Audit of compliance
39. Audit of cases diagnosed v seen
40. audit and review eg peer review, HCC?
41. Audit
42. audit
43. we don;t discuss all new cases and only some relapses due to lack of time. Need two MDTs to cover smaller pop'ns but not enough haematologists in XX [network]
44. all members are responsible professionals . to ask this is to question the integrity of individuals as are some of the above questions
45. Adequate support - clerical and IT
46. Access new cases via histology, referral from specialy clinic etc
47. 1. An electronic failsafe system to record new diagnoses which colates data from: histopathology, haematology and radiology and clinical coders.

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

47 haematologists responded to this question.

1. Write it down; if peoplewantto be identified as for against - doit
2. verbatim
3. try to agree consensus. if however it can not be obtained then the resons should be clearly documented on outcome form. The MDT lead will ultimately have to make the call.
4. Tretament options proposed should be recorded with numbers of votes and then discussed with patient
5. There is often a number of treatment options available and unless the referring clinician is operating outside current accepted practice, they should have the final say, having discussed it with the patient. This should be recorded in the patient's notes and the clinician should be prepared to defend his/her decision
6. The patient's named consultant and CNS makes the final call perhaps even if they are a minority of 2. They know the pt, will have to consent them and will take the legal hit if they screw up. I sometimes resent input from colleagues who have never met my pts, don't know their individual circumstances and then have to sell a treatment I fundamentally disagree with.
7. the major points and basis of disagreement should be noted and the level of support indicated without recording individual named views -
8. Should be documented on MDT form. These usually arise from insufficient knowledge of the patient's wishes/co-morbidities and are resolved at the next consultation. Recording possible treatment options and reasons for the choices would be acceptable and helpful
9. Resolution should be attempted. If not record the nature of the disagreement.
10. Record that there was disagreement and what treatment options were considered.

The consultant treating the patient should make the decision in these cases and what was decided should be recorded

11. Record on MDT electronic record, further time usually needed to gather evidence. I would discuss the options with patient.
12. record and ? refer to network mDT/TSSG chair?
13. Range of treatment option should be given
14. On the proforma...
15. On MDT decision sheet - this usually reflects complexity of case
16. Note made that this is a majority decision, not unanimous
17. MDT record in clinical notes
18. Majority decision should prevail Final decision by consultant responsible for patient taking patient into confidence with informed decision making & explaining the lack of consensus & available options & option being recommended & reasons
19. Local clinicians who know th pts must have their preference respected
20. literally
21. It is exceptionally uncommon to have a split decision
22. in writing
23. In the mdt record
24. I think all treatment options should be discussed and recorded during the meeting
25. honestly and openly
26. Haven't had to face this.
27. give an order of preference
28. Fully
29. free text in minutes
30. Formal minuting of meetings.
31. Final decision should rest with consultant in charge of case unless other consultants feel this is inappropriate. Disagreement should not be recorded, just the outcome.
32. Either, or .... (options can be considered - no consensus for treatment)
33. documented and outside expertise advised
34. Diverse views should be recorded but patient's consultant has final say.
35. Dispassionately, but the ultimate say should reside in Consultant in charge
36. Decision of clinician with direct patient responsibility must be recorded first, other treatments recorded as things to be considered.
37. Debate should be recorded
38. choice of options if all suitable
39. By saying that.
40. By recording that the final decisison should be made by the treating consultant after seeing the patient. The MDT should support treatment change according to the needs and state of the individual patient not by dogged adherence to protocol.
41. Both recorded
42. as just that if there is disagreemenet re best treatment option these can be discussed with the patient
43. As disagreements/split decisions
44. As a record of the discussion which took place and the reasons behind each viewpoint.
45. as a ratio of attendance eg 10/15 members agreed or 15/15 agreed. or 10 mebers agreed with x treatment but 5 expressed reservations because.....
46. Accurately.
47. A offering the patient the choices recognising the views of those who have met the patient

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

75 haematologists responded to this question.

1. Whoever knows the patient's views
2. Key worker as far as my patients are concerned is the consultant in charge of the case who initiates the treatment programme and then alters it when necessary.
3. Varies. Usually consultant, SpR or key worker.
4. Treating physician and CNS. The concept of a 'key worker' is nebulous and does not appear to have taken hold!
5. Those that have seen the patient and assessed them and discussed the patients views with them. This could be doctor or nurse.
6. This is where big SMDTs do not work. The local consultant and team are best placed to clinically/psychologically assess pts needs, clinical state etc. this cannot be done in a room of many many people or across the television.
7. thie doctor and CNS
8. their physician usually their consultant or a member of their team
9. Their health care workers, usually their consultant and CNS, could be an SpR. If the MDT is to confirm the diagnosis and recommend a treatment plan, the latter will not have been discussed in detail or at all with the patient before the MDT, so their precise views are not available unless they are rather extreme. There are very few patients with haematological malignancies who refuse treatment because treatment is associated with good outcomes
10. The physician or nurse who knows the patient best.
11. The nurse specialist. we have found this works well
12. The doctors and/or nurse who has met the patient.
13. The doctor who is responsible for them is the sole person who should be representing them.
14. The doctor who has spent the most time in the recent past with the patient.
15. The consultant or CNS who's met the patient
16. The consultant or clinical nurse specialist who has met the patient and talked to them about the disease and the treatment options
17. The consultant looking after them or the specialist nurse who knows them
18. The consultant + CNS - but not always possible for these individuals to be present e.g. part-time workers
19. the consulant team in charge of the patient
20. the clinician who carries out the most recent assessment along with the CNS
21. The clinician seeing the patient
22. The clinician managing their case.
23. The clinician looking after the patient is usually the only one present who knows the patient
24. the clinician in charge of the patient's care
25. The clinician (doctor / specialist nurse) who has met them
26. The clinican who has spent time discussing the diagnosis and potential treatment options with them
27. Specialist nurse or won consultant
28. Specialist nurse or treating consultant
29. Specialist nurse or consultant
30. Specialist Nurse
31. Specialist nurse
32. Someone who hs met the patient
33. Someone who has met them Inadequate numbers of clinicalnurse specialists mean theymay not have met the patient pre MDT
34. Responsible clinician
35. responsible clinician
36. Physician in charge of case and specialist nurses
37. patients consultantor key worker - with the speed demanded there is nottime to take a patient through in a way they could understand

38. Patient's consultant or clinical nurse specialist
39. Patient's consultant
40. Often has to be the doctor who has seen them at clinic visit, but CNS when involved prior to meeting
41. Often CNS, or doctor who has seen patient
42. Nurse specialist
43. Medical staff who have met the patient
44. MEDICAL AND NURSING STAFF
45. key worker
46. it depends of course
47. Ideally should be the clinical nurse specialist failing that the consultant who has the relevant expertise and met the patient
48. Good question - we dont really do this
49. Final responsibility lies with the consultant looking after the patient
50. Doesn't need to be a specific person, it is often the clinical nurse specialist or the named consultant
51. consultant/specialist nurse(if there is one)
52. consultant who has seen them plus clinical nurse specialist if appropraite
53. Consultant who has seen the patient and nurse specialist input
54. Consultant or nurse specialist
55. consultant or key worker
56. consultant or CNS
57. Consultant in charge/CNS
58. CNS/Key worker
59. CNS/ Dr who is looking after them
60. CNS. Pt's own consultant
61. CNS or Consultant who knows their case
62. CNS
63. CNS
64. clinician who has met pt (Dr or CNS)
65. clinician together with cns
66. Clinician responsible for the patient
67. Clinician or clinical nurse specialist that has met the patient.
68. Clinican or CNS who has meet the patient
69. Clinical nurse specialists
70. Clinical nurse specialists
71. Clinical Nurse Specialist. But CNS need to learn to contribute more to discussions
72. Clinical nurse specialist or other key worker Responsible consultant
73. Clinical Nurse Specialist
74. Clinical Nurse Specialist
75. any member of the team - Consutlant,CNS,SPR

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

72 haematologists responded to this question. 5 haematologists referred to the answer they had given to the previous open question [Q32].

1. Varies. Usually consultant, SpR or key worker.
2. usually the responsible consultant but may be others such as specialist nurse particularly when good relationships have been developed
3. Usually consultant or delegated junior doctor or clinical nurse specialist
4. Usually a physician often with lymphoma/CLL CNS in attendance

5. Treating physician or CNS
6. Treating Consultant or specialist nurse. Occasionally an appropriately experienced registrar
7. their doctor or CNS
8. their consultant
9. The same clinician [*as answered in Q32*] or their team.
10. The physician taking overall responsibility for patient care.
11. The doctor who has responsibility for managing the treatment.
12. The doctor or nurse who is actively involved in their management
13. The Consultant, or their designated deputy (that in our case can be and often is a specialist nurse).
14. The consultant who will be implementing the decisions & giving the treatment.
15. the consultant looking after them
16. the consultant /other senior grades on the team
17. The consultant (or, I suppose, in big teaching hospitals, another doctor in the clinic)
18. The clinician responsible for their care.
19. The Clinician responsible for the care
20. the clinician in charge of the patient's care
21. Specialist nurse assuming options have been already discussed by the specialist and followed up by the doctor
22. Specialist Nurse
23. Responsible consultant
24. Responsible clinician
25. responsible clinician
26. Patients consultant
27. Patient's doctor and/or CNS
28. Patient's consultant
29. Patient's consultant
30. Named consultant
31. Dr /CNS
32. Dr - ideally consultant looking after the pt
33. Doctor, nurse specialist or research nurse.
34. Doctor who next sees patient at planned consultation
35. doctor in charge with key worker
36. consutant
37. Consultant/CNS
38. Consultant responsible for the patient although this may be delegated to the CNS or junior medical staff
39. Consultant responsible for that patient
40. consultant or key worker
41. COnsultant or CNS
42. Consultant or CNS
43. Consultant or CNS
44. consultant or CNS
45. consultant or cns
46. Consultant or a member of their team
47. Consultant in charge of the patient
48. Consultant in charge of patient
49. Consultant in charge of case.
50. consultant in charge of care
51. Consultant in charge
52. Consultant in charge
53. Consultant / deputy if any delays
54. CONSULTANT

55. Consultant
56. Consultant
57. Consultant
58. Consultant
59. consultant
60. CNS. Consultant
61. CNS & Consultant in joint session preferably
62. CNS
63. Clinician responsible for the patient
64. Clinician responsible for care
65. Clinician or CNS
66. Clinician involved in the care of the patients. Only relevant if MDT concludes a different treatment plan to the one already initiated
67. Clinician
68. clinician
69. Clinical Team
70. Clinical nurse specialists
71. By the loally treating consultant
72. Anyone

Measuring MDT effectiveness/performance

What other measures could be used to evaluate MDT performance?

21 haematologists responded to this question.

1. too many impositions will deter the participation anf goodwill to bring case s to the mdt
2. Timeliness of discussion of patient in MDT
3. Time taken from presentation/relapse to discussion; presence of relevant notes/radiology/pathology.
4. There are no resources and no time to start measuring any of the above quality measures. We are sinking under weight of policies and measures
5. resource consumed
6. It is NOT the function of the MDT to dictate treatment. It can recommend and suggest, but "it" has not seen the patient.
7. None of the above. Surely the objective is to review appropriate patients in a timely manner with a management recommendation as the outcome. This may not necessarily translate into improved survival figures!!
8. NCEPOD data on chemotherapy deaths % of patients with incomplete diagnosis (by WHO criteria)
9. MDMs are a tick box exercise. I don't believe they improve care beyond local discussions with colleagues. The effectiveness is therefore whether we keep the DoH happy.
10. It is too complex to summarise it in a questionnaire. Let's get the MDTs working properly with additional resources and support staff and data-bases before we complicate the process further
11. improved quality of life of patients - survival is not always the most important outcome
12. I think there are some fundamental IOG measures still not being met e.g not all cases new or relapsed discussed, lack of radiotherapy input, no palliative care inpit, poor CNS contributions. Address these first then move on
13. equity of access to new drugs and treatments such as transplantation
14. Don't know
15. Do the participants think the process is worthwhile

16. Did MDT discussion alter referring consultants view (maybe we could 'drop' some cases & focus on more difficult ones)
17. Costing. Large numbers of staff tied up for a sizeable chunk of time and to no useful end.
18. case control
19. Ask those who take partwhether they think it is a good use of their time Ask themif they look forwards to MDT meetings positively or negaTIVELY
20. Adverse effects/intolerance to treatments
21. % patients reviewed compared to cancer registries

Supporting MDTs to work effectively

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

52 haematologists responded to this question.

1. Would speed up availablity of results e.g. external review of pathology and imaging, so that MDT decisions are closer to the time when treatment was initiated (which is almost always before the MDT)
2. videoconferencing
3. time to prepare .
4. time and support
5. There needs to be two opinions on most things: radiology and pathology is reviewed, usually several haematologists present, but we only ever get one radiotherapy opinion - need more radiation oncologists involved
6. The video conferencing problems so that we can hear what is going on at the other sites
7. The removal of one particularly forceful character who wants to decide for everyone's patients and doesn't listen well
8. The person who knows the case turning up every time.
9. The lead clinician, IT set up and atmosphere eg coffer available
10. That we were not forced to tick boxes
11. Summary of decision made for each patient
12. Scrap Peer Review. Much that goes on around MDTs is to satisfy a bureaucratic process rather than impacting on patient care
13. Resource it properly. Insufficient Radiologists, histopathologists, data managers data-base
14. Reduce a histopathologist's insistence on excessively detailed (and time consuming)presentations
15. Our mDT covers 2 trusts. Joint working between the trusts managements to support the developement of a truly integrated mdt
16. Oranisational recognition
17. Not discussing patients unless relevant clinican and all relevant results are available
18. New chair of lymphoma MDM. Loudspeakers
19. Need more support to ensure smooth running and full data available Better attendance of peripheral (geographically) members
20. Most MDT's I work in work together well but in the one team in which the MDT is not effective the main problem is a lack of confidence in the aptitude of some members by other members of the team which is vey difficult to manage
21. more secretarial / clerical support
22. make hospital-based. Abolish video-conferencing
23. Less chatter / random opinions
24. In haematology completely abandon the idea of mixing a diagnostic MDT with a therapeutic one. For haematologists a correct diagnosis is the thing that directs treatment.
25. improved preparation time to smooth flow of MDT and ensuring live capture of outcomes
26. Improved data collection and recording
27. Improve attendance by specialist histopathology and radiotherapy
28. Improve attendance and communication by one member in particular
29. If we could do away the need for videoconferencing, but this is not practical.
30. Hi tech equipment
31. Having the time to attend without compromising other things.
32. fewer patients discussed!
33. Equal representation of views & avoid over reliance on ' old school expert'
34. ensure patient seen and staged before meeting and presented clearly

35. Enough staff to give us sufficient time for the meetings.
36. Electronic database/MDT system that would work across different trusts
37. Effective teleconferencing
38. Easier transfer of pathology & imaging materials between Trusts
39. E-mail outcome proformas to responsible consultants as soon as they are typed(currently sent quite while after the meeting in ordinairy post)
40. do not discuss all cases - simple cases can be managed without mdt leaving time to discuss complex cases properly
41. Data Manager to allow outcomes, audits etc to be an effective function of the MDT
42. Colleagues to prepare more for the meeting
43. clerical support
44. Change it back to a forum for joint management of lymphomas and open discussion of difficult general cases.
45. Better teleconferencing - people in the other hospitals are not easy to identify visually and talk too fast and mumble
46. Better IT
47. Better clerical support for notes etc.
48. Better attendance
49. Arranging order of cases in advance
50. abolish them
51. A proper infrastructure (the NHS and Trusts have no idea what this would really involve).
52. 1. Employ high grade MDT co-ordinators with well defined job descriptions and payscales that are realistic for a complex job. 2. Ensure attendance of CNSs but this needs more manpower investments.

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

42 haematologists responded to this question.

1. We are a functional team and actively stimulate each other to work better
2. Time to prepare for the 5 MDT's I attend. A change of working practice which enabled me to reduce the number of MDT's I am allied to
3. time to prepare
4. Time to learn form other MDTs
5. Time resources
6. time
7. time
8. time
9. There is not enough time to do all the things that shouldbe done - for example they are a waste of time for medicalstudents - there isnttime to explain what is going on
10. Remove the video conferencing
11. recognise time in everyones job plans, to include time fro preparation
12. Not having the session after lunch in a darkened room on a busy day - hard to concentrate
13. More time.
14. More time within my week
15. More time to prepare
16. More time to prepare
17. more time to prepare
18. More time in the week. IT systems that identified new patients easily, especially in out-patients Good admin support Lack of interference from network who wish to impose system that does not sit comfortably on normal practice
19. More time for preparation.

20. more time for preparation
21. More time
22. more time
23. More staff at base so I'm doing it in NHS time not my own.
24. more preparation time and better admin/clerical support
25. more clerical support
26. More assertiveness
27. Mor clerical support and MDT co-ordinaor support
28. MDT's should provide opportunities for education but they have become a "tick box" exercise and are just to rushed.
29. Making it more efficient and quicker so I don't feel like I am wasting 3 hours of my week that I could be using more constructively. Shouldn't have a direct educational role (may train indirectly as trainees listen to decision making process but it should be a decision making body)
30. Less time pressures limiting attendance in person
31. less pressure of work
32. Job plan: realistic allocation of SPAs
33. having to present cases and discuss options
34. Having dedicated time to prepare for it and having the resources and support staff
35. Having access to a networked computer so on table top so we can look up national guidelines on internet or access the Haemato-oncology diagnostic information which is on the intranet.
36. Good MDT co ordinator & data collector Effective time available in job plan Filling up medical, nursing & admin vacancies
37. Fewer patients
38. discuss interesting cases .and ones experience to the mdt
39. better vcr
40. Better staffing to facilitate more regalar attendance
41. Better admin adn IT support
42. being allowed to have MORE TIME in my job

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

18 haematologists responded to this question

1. will consider when time identified
2. we have good facilities in place
3. Time! IT training and local support
4. things other mdt's have found useful
5. There are more major issues to address to make MDTs work effectively before training
6. Not much enthusiasm for this, too many other 'workshops, training sessions 'etc are obligatory and tend to block diary without improving patient care
7. need to develop local expertise and team support for MDTs. Technical support, MDT co-ordinators dedicated time. We do not have time for away days etc. Give us the resources, leave us alone for a while and stop trying to complicate it further!
8. Mentoring, visiting other MDT meetings as guests
9. inclusion of responsible managers in training
10. In our MDT, it is all about infrastructure
11. I think all of above could be helpful but it would be difficult for us to find the time unless more resource was provided, in particular more consultant hours for MDT
12. External scrutiny with the power to influence management
13. examples of good working of MDTs, examples of MDT policies avaiable
14. evening out at restaurant or an activity (we had two sessions at 10 pin bowling)

15. eNOUGH TIMETO DO IT PROPERLY Adequate videoconferencing Adequate recording of data
16. Blackberries or some form of on-the-go messaging.
17. adequate time for MDT, preparation and above exercises
18. Adequate resources to do the job - staff, clerical medical, specialist nurses data managers etc

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

12 haematologists responded to this question.

1. Not aware of any.
2. not aware of any
3. Not aware
4. not aware
5. None that I am aware of
6. none
7. Nil
8. nil
9. I have been to enough training courses already some of which are applicable to team working
10. I don't know of any. I have never heard of any MDT training
11. Communication skills
12. ???

Final comments

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

22 haematologists responded to this question

1. we havd a very effective local mdt team that worked well.there has been a deterioration of reveiw and discussion since th eintroduction of a networked mdt. time is spent supporting this rather being patient focussed.trying to improove support across teo or more trusts has been frustraing.
2. Trusts should recognise the importance of MDT and Chairs
3. It is not clear to me that our MDT has resulted in enough significant changes in patient management to justify the enormous amount of effort that it has taken to establish and maintain. Because a large MDT with sub-speciality input is perceived to be too unwieldy we are being encouraged to return to smaller MDTs at single hospitals which re-invent the weekly diagnostic meetings that took place before the concept of MDTs but add nothing to the decision making process as the same individuals are responsible for the decision without any outside input
4. There are serious conceptual difficulties with MDT's that are revealed by your questionairre. The one size fits all theme that is apparent from the above is simply not suitable for all tumour types. We have recently been criticised for not having a radiologist at our acute leukaemia MDT. No amount of explaining that these patients don't have lumps and we don't scan them at all at diagnosis seems to have any impact!
5. The most effective MDTs should be patient centred with preferably all concerned with patient care in attendance, should offer timely discussion for management and with easy access to special expertise. The size of MDT membership is crucial and all cases should be reviewed with some degree of minimal data and not presnted selectively. MDT co-ordinators should be highly trained to carry out all the proper functions and ensure taht all the paperwork is appropriately completed. Data collection and audit should also be carried out by appropriately trained personell.
6. The major barrier to our MDT working is lack of managerial support. The MDT works across 2 sites with little managerial co-ordination which makes clinical co-ordination all the harder.
7. The best-performing MDTs are those that really need to be mutidisciplinary. Haematology does not fall readily into this category
8. Team functionality with people who function as team outside. My experience is that some mdt will never function with the personalities involved
9. Network MDTs are problematic. Videoconference function is poor. Cases are presented in order to tick boxes.
10. MDTs should have a democratic view & avoid overreliance on a ' single ' named expert. My experience is DGH teams tend to make more evidence & patient centred decisions while tertiary centres often make or recommend non evidenced based treatments either not funded or losing the patient perspective & quality of care (eg recommending transplant when terminal palliative care in retrospect could have been an effective option)
11. MDTs not really working because: insufficient resources made available, insufficient committment from some members and trusts
12. MDT meetings have been squeezed into busy timetables, with inadequate support The2 best in my hospital (gynae, breast) takeplace at 9 am ie not pre work or at lunch, have enough timeto do things properly, and dont involvevideoconferencing
13. It's all about relationships and infrastructure.
14. In my view the next step we need to take in haematology is data collection. it is frustrating that we have no data support. In haematology we need to have a high

quality effective person if we are to record our data in all its complexity for accurate diagnostic and outcome measurement.

15. In haematology there are two types of MDT. One is the 'Diagnostic' MDT where a multidisciplinary team arrive at a pathological/molecular/etc diagnosis. They benefit from clinical/radiological input in this process but that is frequently remote because the teams with all these diagnostic facilities are necessarily based in a small number of teaching hospitals. They cannot possibly be involved in all the treatment decisions in all the patients with haematological malignancy in the regions that they serve. The commoner 'treatment' MDT includes clinicians involved in the staging and therapy of the patients. Its most useful purpose is the discussion of patients with relapse. Decisions regarding the primary treatment of most haematological malignancies are frequently uncontentious. The 'treatment' haematology MDT is supposed to serve at least 500,000 population but frequently has to do this across multiple sites. This model is essential in that it is the only way to ensure that a clinician who has actually met the patient is able to be part of the discussions. This person can subsequently explain the outcome MDT to the patient and usually supervises the treatment. We receive 'internal' referals from MDTs that operate more remotely and there is very frequent misunderstanding largely arising from a complete lack of communication with the patient. The problem with the 'small' MDT is that it is difficult for all the relevant specialists to attend all the time: there are particular problems locally with clinical oncology. We would very much welcome better links with the 'diagnostic MDT' (which is 220miles away...). In haematology, percentage of patients with a WHO classifiable diagnosis is probably quite an appropriate measure. So is the percentage of patients entered into the national portfolio of therapy trials.
16. We have been bombarded by cancer related initiatives, inspections etc. Recognise where there are resource issues and solve them and leave us alone to build on the considerable progress we have made so far.
17. If you propose the measures you seem to want we will never get to see any patients
18. I would be very interested in any peer reviewed data that proves MDTs improve patient outcome.Where did the figure of 500,000 for populations come from? What is the evidence that a smaller population base has worse outcomes in haematology?
19. I worry that too much of an MDT's time is spent going over the details of patients whose treatment is straight forward (because of the edict to include all patients presenting with malignancy on the database) and too little time spent
20. can do away with a lot of the red tape measures suggested and let MDTdoctors get on with the treatment rather thanm take more time away from insufficient hours in the day.
21. Beware of imposing ever more data and quality measures: data clerks are thin on the ground. All the grand ideas of cancer care fail if you do not support data collection at the coal face.
22. Adequate co-ordinator support including dedicated leave cover is essential