Multidisciplinary team members views about MDT working:

Results from a survey commissioned by the National Cancer Action Team

Open question responses: Histo/Cytopathologists

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

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

Introduction

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

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

Open questions

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

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

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

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

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

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

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

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

Method

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

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

Responses to 3 of the open questions have been fully analysed to-date and results are provided in the final report issued in October 2009. These are:
- *What do you think constitutes an effective MDT?*
- *What qualities make a good MDT chair/leader?*
- *What one thing would you change to make your MDT more effective?*

Contents

Domains that are important for effective MDT functioning

What do you think constitutes an effective MDT?

84 histo/cytopathologists responded to this question.

1. willingness of staff to debate case management
2. where difficult cases needing combined input by various professionals are discussed to be able to decide on the management of the patient
3. When all of the appropriate members are present to discuss the options for the patient for each relevant decision point ie diagnosis and staging, primary treatment options, adjuvant options, palliative options etc. Also necessary is a clinical representative who has met and knows the patient. Rapid feedback to the patient of MDT decisions/options and to the GP. Assessment of the patients view of the process. These parameters could be simply measured.
4. well organised protocols for management professional discussion
5. Well chaired, effective IT back up with live MDT on screen collection of data. ection
6. Well chaired and organised meeting with adequate technical support (ie microscope, PACS, videoconferencing etc)
7. Time, resources, good room, good tele-conferencing links
8. Time and membership
9. The presence of at least one radiologist, surgeon, pathologist and oncologist together in one sitting. Effective facilities to view related images and access to the hospital computer system to view previous results and letters at the same time. Auditing performance.
10. The presence of all team members Urologists,Pathologists, radiologists, Oncologists /radiotherapists and Nurse practitioners
11. the one that is functional, constructively critical with good clarical support and attedance by the medical professionals
12. The input from various specialties in the management of the patient.
13. The clinicina of the aptients discussed should be there (or a member of the team) If old histology/ radiology is up for review there should be information provided to specify what particular questions need answering so that one knows what to look for. there should be enough time for preparation
14. team work between different groups involved
15. Team work
16. Strong leader. Good procedures. Using Somerset Cancer Registry software live in MDT for data collection and minuting actions.
17. Starts on time, all relevant people present and treated as equal members, genuine discussion and not all decisions made by senior surgeon, ability to view histology and radiology, presence of oncologist (sadly not available at all meetings)
18. Specialised knowledge, mutual respect and ability to work together.
19. robust coordination between clinical, radiological and pathology teams
20. Right people, right place, right information, right time
21. Only 3 of the 4 MDTs I attend have a designated MDT co-ordinator. The latter is essential to effective MDT functioning.
22. Punctuality, courtesy, accurate documentation, attentiveness between members, knowledge of patients' details and potential diagnostic modality disagreements prior to the actual MDT in order to allow the most effective use of the presence of all members for the benefit of the patient, clinicians present who are looking after those on the MDT list, patients notes available at the MDT
23. presence of all key members - oncologist, urological surgeon, pathologist and radiologist to discuss all cases particularly the complex ones. Coordinators, nursing and ancillary staff are also key components
24. Opportunity for full discussion of all aspects of diagnosis and treatment.   Access to all relevant histology and radiology in a timely fashion
25. Openness, respect and above all, regard for patients' welfare

26. Open minded clinicians who do not have a preconceived idea of what treatment should be given. Surgeons seem to make poor MDTs leads as focussed on their specialty and tend to push for surgery to increase their numbers of operations
27. One which is well attended, patients well known and documented, and good discussion to come to agreed plan
28. One which has only the relevant people at it.
29. one where the oncologist isn't allowed to hijack the meeting for purposes of reviewing unrelated radiology
30. One that finishes on time
31. one inwhich core members participate and team decisions are made
32. One in which the consultant physicians, pathologists adn consultant surgeons particpate withother staff groups as appropriate
33. Mutual respect
34. Multidisciplinary discussion and management plan formation. A lead is needed to control the meeting. A coordinator and data collector are also needed.
35. Memebrs: Neurosugoens, Neuroradilogist, Neuropathologist, Oncologist, Secretary. Aim: Best care for the patient
36. Making decisions on patient management based on all relevant information and with attendance of all relevant clinicians
37. Leadership and good team working Appropriate support
38. Good team spirit, good leadership, good data collection and good support
39. Good support from MDT co-ordinator Providing histological slides and reports as soon as possible before the meeting Attendance by all core members Restricting the meeting to one hospital or trust Meetings involving several hospitals or trusts do not work and use up a lot of time
40. good strong leadership, decisive action, keeps the rabble under control & focussed on the MDT rather than drifting on to other timeconsuming issues.
41. Good preparation, concise communication, recognition of contribution of the whole team
42. good organisation, attendees remaining focussed on MDT function, effective representation & participation from clinical areas & support services relating to patient so that care can be truly multidisciplinary in practice; good team interpersonal dynamics; shared patient centred aims and values; valuing and encouraging participation of all MDT members in discussions; keeping to the agenda; agreed management protocols (or valid reasons for varying care delivery for individual patients); clarity over team member responsibilities in actioning MDT management plan; a skilled co-ordinator to ensure notes/imaging/slides etc are all available
43. good communication; and a recognition from the surgeons that they are not 'in charge'
44. Good communication, good leadership and adequate support for data recording, note pulling and slide and report pulling
45. Good chairman skills. Good time management. Ruthless abbreviation of surgical anecdote. Focus on the case in hand. Willingness to involve the less histrionic specialities in discussion
46. Good chairman Quick and efficient Adequate representation and support
47. GOOD ATTENDANCE BY CORE MEMBERS
48. Giving enough time to discuss cases rather than rushing . This will give us enough time to explain the pathological changes and understand the reasons for the management decision. The process now could be replaces by reading out the pathology report by anyone and one clinician to attend to decide how they are going to treat the patient. Any further discussion to understand the reasons for a decision is considered as waste of time and looked at as being inconvenient. It should be a mandatory requirement for a pre-meeting review of all pathology to discuss cases. cases presented at the meeting should have enough time for pathology presentation. the clinicians should not feel that they are above and beyond any questioning to their decisions by any member of the MDT. discussion should be considered as a healthy method to improve the service.
49. Full membership discussion of all cases

50. Full appraisal of all diagnostic information and management plan formulated with input from all relevant specialties i.e surgery, oncology, palliative care etc
51. Focussed mutidisciplinary discussion leading to effective patient management decisions
52. Fewest people possible lists ready early
53. Evidence based, efficient decision making allowing optimum patient management
54. Equity between all clinical groups, presence of all key clinical members, effective recording of decisions, careful case selection, enough time to discuss all cases properly, effective IT, effective means of showing and discussing histology, suitable premises.
55. Equal input from core members Effective leadership by lead clinician
56. Enough time to discuss cases. All team members present. Good communication at all levels. Minimal paper work.
57. efficient data collection   effective decision-making process
58. Efficiency and co-ordination. Patients should only be discussed when ALL the appopriate information is available. Valid care pathways require knowledge of all patient results.
59. Effective Chairman, efficient use of time, good support (technical) for audiovisual equipment
60. EFFECTIVE AND COMMITTED SURGEONS, PATHOLOGISTS, RADIOLOGISTS AND ONCOLOGISTS WHO ALL RESPECT EACH OTHER'S SKILLS
61. Effectice business meeting to agree a plan for each patient. IT IS NOT THE FORUM TO REVIEW HISTOLOGY AND RADIOLOGY: THOSE ACTIVITIES SHOULD BE DONE OUTWITH THE MEETING AND THAT CORROBORATION OS THE HISTO OR RADIOLOGY REPORT USED IN THE MEETING (I AM SHOUTING NOW)
62. doctors not interrupting each other
63. Discussion on cases with complete documentation, not repeating after each step of examination. Prtocol type handling of "simple", routine cases, and broad discussion only on complex and extraordfinary cases.
64. Consise discussion of each patient with the full clinical, radiological and pathology findings known. Complete team of experts surgeon, radiologist, pathologist and oncologist who are experts on that site and preferably regional experts. Input from the cancer units. Data collection done at the MDT and a database of all tumour sites.
65. Communication and time.
66. Collective pragmatism and democratic processes
67. Cases to be discussed must be properly worked up with all relevant investigations to hand and appropriate team members available. Video conferencing decreases the effectiveness of the meeting
68. Cases should be reviewed and discussed to ensure that diagnoses and staging and other prognostic data are robust. Co-morbidity should be taken into account and a personalised and unambiguous treatment plan should be agreed and recorded. Trial entry should be considered. Meetings should be properly chaired to ensure that, while thorough, they are expeditious. All relevant material should be available in advance to allow proper preparation. Decisions should be communicated to appropriate people in a timely manner.
69. An MDT where the cases discussed are relevant to patient care not just a means of transferring results of radiology/pathology to the clinicians and where there is a genuine difference of choices of treatment
70. An MDT that is based on a regular audit system that includes quality of work and not just the quantity.
71. An effective chairperson (not necessarily a surgeon) who has to be adequately resourced to direct the MDT meeting and ensure effective participation by all members.
72. All core members actively taking part in decision making
73. Agenda - has to be sent out in advance & include relevant patient demographics & clinical information. The chair who needs to move discussion on & summarise the treatment plan

74. Adequate understanding of the indivdual roles and the expertese of each member. Good organisation resulting in the correct patients being brought to MDT. Good time keeping/chairing.
75. Adequate notice and preparation time of cases to allow short sharp and succinct review of cases. need good communication between all parties.
76. A well-mannered pleasant non-aggressive non-egotistical meeting that exists purely to decide the best management of patients
77. A team that makes informed decisions about patient management in an orderly and timely fashion
78. A structured meeting in which decisions are reached in an efficient,
79. a meeting with all the relevant people and where management desicions are made
80. A focussed group of professionals making appropriate treatment plans with all relevant information available to inform patient choice.
81. A cohesive core team of motivated professionals with good relationhips within the team
82. A central MDT coordinator who compiles a list of suitable patients to be discussed when the clinical, radiological and pathological findings are all ready. This saves reduplication by adding patients to the following weeks meeting.
83. 1. A written protocol that states how it operates, specifies deadlines, standards being met, and defines turnaround times 2. Dedicated administrative staff. Full minutes taken and circulated to members. 3. All staff have to have enough time to attend and thereby get to know each other and how each member works 4. Pathways are defined for 'standard' presentations/tumour types to avoid repeated discussions 5. Patients have more than one professional opinion from oncology, surgery, imaging and pathology perspectives.   6. Imaging and pathology are reviewed before the MDT and findings are triangulated in the MDT to avoid discrepancies (implies MDT list 2 days before scheduled meeting and no last minute add-ins) 7. Patients are kept on the MDT and management decisions deferred until all aspects can be presented and discussed. ie no patient goes 'off road' 8. Referral pathways for external opinions are predefined with service agreements in place 9. An effective MDT can be measured by: * audit showing attendance by members * audit showing compliance for target turnaround times for management decisions * audit showing compliance for target turnaround times for treatment * audit showing compliance with relevant quality guidance from Medical Royal Colleges eg RCPath tumour datasets or patient care standards * audit showing low rates of diagnostic discrepancy for imaging and pathology services on peer review. Implies regular sampled peer review/audit of cases in the MDT. * audit showing no patients 'lost' from pathway. Prompt rescheduling if need for re-biopsy because of sampling error. * An autopsy request rate should be specified to validate reasons for death (the request rate will eventually translate into an autopsy rate, depending on consent). This is especially relevant when not-to-treat decisions are made based on clinical or imaging findings.
84. 1 good coordination 2 list available early 3 Able to discuss non cancer cases as well 4. membership sufficient for decision making

The team

What qualities make a good MDT chair/leader?

52 histo/cytopathologists responded to this question.

1. To be able to listen to eveyone, abnd to keep the pace of the meeting going
2. time to put in preparation time,, otherwise same as any other good meeting chairman
3. Time management skills;
4. the same qualities which define a good chair of any meeting
5. The ability to command the respect of the whole team and good diplomatic skills without bias or derogatory comments about care already given
6. Team player who respect all those at MDT
7. Someone who is organised and will motivate the team to keep to the agenda
8. Sense of humour, patience, decisiveness
9. Professional competence
10. Politeness, insight into the pressures on other departments, good understanding of "local politics"
11. personality
12. patience, focus, humility
13. Not need in a properly functioning MDT
14. Leadership, communication, fairness, respected, responsibility, authority
15. Knowledge, good control, assertiveness, good relation with team members.
16. intelligence, communication, common sense
17. Insight, broad understanding of contribution made by different colleagues. Respected by other team members. Excellent communication skills. Excellent organisationala and tiem management skills
18. If the team is truly that (i.e. a team) and a functional unit with agreement re objectives of the MDT meeting, I do not think it matters who is the Lead/Chair and can vary from week to week. The idea of importance and training etc for this individual seems very odd to me.
19. Humility and availability (must be present on time at all meetings)
20. Good timekeeping, fairness, general medical knowledge in subject area
21. Good time management, decisive, prepared in advance
22. good leadership
23. Good leader aware of recent literature and modalities   team player aware of all aspects that are related to the treatment process so that time is not wasted on unrelated issues.
24. Good clinical skills, patience, calmness, easy going nature, friendliness.
25. Good "people" skills, good at moving on the discussion and arriving at consensus
26. generous personality who can listen to others. Bright enough to grasp the issues. someone who walks the walk not just talks the talk
27. focussed, able to get straight to the point good chairing skills generally
28. Focus, organisation and commitment.
29. Firm politeness
30. Experience in multidisciplinary co-ordination
31. Excellent communicator, understanding of contributions from radiology, pathology, oncology and palliative care.
32. Excellent communication (summarising) & interpersonal skills. Empathy. Good organisational skills. Leadership.
33. effective management of time
34. Effective communication and control
35. Different teams will function in different ways and the leader will need to be different. eg Most teams will function best with a single leader- others may rotate.
36. Decisive, fair, articulate and good communicator, well-informed and up to date with

current literature, patient centred, inclusive.

37. decisive cuts the xxxx diplomatic when necessary listens & then summarises up to date knowledge
38. control of the discussion to avoid delays and being side tracked.
39. Communication, ability to stay focussed on track, ability to ensure all MDT members can have a say
40. Clear understanding of management issues. Ability to keep the meeting on track. Be able to tactfully resovle differences in opinion
41. Authority. Good leadership and communication skills.
42. Authority without bullying. Focus. Charisma. Humour. Guile.
43. Assertiveness
44. assertiveness
45. All the above qualities.
46. All the above objectives are good and impossible to rank. MDT chair should be a good leader and team player.
47. ALL ATTRIBUTES IN QUESTION 35
48. Ability to keep things moving and keep to time
49. Ability to chair a meeting, understanding of the role of different core mebers
50. A sense of humour and good leadership
51. a formal chair is not essential
52. A business-like way of conducting the meeting. Good interpersonal skills, with respect for all colleagues. Being able to elicit views and discussion, but maintain its focus.

What types of training do MDT leaders require?

39 histo/cytopathologists responded to this question.

1. Would have to be invented
2. WILL DEPEND ON THE INDIVIDUAL.
3. Very little
4. Time management skills;
5. The idea of specific training for an MDT chair seems unusual and the concept of yet another training course to attend (to advise on leadership skills) fills me with dread. Done it, got the T-shirt.
6. Team building excercise and national updates on targets
7. Not sure leadership skills can be taught but team working can
8. None, its a personality issue
9. None special.
10. none special
11. None - we are all attending so many training schemes for so many different aspects of our work there is barely time to do any frontline work. We are 'trained-out'.
12. None - it's part of their day-job!
13. most of the ones I see do very well with no specific training. Who is to give the training? In the NHS at present I see too much training given by people who actually dont do the job
14. Man management, effective communication, IT.
15. Limited - on reponsibilities and resources
16. Leading discussion so that everyone feels involved but keeping the focus on the decision-making process.
17. Leadership, team work
18. leadership, communication, handling difficult people
19. Leadership and cahiring meetings and communications
20. leaders are probably born not made
21. knowing the trust objectives etc
22. its either in you or it is not... some basic training in communication. If you have to

train somebody to be MDT leader they are probably not suitable :-)

23. Ideally medical training so they can understand all aspects and implications of patient treatment etc
24. I have never considered this: I have never come accross anyone getting any training on anything to do with MDTs
25. How to use videoconference kit, how to use the databases, principles of quality assurance and audit as applied to the MDT Standards that apply from all professional groups involved
26. effective meeting strategy
27. Diplomatic skills
28. Depends on whether they fulfil the above
29. dealing with difficult colleagues' 'team leading' etc
30. Communication, team working, time management, technical expertise
31. communication, management etc
32. Communication, leadership.
33. Communication skills, time-management, training on how to effectively chair a meeting
34. Chairman skills. Communication skills. Time management skills.
35. Chairing. leadership
36. Chairing skills, decision-making skills
37. chairing a meeting Generally I think the skills are elarned on teh job by all doctors
38. as above
39. A first class psychology degree

What makes an MDT work well together?

45 histo/cytopathologists responded to this question.

1. They get on well and know their jobs
2. The common aim of arriving at the best treatment plan for each patient based on the information supplied from all specialities.
3. Team spirit, willingness to contribute and work, Valuing each other's contribution,
4. Team development, equality, respect
5. Small number of memebrs
6. Small cohesive group from one organisation
7. Shared objectives; agreed processes; takes place at the best time (not just when suits the surgeon); job-planned
8. Shared goals.
9. Shared goals and objectives. Lack of turf wars. Lack of private practice wars. Lack of merger threats. Partnership working. Conspicuous regard for all opinions.
10. shared goals respect for other members of team understanding of the role/remit of each team member
11. Shared goal.
12. Respect for others and wish to serve patients well
13. Respect for other's contributions and good communication.
14. protocols people who are prepared to work in a team and compromise
15. practice
16. Mutual respect. Awareness of the contribution of individual members
17. mutual respect,good facilities, humour
18. mutual respect, knowledge and experience, equality
19. Mutual respect of everybody's specialist knowledge in their own fields.
20. Mutual respect of all participants
21. Mutual respect and rapport. A patient-focus (rather than self-focus). Efficiency in identifying cases and presenting them. Good infrastructure.
22. MUTUAL RESPECT AND PROFESSIONALISM
23. Members that beleive in the usefulness of the meeting

24. low ego to intelligence ratio
25. liberte, egalite, fraternite
26. Knowledge of the subject. Ability to take difference in opinion without feeling personally slighted. Respect for colleagues
27. having the same aim which is improving patients care and delivering high quality service with the patient interest as top priority. other personal agenda items are key reasons for the failure and reduce productivity of the meeting.
28. good working of core members
29. Good training for members
30. Good communication, team work and effort
31. friendship
32. fortunately even difficult team members fall into place with peer pressure. Chairman of MDT should ensure that this happens
33. Focussing on patient care
34. Everyone pulling together for the benefit of the individual patient
35. EMphasis on good communication not arguments.
36. courtesy, preparation
37. Cooperation
38. Communication and respect for eveyone's roles and expertise
39. communication
40. Common goal of patient centered care, good communication, support of each other, cooperation and goodwill.
41. Clearly defined roles & responsibilities. Good professional behaviour e.g. time keeping, attentive listening. Peer support when something doesn't work/function as best it should.
42. clear purpose and outcomes
43. clear objectives good leadership no prima donnas IT / radiology systems working documentation outcomes audit /feedback every so often
44. Atendance of relevant clinicians
45. all member's opinions being valued

Infrastructure for meetings

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

77 histo/cytopathologists responded to this question.

1. Videoconferencing
2. video conferencing. All core members need to be in the same room
3. Uninformed core members, egotistical attitudes of some groups and lack of team working.
4. too many cases, large crowd which includes visitors
5. Too many cases and staff shorthage.
6. Time Seating arrangements
7. The video conferencing needs to work better, frequest lost connections
8. temperature, space, technology
9. technology failure....which happens 9 times out of 10
10. stuffy overcrowded rooms
11. small, crowded room with poor ventilation and poor viewing of information presented
12. size of the room
13. Size of room development of cabals in the front row Hierarchical seating
14. sitting in rows looking forward and trying to talk to people behind you
15. Site to site video conferencing - poor in this area.
16. Rooms are typically poorly adapted, too small for the number scheduled to attend, and have inadequate IT to present diagnostics.

17. Room too small or uncomfortable
18. Radiology from other sites not being on our radiology system Difficulty getting slides from patients who had biopsies abroad
19. poor radiolgy viewing facilitiesand breakdowns in videoconferencing
20. poor preparation of cases...with people having to read notes at the meeting...causes delay and confusion at times and upsets those who regularly prepare e.g. pathology and radiology. also adding cases at the last minute is rather poor.
21. Poor or lack of projection facility for diagnostic tests.
22. Poor layout of tables & chairs & imaging equipment
23. Poor IT support
24. Poor imaging and pathology set up
25. Poor facilities including radiology and pathology projection, too many cases, too many members who do not contribute.
26. Poor cramped conditions, often too hot!
27. Poor chair, poor MDT co-ordinator, poor preparation, pooor facilities (IT and meeting room).
28. poor aucoustics in the room: we sometimes can't hear what's being said
29. Poor attendance
30. people sitting with their back to the pathologist/radiologist
31. people being hidden behind others. Too much equipment/too many people in too small a space
32. overcrowding, inability to show all diagnostics.
33. Overcrowded room, room too hot, inadequate seating
34. Overcrowded room
35. not having facilities to display information to all members (ie good IT PACS/AV devices)
36. Not enough space so not all members can see images.
37. not correct accomadation, no computer audio visual , no microscope no link to other centres
38. non functional equipment / IT problems (usually PACS) not enough room / cramped facilities fixed microscope vastly preferable to m'scope on a trolley / table which is individually set up for each MDT (sorry, thats 3)
39. Non availability of case material Lack of time for preparation
40. NO SINGLE ITEM
41. Networking by computer-link
42. Layout of pathology and radiology consoles / microscopes
43. Lack of proper projection equipment and lack of technology to ensure effective videoconferencing. Holding meetings in cramped conditions
44. Lack of preparation and knowledge of the patients
45. lack of IT or key personnel
46. Lack of IT capabilities. Too many cases for discussion. 1 week results target.
47. lack of attendance due to other commitments
48. IT short comings
49. IT playing up!
50. IT not working
51. Insufficient space in the MDT room, certain members e.g. pathologists and radiologists behind physical barriers such as desks and monitor screens
52. Ineffective IT
53. Inadequate venue
54. In my experience MDTs are let down by poorly maintained and old-fashioned technology. Videolinks are ineffective in most instances, with poor sound and image quality and frequent loss of contact. Microscopes and projectors are often not kept in good working order.
55. Improper display of images. Multimedia not working effectively.
56. heat!
57. having to teleconference to remote locations
58. Have never worked satisfactorily with teleconferencing - would be better to have

everyone in the same room

59. From my perspective operation of audiovisuals with display of slides and X-rays
60. failure of technology
61. Equipment failure
62. Effective video-linking to other hospitals to allow members at other sites to participate fully in cross site meetings.
63. Doctors arguing and interrupting each other. Bad temper.
64. Distance and naff videoconferencing!!
65. Disinterest by clinicians
66. Difficulty with parking on site for those who attend from other trusts for network MDTs.
67. Databases, videoconferencing or imaging failures
68. dark for projection of images makes it stuffy and since most meetings are at lunch sends everyone to sleep
69. Cramped environs
70. Chairs in rows - where people have to look around to see who is talking or listen to the backs of people
71. Broken/unusable teleconferencing kit.
72. Broken equipment and malfunctioning technology
73. Bad acoustics
74. Any arrangement that impairs discussion (pillars, noise, etc).
75. Acoustics
76. Absence of key members or information, eg casenotes.
77. a core member not being around (and not excused)

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

79 histo/cytopathologists responded to this question.

1. works well if people are disciplined and ensures full attendance. when the system fails (as it regularly does) it stalls the meeting and causes extreme frustration.
2. works OK if you have to have it but discussion is somewhat artificial, good to allow peripheral units to contribute
3. With the BT 56KB line some hospitals appear to have - very negative. We videoconference to 4-5 other hospitals x2/week - videoconferencing facilities constantly breakdown/opoor sound etc. e.g. This morning one of our 2 projectors was not working at XXX [hospital] and the camera was not working at the XXX [hospital]. Now 3rd week in a row that our equipment has malfunctioned. 2.5 hours looking at a blank screen is very frustrating!!
4. With current technology poor quality - fairly useless histology and Xray images. Poor communication - have to shout etc
5. Whilst I support video-conferencing, I do not support teleconferencing. It is essential to be able to look at the histopathology and radiology images to understand the case. Next on the list, it is important to be able to see other people and interact with them. Sometime we have connection difficulty but on the whole it is an excellent way of communicating with colleagues in other departments without disruption and also time efficient as it saves on transport time.
6. We have tried this on several occasions - poor set up wastes time. Ends with telephone conversation betwen leads. Should be available to ensure effective decision making.
7. Waste of time
8. videoconferencing reduces decision making, noise interference (eg by lunch eating) occurs and though it is better than travel time fordistant meetings it is poor. Interpersonal relationships- which functioning of MDTs depend on do not develop on camera, though camera can be used OK if people already know each other. Never

16

experienced teleconferencing I can only think that it would be worse.

9. videoconferencing is good at saving travel time, but where there is a central operating department and a number of peripheral diagnostic departments, it is unworkable to have all members present for the whole event as while one peripheral site is discussing patients with the centre, the other site(s) are sidelined and find it impossible to contribute. personally I think mdT meetings run beat with everyone in the same room though this is very costly.

10. Video-conferencing is rarely effective and lengthens a meeting considerably. In my view it is done for political/public relations reasons rather than for proper case review, but it does allow the MDT to include distant units.

11. Very time-consuming. Despite good quality link, discussion is difficult. Something to be avoided if at all possible!

12. Very slow and ponderous way of running an MDT. Would not recommend as a routine.

13. Useful, but poor substitute for physical presence. Much time wasted getting teleconferencing to work.

14. Time wastage - no matter how good the connection, there's always communication issues (can't hear what being said or asked); saves on travel time/disruption to working day

15. Time travelling

16. time for meeting increased, but enables dispersed staff to contribute to MDT (eg regional sarcoma service); ours works quite well

17. the tecnology is usually inadequate for purpose, hindering communication and slowing decision making

18. The quality of sound and images is TERRIBLE: makes the meeting impossible

19. Tends to curtail case presentation and discussion

20. teleconferencing not a good idea as can cause misunderstanding due lack of visual link. video conf better but only as good as the integrity of the technology as constant breakdown is disruptive.

21. Teleconferencing is still not a feasible method of working, it is too slow, the converstions are stilted and the radiological and pathology images are not of diagnostic quality

22. Teleconferencing is better than no meeting but interaction is inhibited by the technology

23. Slows things down, cluncky etc.

24. Slows it up terribly as people in smaller centres "hog" time discussing a small number of cases without regard to much larger number of overall cases to be discussed

25. slows it down. People on video are never as involved. Technical support needed

26. Slows it down. Massively testing of chairmanship skills. Often deteriorates to a free for all. Technological glitches often detract. Can exacerbate poor team functioning

27. Seem still to be technical problems. I'm not sure its very effective.

28. saves travel time but cant always hear everything being said and difficulties reviewing some radiology/pathology at a distance rather than directly in person

29. Saves time/money but leads to sub optimal contribution to meeting

30. Saves time needed for travelling to be on one site. Negative impact is poor projection facility and technology not working most of the time.

31. Saves on travelling time but communication sometimes less than ideal - a reasonable compromise nonetheless

32. rarely used

33. prolongs the meeting time

34. Positive: Discussion of cases with specialist centre. Negative: Results in a perception of displacement from the other centre, which sometimes results in impolite behaviour from members of the specialist centre towards members of the peripheral (district general) centre - an air of superiority.

35. Positive: can discuss cases with distant team, saves travelling Negative: conversations not easy - delay in transmission and difficulty hearing some people. Reduces team building.

36. Positive links people together, negative poor connections

37. Positive - ensures attendance. Negative - does not allow a team building relationship. Pathology and radiology project poorly.
38. Positive - can involve staff at other trusts/location negative - equipment failure can scupper a meeting
39. Only required for Cancer-Centre type MDT's, where it is useful.
40. NO RELEVANT EXPERIENCE, ALTHOUGH LIKELY TO HAPPEN IN DUE COURSE, BUT BEING OLD FASHIONED (AND OLD) I BELIEVE STRONGLY IN PERSONAL PARTICIPATION IN THE FLESH. I RECOGNISE THAT THIS MAY NOT BE FEASIBLE IN SOME ENVIRONMENTS, BUT I BELIEVE THAT THE RESULT WILL BE LESS SATISFACTORY TO TEAM FUNCTIONING AND INTERPERSONAL RELATIONSHIPS WHICH SEEM TO ME TO BE ONE OF THE MOST IMPORTANT ASPECTS OF THE MDT
41. No experience.
42. No experience of these
43. Negative...wastes everyone's time
44. negative in my experience. We have abandoned it for one MDT and I no longer attend for another (network) MDT
45. My experience with teleconferencing in other MDTs that I've attended has not positive,. I do not believe people interact as well.
46. More convenient but loss of interpersonal contact detrimental
47. makes network MDT meeting function smoothly
48. main disadvantage is of pathology specimen projections, the quality can never be good to allow another pathologist to make safe interpretations, especially during videoconferncing with central MDTs
49. Larger attendance
50. It often takes considerable amount of time to establish a connection and wait for everyone to arrive. It is almost impossible to control the background noise of people talking etc at the other venue and not paying attention. It allows people to participate who would otherwise not attend.
51. It is highly time consuming and is difficult to ensure that all members are actually listening. The balance has to be set against the problems of travel by consultants to MDM's timewise. Wasted time either way is likely to increase as pathology labs are centralised.
52. It is essential for our regional weekly meeting otherwise colleagues in W [area], X [area], Y [area],and other sites in Z [area] could not realistically participate
53. It is a sop pure and simple and precludes effective interaction
54. It imposes the need to have only one preson talking at once.
55. it helps ensuring involvemnt of all team members and to take ownership in the decision making. It is slightly disjointed but positive outweigh the negative
56. It can slow things down. But does mean that in a spread-out area like ours, multi-hospital MDTs can take place.
57. It allows meetings across two sites situated 30 miles apart. It therefore increases efficiency in use of time (by saving travel time) and improves the availability of expertise, enhancing discussion.
58. It's great when it works but. of course, the NHS have purchased a seriously substandard system which is rarely reliable and usually unbearable in terms of image and sound quality
59. Increased risk due to pooor communication.
60. improve communciation and obtaining second opinion
61. Impossible to hear and particpate fully with our teleconferenceing facilities and these MDTs are going to be scrapped.
62. If it works, ensures reaching out to peripheral hospitals and better decision making
63. I have attended videoconferenced MDTs in different meetings in different parts of the country between different hospital and I have never seen a satisfactory one. There is insufficient and poor discussion, and more time is spent shouting at each other "can you hear us"
64. helps staff in other hospitals to attend with out travelling
65. have not done it yet
66. good for input from shortage specialties spread thinly across a network especially

when there is illness or other absence poor without strong assertive chairing especially when groups on different sites chat amongst them selves when not directly involved in the case under review.

67. Good
68. frustrations about technical hitches! - wastes time & causes tension and makes participation of members more difficult difficulty in communication due to suboptimal images of video-conference venue;
69. Don't know- the only times I have used it ... it is slow
70. Disruptive waste of time
71. Difficult to get involved in a detailed discussion because of lag in acoustics, otherwise, if cases are straightforward, this works OK, but not perfectly.
72. Creates large unwieldy meetings with too many cases and paticipants. Destroys communication and motivation.
73. Cannot assess images with teleconferencing. Videoconferencing important with networking of widely spaced centres
74. Can cause delays for uninvolved team members
75. Can be time consuming
76. can be difficult to ensure you are all discussing the same patient, particularly if many cases - very dangerous
77. attedance throughout network
78. Although it makes attending meetings easier, it is not always easy to interact via VC as well as if you are there in person
79. Allows interactions across network. Interactions are not as effective as when people are in the same room.

What additional technology do you think could enhance MDT effectiveness?

57 histo/cytopathologists responded to this question.

1. Virtual slides. Areas of histologcial interest can be located quicker. No need to retrieve slides for every MDT - they will already be available, PACS like.
2. Virtual microscopy would be useful.   Better more reliable internet connections and equipment
3. to have all macro images (cystoscopy, macro specimens (from clinics, theatre archived on a database accessible from on the MDT computer)
4. Telepathology equipment to obtain second opinons at MDT
5. Technology should work, if it has been provided.
6. Technology is not the answer to the effectiveness of the MDT, given that certain elements are in place.
7. Speed of lines could always be enhanced.
8. Real-time decision-making as a routine using software
9. Re: Microscopy projection. The other members of the MDT seem to have no real interest in the actual images that are shown.
10. Proper vieo conferencing that doesn't break down
11. Projection facilities in all MDTs. Needs to be linked with increased A&C funding due to the rapidly increasing time required of our secretaries to obtain cases for MDTs
12. permanent microscope facility in 1 of my MDT venues
13. PACs storage of macroscopic and microscopic pathology images. Long promised, never delivered.
14. None apart from that mentioned n the questions
15. NO VIEWS
16. No opinion.
17. Never thought about it
18. Need better speed links and microphone technology than currently exists. i.e. need to wait for better and cheaper technology

19. mdt management software with automatic outputs, database for clinical data to allow real time analysi sof past similar cases and results of treatment and audit, and database support - not just data entry, someone to pull out and analyse
20. it just needs to be better....
21. it hasnt been invented yet
22. It's not the technology but the abysmal lack of technical support that is the problem. Technical support personnel are key.
23. it's a bit of a nonsense projecting the computer documentation- I am short sighted but not that much and I certainly can't read it anyway- it means people think there is agreement but few people have necessarily read it
24. If we prepare the cases prior to the meeting, we could replace the microscope by virtual microscopy and scan the slides in the department instead of transporting them.
25. I use digitised histology images on a dedicated system & rarely project glass slides.
26. High-quality (expensive!) video technology, with the same system at each hospital would be more effective (our MDT connects with 3 different systems).
27. Good projection facilities for radiology and pathology. Proper IT support for minimum data sets.
28. Good dedicated MDT software with links to PACS, LIM. patient E-RECORD ETC.
29. Good cancer databases
30. Get it to work
31. Failure-free IT! Or at least an IT person who is always available to help.
32. Electronic booking of appointments and test requesting
33. Direct connection to the PACS system, a sensible CRS system, the pathology system and dual screens so that both radiology and path can be shown together etc. If videoconferencing is used dual screens are mandatory in my opinion as switching between room, microscope and radiology is highly tedious..
34. Digitisation of all pathology specimens as virtual slides and access to this archive direct from the MDT room
35. digital pathology
36. decent, reliable video-conferencing is key
37. Computer with screen projection for MDT decisions
38. Common sense - we seem to have forgotten that!
39. Coffee machine!
40. coffee machine
41. Cattle prods to stop outbreaks of surgical meandering
42. Better videoconferencing links. Electronic linkage of microscopy.
43. Better teleconferencing technology
44. Better system of projection Connection with pathology database for reviewing retrospective reports
45. better road transport and car parking
46. better quality videoconferencing equipment, connectivity and technical support
47. Better microphones.
48. better IT, speed & resolution. Multi screens
49. Better databasing and decision support systems. It is not uncommon for different decisions to be made in different weeks given the same context - which should not happen...
50. Better computer access to pathology
51. As above
52. Adequate IT support and video conferencing equipment at both ends
53. Adequate computer and teleconferencing link
54. access to the MDT minutes by all core members
55. ability to project the pathology datasets, treatment decisions
56. Ability to link with other pathology labs so that histology reports and tumour markers done at other labs in the region can be viewed.
57. A computer with access to old histology reports and imaging reports

Meeting organisation and logistics

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

90 histo/cytopathologists responded to this question.

1. Very little apart from production of a list and producing relevant notes/reports. Too much work is done for little return. There are no agreed standards for preparation nationally which makes local protocols difficult to formulate
2. Urgent report of 'outstanding' new patient biopsies. Review diagnoses for new patients from outside trust Review reports for new and old patients not personally reported
3. The radiology and histology/cytology should be reviewed and, I believe, the clinical summaries should be organised so that succinct presentation happens. But it never does because the clinical presenters never prepare beforehand.
4. Slides, images and notes available for review.
5. Slide review, discussion with colleagues, literature data for difficult cases.
6. slide review
7. Selection of slides, printing reports,sorting according to list provided by MDT coordinator. Saving of laboratory time where MDT coordinator provides relevant histopathology/cytology report number
8. Reviww histo and previous reports
9. Review the case prior to the meeting Obtain case notes, pathology reports and slides, and radiology reports and images
10. review slides and reports
11. Review slides / imaging reports
12. Review slides - review slides of previous operations if any review the pertinent literature if necessary take images and prepare powerpoint presentations
13. Review of some cases I did not give primary report on. review of previous histology on some problematic cases
14. review of slides and reports for histology
15. Review of slides and reports
16. Review of reports and relevant slides. Notes available and cases known to clinical staff, readiologists able to access images and reports
17. Review of recent/previous results and reporting of recently received biopsies/cases
18. review of radiology, review of histology/cytology, gathering case notes and patient information eg appointments
19. Review of radiology and histology by lead clinicians Proper list of patients with all details correct Notes pulled
20. Review of pathology, radiology and clinical notes
21. Review of pathology and imaging in the context of clinical question. Responsible individual to know the patient, relevant co-morbidities, biological age etc
22. Review of histopathology
23. review of histology/cytology
24. Review of histology slides & reports
25. review of histo slides, need to check no old samples need reviewing
26. Review of everything that is relevant particularly pathology and radiology: I am a little ambivalent that all review must take place before a meeting - pre-meeting rapid review is useful but one could argue (strongly) that pathology review is as useful after the meeting (and resource cna then be targetted at the right cases rather than the majority where everything is straightforward. Cancer is not magic and diagnosis of it is often VERY straightfroward: it's the cases with doubt which need the efort.
27. review of clinial notes, histo-cytopathology and radiology by respective members

of the team

28. Review histology/cytology/radiology
29. Retrieve slides and reports. Review slides and check diagnosis. Ensure any further tests are performed.
30. Proper clinical, radiological and pathological review of cases, so the presentation of the information is concise and timely, allowing for effective decision making
31. prompt list. slides pulled. reports printed. slides and reports collated. slides and reports reviewed with colleague
32. Preparation varies between meetings. Histopathologists need time to read the reports and review the slides, this is currently not always possible.
33. pathology slide review
34. Pathologist(s) need time to review slides, previous slides and research literature and consultant colleagues if appropriate.Difficult slides may need joit or double reporting etc. May need time to make digital images or cross load digital images into a presentation. Physicians and surgeons need the notes and time to prepare the cases.
35. Pathologist reviews sections/reports. Radiologist reviews radiloogy. Clinicians know at least something about the patient.
36. pathological review of all cancers- sometimes more than 50-60 cases
37. Need to be familiar with all the data which one will present and agree with it.
38. Looking at propsed list to ensure that all cases reported (histopathology), examination of reports and some slides to ensure accurate diagnosis and staging
39. list of cases no later than 24 hrs before the MDT, pref 48 hrs no late additions adequate time to prepare material (histo - slide & report review) funded clerical / lab support for histo medical staff, who will retrieve slides & reports in the appropriate timescale split site MDT's require coordination with available transport
40. Late cases reported, slides found, reports   printed & collated, cases reviewed discussed   with colleagues if necessary
41. in my case, reporting of all new and selected review of older pathology
42. in my case double confirmatory reporting of new cancer diagnoses
43. I review pathology reports and slides
44. I need to review the histology/cytology diagnoses and slides before the meeting, discuss with colleagues if necessary.
45. I have to review the histology of the cases
46. Histopathology macro images & slide review. Radiology review.
47. Histopathologists have to review all relevant microscopic slides and confirm or change the original diagnosis/grading/staging etc., and compare with any previous reports. Same applies for radiologists. Clinicians should know medical history and all relevant laboratory and other important results of each patient.
48. Histopathologist reviews the slides diagnosed by colleagues.
49. Histopathologist prepares all cases. I am not sure if all other team members do.
50. Histology case review, assembling evidence either photos or slides to show Review of radiology and evidence of staging review of case notes by clinician
51. histology and radiology review checking notes and results available knowing next appointment patient has had made
52. Full evaluation of each case
53. From a pathology point of view, all of the previous and current histology needs to be retrieved and reviewed, all of the reports have to be retrieved and reviewed, so it is important for the MDT lists to be prepared and sent to Path departments well in advance of the meeting. The review should also be carried out by an MDT pathologist other than the primary reporting pathologist to ensure audit of the original diagnosis, and for the purposes of governance. Any additional investigations eg immunohistochemistry should be instigated at the time of the review if this is deemed necessary.
54. From a histopathologist's point of view: - patient list needs to be circulated - all reports, present and past need to be printed and read - from those, relevant cases are selected and slides reviewed - for selected cases (eg. pancreatobiliary cancers) images of the macroscopic findings are often more informative than microscopic findings.

55. Formal audit/review of histology slides and radiology imaging before the meeting. Written review report for network/specialist MDTs
56. for me, reviewing histology slides & reports to confirm diagnosis, identify any errors or missing information, research any additional information for unusual tumours
57. For histopathology: Receive list of cases Check on several computer systems to see if patient has had a biopsy, recently or in the past Expedicte laboratory processing for patients with a biopsy not yet reported Print out copies of all reports Get slides out of file Collate reports/slides/meeting list Physically rview sections and read all reports to be prepared to present the case in the meeting with the minimum of time delay Check diagnosis and diagnostic accuracy. Check written report for accuracy. Create a pile of slides and reports ready to take to the MDT
58. Ensuring that the case is reported and at least a draft is available to take to the meeting
59. Discussion between core members and other involved Professionals from the same discipline
60. differs for each member of team but all relevant information, imaging pathology should be available
61. Depends on setup. We often have to make powerpoints for cases, paticularly for meetings in rooms with microscopy. Ideally clinicians should be ready to present patients. Oftenit is only the radiologists, pathologists and coordinators who have put any time nto the meeting. Clinicians just pitch up a read history off sheet or blag it!!
62. correct list of patients, no omissions. Pathologist: complete knowledge of the case (this csn be time consuming)
63. compling of the reports with particular importance to the salient points to be discussed at MDT which would influence the management; organisation of the MDT list
64. collection of info, often from other specialties or computer systems, analysis updating of patient summary so no time wasted covering same material twice
65. collect all relevent test results and clinical information
66. collation of slides and reports. review of slides. ordering of cases wrt list
67. Collation of information and reports, review of diagnostic material, consideration of relevant questions, consideration of patient pathway, ensuring that there is cover for absent core members
68. Collation and review of core clinical, pathological and radiological data
69. Clinicians should know the case, including previous diagnosis and treatment. The radiologist should be informed of the cases, and the particular imaging required (and question being asked). The pathologist should receive a timely list of cases, with appropriate (and correct) histories, and with details of the specimen(s) to be reviewed and a clear reason for the review.
70. clinicians need to know patients imaging needs to have been reviewed histo/cytopathology needs to have been reported/reviewed
71. check slides and reports
72. Case selection, locating all relevant biopsies, biopsy review, taking macroscopic photographs where useful, failsafe to ensure that all cancer diagnoses are discussed (speaking for histology only). Clinicians need to know case histories!
73. Case notes reviewed and summarised. Discussion with referring doctor.
74. Be familiar with each case, whatever one's discipline.
75. Availablity of all the relevant information - notes, radiology and pathology
76. Asa a histopathologist, our A&C staff require a list at least 24 hours prior to the meeting (doesn't always happen!). Our clinicians need to inform us (ie communicate with our A&C staff and ourselves) in advance of putting the case on the meeting that they require review of outside histology where applicable (doesn't happen in all instances)
77. As pathologists we review cases (not every slide) as a team. this allows input in difficult cases as well as allows individuals going to the meetings to be prepared.
78. AS A PATHOLOGIST I MUST REVIEW THE SLIDES AND REPORTS RELATING

TO EVERY CASE, MARK AREAS ON SLIDES FOR DEMONSTRATION AND DISCUSSION, DISCUSS DIFFICULT OR DISPUTED DIAGNOSES WITH OTHER PATHOLOGY COLLEAGUES AS NECESSARY. SIMILAR REQUIREMENTS FOR OTHER SPECIALISTS INVOLVED.

79. As a histopathologist, I review the slides of the case to ensure diagnoses are accurate and the data are complete. Radiologists should do the same. Clinicians should be familiar with the patients details, including co-morbidity and social factors. They should also consider trial entry.

80. As a histopathologist - review of all cases including previous pathology if applicable. All members of the team should have a list of the cases to be discussed and be similarly prepared

81. All pathology and radiology review. Hours wasted on radiology trawling at ours. Clinical note reviews never happens but might save a lot of messing around

82. ALL parties involved should prepare, not just radiology and pathology!!!!Clinical questions should be known, at least to the person asking for the case to be discussed at the MDT

83. All histology slides need to be reviewed for individual cases and photographed for presentation

84. all contributors need to have reviewed case notes/imaging/pathology

85. All clinicians should summarise case notes before the meeting. Pathology & Radiology usually look at images & slides prior to the meeting

86. All clinical info should be known by the clinicians so that this can be clearly and succinctly presented. Pathologist must review all of the cases and external review done. Radiologist to have time to review all the cases. Oncologist should be aware of the diagnosis and research unusual cases as should the other members of the MDT.

87. all cases need to be reviewed by the individual practitioner.

88. Agenda circulated, cases should be prepared and minutes of the previous meeting to avoid patients being repeatedly bought to MDT

89. adequate notice 24-36 hours to ensure all histology cases and slides are available as well as reports. This would allow time for cases to be re-cut if slides not available. neet accurate patient details and full relevant past history of all tumours

90. A pre-meeting prepartion for the cases should be made mandatory. The process should be documented as evidence-based and audited regularly. This is a safety and clinical governance procedure that is usually bypassed. All related previous biopsies MUST be reviewed and documented as a summary of the conclusion. This should be either added to the minutes of the MDT and/or to the new report. The same applies to the clinical side. All members should be encourage to participate in the discussion.

What makes an MDT meeting run effectively?

79 histo/cytopathologists responded to this question. In addition, 3 referred to answers they had given to previous questions.

1. Well organised with small core team NO video linking with other units to create supraregional meetings.
2. We often discuss over 45 cases and have a meeting lasting over 3 hours. The pathologist involved in most cases while the urologists and oncologists are involved in proportion only..
3. Timely start, good chair who keeps the meeting concentrated on the job in hand, all relevant people present and able to contribute.
4. time must be given to staff for attendance if niche specialities are present it may not be appropriate for them to wait the whole meeting through minimum dataset of info may not be available for all patients at all sites
5. The pathologist keeping control and discusssing the differential diagnosis and limitations if no one else does
6. The chair keeping time and having timely discussions with a clear plan of action.
7. Sufficient amount of time to discuss the cases appropiately
8. Starting on time.
9. Resources, time, team spirit, coffee
10. Quick and to the point presentation and decision making with recording of decisions made. Good quality IT to support the meeting. Abitity of all disciplines to have an input into the decision.
11. punctuality, politeness and focus
12. Protected time??!!! Co-ordination between team members. Listening. Not talking over each other.
13. Proper chairing to facilitate review and decision-making and to prevent digression. Timely notice of cases to be presented to allow familiarisation with each case. Good IT to allow projection of images, data and reports. High-quality video-conferencind, where needed. Good relationships within the team and a spirit of mutual respect. Team-working skills.
14. prompt start of meetings. members should all come on time. if any member or their deputy would not be attending, their cases should not be put on the meeting
15. Prompt start and concise discussion - keeping to time
16. Prompt circulation of the list List is annotated with reason for MDT discussion to allow a 'cut-to-the-chase' The room has enough seats, people can see screens etc, - too many MDTs are in inappropriate rooms lacking facilities to show pathology, imaging etc Chair runs the meeting and maintains a pace, using judgement to stop circular or irrelevant discussion People turn up on time to present cases. People know who is on the list and have prepared. A management decision, summary note is always made for each patient - read aloud by the chair and recorded by the coordinator before moving on to the next case More than one opinion available for each domain eg pathology, imaging, oncology, surgery. Just having one person's view is not always useful and goes againt equality of access and patient choice agendas. Deferred decision making is always picked up at the next MDT. There is space for an educational component in each meeting eg review of a rare tumour that has presented, presentation of evidence for an uncommon lesion. These need to happen 'with the case' to be effective learning.
17. pertinent information and descision making
18. People arriving on time having done the necessary preparation, and all core members attending
19. Pathologists and readiologists have prepared cases (this happens with us); the clinicians must know about the cases/ communicate effecively(still nor always the case here)
20. Organization and preparation
21. organisation of cases with a good strong chairperson

22. Organisation and team work and good co-ordinators and chairman
23. Organisation Availability of radiology and pathology
24. organisation
25. optimumof cases depends on length of mdt.
26. Optimum number of cases depends on complexity A formal chair is not necessary
27. No bleeps/mobile phones, no idle chit-chat, people entering/leaving the mdt
28. Membership and preparation
29. Many of our MDTs are networked (video conferenced). As the main centre we suffer 2.5+ hours per meeting for upper GI and pancreatobiliary meetings - this certainly does not make for effective running. Strong even-handed chairmanship, preparation and good IT support are crucial (video conferencing constantly breaking down)
30. Key information available, Concise presentations of relevant information, well lead discussion, consensus development of clear management plan
31. Keeping strictly to the agenda and no discussion of irrelavent issues
32. Individual commitment and effort
33. If the team notices that the MDTs are getting longer then they should split the meeting for e.g. new cases vs post op rather than rush the cases or extend the MDT to unreasonable long time which can be exhausting. This reduces the quality of the meeting. Prior preparation Continuously improving education so that the entire team would be of the same understanding.
34. Having a manageable workload
35. Good preparation, not too many cases and adequate time for discussion
36. Good preparation and coordination of all core members.
37. Good preparation & effective MDT software on screen
38. good planning,all core members present ,
39. Good leadership, equality of opportunity to contribute
40. good leadership agenda beforehand / available, with pertinent info already summarised all equipment working - IT & PACS in particular keep discussion to the MDT & cut the individual ranting which is irrelevant to the MDT(keep those stroppy surgeons under control !) adequate documentation
41. Good leader, clinician present who actually knows the patient (ESSENTIAL), prior review of path and radiology, finishing off the paperwork AFTER (NOT DURING) the meeting.
42. Good coordination among team workers and proper organization
43. Good co-ordination and communication between all members assisted by an efficient MDT co-ordinator and chair of the meeting.
44. good chairmanship, coordinator who has done his/her job
45. good chairmanship, an excellent MDM coordinator, proper pre-meeting preparation
46. good chairing, stopping unnecessary and irrelevant posturing, curtailing useless discussion
47. good chairing
48. Good chair, good preparation.
49. good chair person, preparation, run to time, no disruptive personalities.
50. Good Chair and good pre-meeting organisation. Time to discuss cases. All members of team present. Ample notice of cases to be discussed.
51. Good chair Sorting and prioritising of cases Prior preparartion
52. full documentation of the case and full knowledge of the history presence of the coordinator attendance of all core members
53. Focussing on the patients and not indulging in irrelevant conversation. Also time is often wasted showing radiology and pathology. It is the results that are important not the demonstration of images. The format has been influennced by old-style CPCs which these meeting have often replaced.
54. FOCUS ON ESSENTIALS AVOIDIDNG DIGRESSION. FIRM CHAIRING. GOOD PREPARATION BY ALL INVOLVED
55. excellent chairing of the meeting with elimination of irrelevant and tangential discussions. excellent coordination with all necessary info prepared in advance

and to hand. good general working relationships between core members. nothing slows a meeting like a dose of backbiting

56. Everyone present on time and staying for the entire meeting (not having other work scheduled for the same time); preparation of cases to be discussed; lack of interpersonal in-fighting/points scoring; effective contemporaneous recording, which is seen by the whole group (not just handwritten comments in the patients' notes)

57. Effective listening and understanding of contribution from different disciplines. Preparation is paramount.

58. effective chair (usually lead clinician) manageable caseload core members present to enable decisions to be made

59. Effective chair (cutting the cackle)

60. effecient chair and a good coordinator, availability of all patient material

61. Cooperation from all members

62. Concise presentation of cases. IT Godd chairing of the meeting

63. Co-operative working, lack of aggression, lack of egotism, full technical provision without hitches

64. Clinical/radiological/pathology/oncology information all available for discussion.

65. Chair, brief correct histories, no rude obstructive comments by some clinicans who feel IOG is unimportant and they will not send patients centrally, strong leadership is needed centrally, i.e at DOH level to remove these problems

66. Cases having been reviewed before meeting, all core members present for whole meeting.

67. Brevity, courtesy,

68. Availability of patient information, attendance of relevant members, working video/microscope technology, lack of repetition, inclusion of appropriate cases only and avoidance of unnecessary discussion (sidetracking)

69. availability of diagnostic information

70. Assertive chair with good communication and chairing skills, no place for ranting bullies

71. Not too much talking.   Anyway I am not sure if MDTs are ever really "effective".

72. An effective chair

73. all participants knowing what is needed of them

74. All information available and reviewd by the appropriate consultants: clinical, imaging, pathology.

75. A leader preventing doctors from interrupting each other.

76. A good co ordinator and a good chair, all present at appropriate times, good room and technology.

77. A good Chairperson

78. A good chair/clinical lead and MDT co-ordinator. Good preparation by all subspecialties involved; no missing notes/files/radiology/histology. Good planning of the agenda, good technology and venue.

79. A good chair, clear case presentation, good preparation, no rambling

Clinical decision-making

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

32 histo/cytopathologists responded to this question.

1. They should be discussed at the MDT. Treatment of recurrent disease is often more contentious than the primary disease.
2. They should be discussed at MDT. the burden of responsibility is those cases is too large for them to have treatment options on the hoof
3. they are discussed at the MDT meeting i participate in
4. there should be flexibility regarding these patients and it should be at the discretion of the oncologists to refer these patients to the meeting if and when they feel it is appropriate
5. Should be discussed (briefly) at MDT
6. Review at MDT if patient progresses in an unexpected manner (either better or worse than expected) - although personally I think all patients in whom disease status has changed should be reviewed at MDT. I also think all deaths of MDT patients should be reported to the MDT and if unexpected deaths then there should be a thorough MDT review.
7. Professional discretion with reference to best practice guidelines
8. Oncologists should seak an MDT review only in unusual or uncertain cases. Otherwisae they should be able to make decisions about further examination and/or treatment and be responsible for it.
9. Oncologists could meet together sparately
10. Not sure: I am a histopathologist!
11. NO OPINION
12. no opinion
13. Need MDT
14. isnt this what the oncologists do ?
15. Individual clinician decisions.
16. Individual clinician choice
17. I think that ALL patients with recurrent or advanced disease should come through the MDT.
18. I believe treatment should not be delayed in such cases to wait for the MDT, but problems should be brought to the MDT. At the moment there is too much commitment to the new patient at the expence of those with recurrent or advanced disease, and I think greater review of patients post first treatment could improve survival
19. I am not competent for commenting on this
20. Down to the nidividual oncologist involved in that particular case, with the option of referring back to the MDT in difficult cases
21. Don't know
22. discussed if required only. Straightforward decisions by individual clinicains
23. Decision making in clinic is fine and can be either supported by protocols or subject to retrospective MDT discussion
24. Current accepted guidelines
25. clinicians can do most of this by themselves, and just discuss difficult/unusual cases
26. Clinical opinion of responsibe clinician
27. Clinical hierarchy
28. clinical expertise
29. Case conference; ethical committee
30. Autonomous decision making by a trained clinician

31. Agreed protocols
32. A sub-groupd of key people eg. CNS, oncologist and palliative care team

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

30 histo/cytopathologists responded to this question.

1. UNFORESEEN CLINICAL EVENTS OR DEVELOPMENTS, I SUPPOSE, BUT NOT MY PERSONAL ROLE AS PATHOLOGIST
2. Sudden deterioration in patient Death of patient Non-attendance of patient
3. Request forms getting lost. Waiting lists for follow-up too long.
4. Initial treatment recommendation is made AFTER MDT discussion
5. Ptient choice
6. Presume patient preference.
7. poor communications. some resistant players who dont have time to attend the MDT and instigate treatment outside the MDT
8. people not listening or documenting the recommendation
9. Patient wishes. or patient disease progression, or inadequate information about patient at the time e.g. performance status
10. Patient choice.
11. Patient choice, reactions to drugs, detection of other diseases that influence choice of treatment.
12. Patient choice!
13. Patient choice
14. Patient choice
15. Patient choice
16. patient choice
17. patient choice
18. Patient's physical condition does not allow MDT recommendation. Further staging investigations at a referred hospital show progression / undiagnosed disease.
19. Not all surgeons are present at the MDTs
20. New factor
21. N.A.
22. Lack of resource eg PET scans etc.
23. Lack of communication
24. I never realised that this is an option1
25. Dont know
26. Dont know
27. comorbidity, social circumstances,
28. Clinician who knew the patient was not there and the management plan therfore ignored patient performance status or wishes.
29. Change in the patient's clinical stage/radiology/pathology.
30. Additional clinical information not available at MDT

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

42 histo/cytopathologists responded to this question.

1. we use a system on the histopathology computer to flag up all malignant diagnoses, similar markers on radilogical and clinical databases may help
2. Tricky. Path & radiology records are one way but this will only pick up those with histology and imaging.
3. those who might refer should be members
4. There should be a dedicated and trained individual to assess all reports of new malignancy. It should not be down to reporting pathologists or radiologists to refer every cancer case to the appropriate MDT
5. Straighforward cases should be discussed by the relevant doctors e.g. in a clinic or phone conference but not necessarily at an MDM. It is becoming a mantra that an MDM is necessary leading to medical time problems. I service 4 MDM's at 4 different hospitals. I can't always attend but I can usually answer my phone.
6. Search databases
7. Sanctions when aware that not
8. Protocols, patient pathways and awareness of all staff of role of MDT
9. protocols and audit and peer pressure
10. Probably through the pathology database A printoff of all cancer diagnoses could go daily to a designated co-ordinator
11. Not applicable
12. no idea
13. Linking pathological and radiological diagnoses to relevant MDT Co-ordinator patient lists
14. Linkage between histopathology diagnosis and MDT case finding
15. Junior staff should be made aware of the relevance of MDTs
16. histology SMOMED coding radiology rapid referral
17. Good trust processes - awareness by clinical teams, identification of cases through radiology, pathology, endoscopy etc
18. failsafe processes whihc rely on several disciplines. coding of cases for referral in pathology/radiology than can be regularly searched. Surgeons should be less supine in referral.
19. Failsafe mechanisms devised with full knowledge of local practice and pathways.
20. Ensure that everyone is aware of new patients.
21. ensure all disciplines have agreed communication protocols with the mdt co-ordinator for all new and unexpected cancer diagnoses
22. Electronic flagging of all malignant diagnoses on pathology computers, with automatic messages to a central MDT organiser.
23. Effective failsafe mechanisms
24. Education, education, education
25. Education of pathologists, surgeons, radiologists etc to ensure that all relevant patients are referred.
26. education
27. Dont know
28. Don't know, check patient pathways
29. Don't know of any foolproof method. Must allow for all members to be able to list patients for discussion and there must be good communications between different MDTs to catch those patients with unknown primaries
30. difficult
31. Data collectors secretarial support regular MDT co-ordinator and cover (for leave and sickness)
32. Computerised automatic flagging of cases diagnosed either clinically, pathologically or radiologically (can certainly be done with pathology now)
33. check pathology for all new diagnoses and check radiology for all possible

malignancies and add them to the MDT agenda to chase up if they are not already being presented

34. Central database that's easy to check
35. By multipronged information alerts ie allowing all members of the group to contribute cases within a time frame
36. by ensuring that no oncological treatment is initiated without a member being involved. unexpected diagnoses of malignancies have a clear pathway of referral to an MDT
37. Better organisation!
38. Automatic notification link between all histopath IT systems & MDT system
39. Audit of trust cancer database against MDT agendas & patient notes.
40. Audit and corrective action...
41. AS PATHOLOGISTS, WE ARE INVOLVED IN MOST MALIGNANT DIAGNOSES. WE PROVIDE LISTING FOR THE MDT OF NEW CANCER CASES DIAGNOSED IN OUR DEPARTMENT . OTHER FRONT LINE STAFF SHOULD BE EQUALLY AWARE OF THIS RESPONSIBILITY.
42. All pathologists putting all cancer biopsies on the list for the MDT meeting immediately

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

44 histo/cytopathologists responded to this question.

1. you may not believe this but I have no recall of agreement not being reached.
2. Write them down, and communicate these to the patient - so the patient can make a choice.
3. who recommended what and why. Outcome if there is one agreed. It is not appropriate to think of it as a 'majority verdict' as this does not nec reflect evidence base- there will always be new treatments that only some clinicians have the knowlege to recommend or avoid. These cases may be referred to a tertiary centre.   Patients cannot 'choose' treatments as they may be ineffective or damaging to the patient and clincians are not obliged to hurt people at their request. Usually this is is not an issue and we are talking about the autonomy of a patient to refuse certain treatments or chosse from a limited range (eg having refused surgery).
4. verbatim
5. this should be minuted and referral to clinicians initials and opinions is made.
6. The MDT outcomes should note the disagreement.
7. recorded in minutes and discussed with patient
8. Record on the mdt sheet with which clincans and then what was the majority view
9. Politely
10. Options listed, degree of support for each option listed and reason for final decision noted
11. On MDT record
12. On MDT IT system, live on screen in meeting
13. Not really an issue, if there is good team working and consensus
14. NOT MY FIELD. THIS HAS NOT ARISEN IN MEETINGS THAT I ATTEND
15. Non-judgementally
16. Meeting notes
17. In writing
18. In the patient notes.
19. In the patient's notes by the MDT chair
20. In the minutes

21. in the mdt minutes and in case of disagreement a vote of majority from core members to be taken
22. in the clinical database
23. In the case-notes.
24. In patient record and referral to the cancer network
25. In full detail.
26. in detail
27. Honestly. However, this should rarely occur. Consensus should normally be achieved.
28. honestly!
29. factually. the patient is presented with options not a decision as to what is recommended
30. Factually
31. Excactly as they happen and be presen ted to the patient.
32. Evidence based review at the next MDT
33. electronically in MDT record
34. Don't know
35. coordinator records on form that there is split agreement
36. clearly and legibly, both in the notes of the meeting and in the patient's case notes
37. by the chair
38. As they are.
39. as they are
40. as such
41. As split decisions and recommendations with patient made aware of the differences in opinion.
42. As majority agreement of the treating team. Other members not agreeing may not be directly involved in the patient's care
43. all recommendations to be recorded and put to the patient
44. Accurately

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

61 histo/cytopathologists responded to this question.

1. will vary case to case, clinical nurse specialist, junior medical staff, key worker
2. Their clinician and / or nurse specialist
3. the specialist nurse/ consultant
4. The referring clinician
5. The patients main clinician.
6. The patient but that is not practical. It usually falls to the specialist nurse or physician.
7. The patient's views do not necessarily need representing. Treatments are only recommended, the patient ultimately chooses following discussion of the options with the clinician
8. The key worker e.g. breast care nurse
9. The Key Worker
10. the first senior investigating clinician who has met the patient on the correct referral pathway
11. The Consultant treating them, or at least one of the clinical team who has discussed the issues with the patient.
12. the consultant + their team
13. The clinician/surgeon involved.

14. THE CLINICIAN WITH DIRECT RESPONSIBILITY FO THE PATIENT'S CARE. oR A RELEVANT SENIOR NURSE SPECIALIST WHO MAY KNOW THE PATIENT BEST
15. the clinician responsible for their care
16. The clinician or specialist nurse in charge.
17. Surgeon
18. Specialist nurse?
19. Specialist nurse practitioner
20. Specialist Nurse or doctor
21. Specialist Nurse or Clinician who has seen the patient in clinic.
22. Specialist nurse for the cancer site.
23. Specialist nurse
24. specialist nurse
25. Someone who met the patient (specialist nurse or Consultant or trainee
26. Someone needs to document any known views. Often a patient will have no view, as they won't know teh diagnosis yet... an MDT may be making a decision to biopsy, prior to further planning. The decision to biopsy is informed by an oncologist making a decision, based on comorbidity/condition, that they woudl treat teh patient if the biopsy showed a particuolar diagnosis.
27. Person who has spent the most time with the patient
28. Patient
29. patient
30. Patient's primary clinician (surgeon, oncologists etc) + nurses involved
31. Nurse.
32. Nurse specialist.
33. Nurse specialist or Consultant
34. Nurse specialist
35. Nurse
36. managing clinician/nurse
37. macmillan nurse specialist or oncologist
38. macmillan nurse
39. key worker or Clinician who has had direct contact with patient
40. In practice, the specialist nurse
41. Either a clinical consultant or nurse practitioner.
42. Doctor or Nurse
43. Doctor in charge talking to the patient before the MDT meeting.
44. Consultant surgeon / oncologist
45. Consultant is charge of the patient
46. CNS or clinician who has met the patient
47. CNS / Consultant
48. CNS
49. cns
50. Clinician who is in charge of patient.
51. Clinician or specialist nurse
52. Clinician or clinical nurse specialist
53. clinician or clinical nurse specialist
54. Clinical Nurse Specialists
55. Clinical nurse specialist or doctor
56. Cancer support nurse
57. cancer nurse. But patient views cannot inform the initial treatment recommendation if we are to follow protocols. Later on once a 'scientifically' best treatment is recommended then patients can input so it could be moderated if nec.
58. Cancer nurse specialist.
59. Breast care sister or clinician
60. breast care nurse at breast cancer MDT

61.   attending clinician

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

57 histo/cytopathologists responded to this question. In addition, 7 referred to the answer they had provided for the previous open question (Q32)

1.   their consultant physcician/ surgeon/oncologist; or a specialist nurse if he/she has the expertese
2.   Their clinician.
3.   The responsible clinician
4.   THE RELEVANT CLINICIAN
5.   the referring clinician
6.   The physician or CNS
7.   The named clinician in charge of the patient's care or a clinician to whom the patient is being referred for further management,eg oncologist
8.   The consultant in charge of the treatment.
9.   The clinician who brings the patient's case to the MDT
10.   the clinician looking after the patient
11.   The clinician in charge.
12.   The clinician / surgeon
13.   The appropriate clinical consultant (surgeon or oncologist)
14.   specialist nurse/consultant.
15.   specialist nurse/consultant
16.   Specialist nurse or physician.
17.   Specialist nurse or key worker
18.   Specialist gynaecologist who is in charge of the patient.
19.   should be decided on a case by case basis at the MDT. Often the surgeon, oncologist or specialist nurse depending on the phase of investigation/treatment.
20.   Patient's primary clinician (surgeon, oncologists etc)
21.   Nurse specialist or clinician
22.   nominated managing clinician
23.   managing clinican
24.   key worker
25.   Ideally the Consultant in charge of the patient's treatment.
26.   Either a clinical consultant or nurse practitioner.
27.   DOctor or Nurse
28.   consultant who referred the case, NOT a letter copied to the patient from the MDM which may not correspond with the final treatment.
29.   consultant treating patient
30.   Consultant surgeon / oncologist
31.   Consultant or specialist nurse
32.   consultant oncologist or surgeon depending on situation
33.   Consultant looking after the patient
34.   Consultant in charge of care
35.   Consultant / Registrar
36.   CNS or reffering doctor
37.   CNS or Consultant
38.   CNS or clinician who has met the patient
39.   CNS
40.   cns
41.   Clinician/ specialist nurse practitioner

42. Clinician responsible for the patient
43. Clinician caring for the patient
44. Clinician
45. Clinician
46. Clinician
47. clinician
48. clinician
49. Clinician - surgeon or oncologist.
50. Clinican
51. cancer nurse/consultant depending on nature of team
52. attending clinician or the specialist nurse
53. attending clinician
54. as above/ lead clinician responsible for the patient's care
55. Any consultant
56. A member of the clinical team, ideally the consultant
57. A clinician (Registrar or above) from the team

Measuring MDT effectiveness/performance

What other measures could be used to evaluate MDT performance?

22 histo/cytopathologists responded to this question.

1. Turnaround times of tests
2. The only real measure must be patient outcome and experience. It is astonishing that all sorts of improving outcome guidance is continually imposed on us and actual outcomes do not figure in this.
3. Suggested earlier... Survival is too crude a measure to use alone - and may not be best for some tumour sites
4. Speed - minimal wasted time during a meeting (looking at unnecesary images or discussin patients that no-one really knows)
5. quality of life of those undergoing treatment
6. Percentage inappropriate cases discussed. Percentage of cases where information is incomplete. Numbers of cases that have to be discussed at the MDT on more than one occasion before a treatment plan is produced.
7. Peer review
8. Number of cases that never go through an MDM
9. None
10. NO VIEWS
11. MDT meetings are a means to an end, not an end in themselves. Performance appraisal, benchmarking, etc, implies they are the end. Don't need to get bogged down in governance and bureaucracy
12. External assessment rather than self assessment to avoid bias. The assessors should meet the members of the MDT separately to give them the opportunity to say their opinion freely.
13. Data collection and submission
14. Cost of whole patient journey to NHS
15. Completeness of records/datasets
16. Auditing number of patients lost to follow up   Mortality review
17. Attendance. Late additions to list.
18. Appropriatness of treatments for each patient.
19. annual appraisal of all core members
20. Why do we need to measure everything? Hours of time and significant resource are wasted evaluating irrelevant things in the NHS. Improvement could be made

by making it easier for me to report cases during the day rather than in the late evening by giving me enough technical staff or relaxing the targets, or even a secretary!

21. Absence of disagreements
22. (waiting times achieved via Trust wide cancer team monitoring not down to individual MDTS alone)

Supporting MDTs to work effectively

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

53 histo/cytopathologists responded to this question.

1. Timing of the meeting. More time to discuss cases.
2. Time provision
3. Time allocation and timetabling
4. the venue and its IT support
5. the timetable of attendees so that everyone can be preaent for the appropriate periods
6. Stronger leadership
7. Stop supraregional video-conferenced meetings
8. Stop showing most of the pathology and radiology and focus more on management.
9. Resolution of personality difficulties
10. Replace the chair/so called lead by someone who has leadership qualities and is not just driven by personal ambition or convenience
11. Remove the excessive attendance by those who don't need to be there
12. Remove PACS and / or only allow clinicians to look at radiology images if it's actually relevant (if the report and radiology review says there are lung and live mets we don't need to look at the images again).
13. Reduce the number of patients discussed and the necessity to give a biopsy result within 24hrs to make it available at the MDM (because of 1 week biopsy to diagnosis target)
14. Reduce the number of non-core non-medical attendees. Provide refreshments/lunch
15. reduce the number of cases being discussed
16. Reduce the number of cases - / need for 2 meetings per week to chieve this
17. Reduce numbers attending.
18. preparation
19. Peoples personality
20. Only have appropriate cases added to each meeting.
21. nothing in one, recognition of time constraints and needs of diagnostic staff in the other
22. Not chaired by a surgeon
23. NO SINGLE ISSUE
24. My current MDT is effective; the only thing that could improve the MDT environment is to review the patient pathway so that all of the subspecialties involved in the MDT are based in one centre.   I have worked in dysfunctional MDTs before where chairs have failed to deal with difficult personalities, to the detriment of patient care and service quality. The chair needs to be accountable to a higher authority and appraised in his/her role as chair to facilitate the resolution of such problems.
25. More time. Summarise decisions before moving on to next case.
26. More time and better venue. Coffee would be appreciated in the very early morning ones.
27. More staff - they are very time-consuming if one has several in a week!

28. IT systems not going down
29. Introduction of a strong Chair
30. In some cases the clinicians arrive at the MDT and do not not remember the patients in question as they have not gone over the case notes prior to the meeting
31. Improve video conferencing facilities
32. improve the videoconferencing equipment...seriously
33. Improve organisation before the meeting
34. If core members would keep abreast of the literature in the field and engage in discussions during the MDT meeting (there are bums on seats there too!).
35. I am involved in several. In one I would get rid of a negative person, in another I would want to start on time, in another I would change venue.
36. Have everyone turn up on time and stay for the whole meeting.
37. Have a nominated Chair
38. get the clinicians to come at the right time (they have lists/ clinics etc)
39. Get everyone to turn up on time Get everyone to turn up every time
40. Everyone attending on time
41. Downsize to a genuine core group of clinicians
42. dicuss only problem cases, not blanket mindeless discussion of all cancer cases. Good preparation and attendance by all in the team
43. Consultants being more involved in discussion
44. Closer supervision of the cases submitted for discussion - we often waste time on incomplete cases where key information is not yet available.
45. Clear summaries of each case
46. Clear communication with referring doctors from other hospitals thst cannot attend the meeting.
47. Change the chairman (of one meeting).
48. be more clear about agreed outcomes.
49. Appropriate and timely intradepartmental support for slide retrieval & report generation at the time it is required (within 24 hrs of a non base site MDT); better transport between 2 sites as cyto is done at 1 site & histo the other
50. all core members attend regularly and this was recognised by empolyer as part of job plan
51. A leader preventing arguments and counter-productive communication
52. 1) Having a pre-meeting dicussion and summary of the cases in histopathology. 2) mplementing specialist reporting. Following the RCPath definition of a spcialist in the field especially working in a tertiary referral centre. 3) raising the standard of reporting histopathology and improving local protocols. 4) to give each case a fair chance to be discussed and opinions are respected from all members of the meeting. 5) implementing guidelines 6) be aware of recent literature and progress for all members and specialities. 7) always remember that the reason we are there is to deliver a better service rather than ticking a box 8) regular audits of all aspects of the MDT with proper documentation.
53. !!! feedback for the wofflers

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

43 histo/cytopathologists responded to this question.

1. To have the time spent accredited to my job plan and acknowledgement of contribution
2. to be able to discuss all the histology cases at a specified time, then leave the MDT when there are cases which need only clinical / radiological discussion - in an MDT which can often last for >2hs (I may give other pressing activities eg frozen section, cutup, student teaching in order to advance my cases so I can leave before the end of the MDT)
3. time to prepare and attend
4. time in my job plan to do the work
5. time and money
6. time
7. team members are professionals and should have learned about working in teams elsewhere and should not need specific training.
8. Support in collating case material prior to the MDT, adequate time in preparation in job plan, good IT
9. Slide projecting facilities (for Histology) as well as projecting facilities for Macro pictures.
10. Reduction in the necessity to report cases late pm (circa 9pm) for an early am meeting just to get inside the targets. It's unsafe.
11. Protected time in the pre-meeting period. I need to retrieve and review the cases prior to the meeting, but have to fit this in around other tasks. This is made more difficult with the addition of extra cases outside the normal deadlines.
12. Preparation time
13. one site not video conferencing
14. NO SINGLE REQUIREMENT
15. More time, more histopathologists
16. More time to prepare.
17. More time to prepare and discuss cases
18. more time to prepare
19. More time to audit and learn from previous experience. I can remember individual cases, but do not have an "overview" - would need time to look at decisions that were made and eventual patient outcome. I/we would learn a lot from that, but there is no time/support for this.
20. more time for specialist training courses and adequate staffing levels in pathology
21. More time for preparation.
22. More time for preparation and follow up
23. More time available
24. More time and support. Currently sop many patients that there is little if any learning opportunity - no time to discuss interesting cases etc.
25. More time
26. More time
27. more time
28. more time - ie fewer cases
29. More recognised time as part of JP
30. More MDT Co-Ordinator support
31. If preparation is deemed essential, ie reviewing microscopy, more time would be beneficial
32. I should ask my MDT peers for constructive feedback about my performance.
33. Having enough time to attend more sessions. Job planning is crunching down to suggest that only one pathologist, one imaging specialist needs to attend each MDT - and 'reads out' the report. This direction demonstrates a fundamental failure to recognise the importance of the clinical contributions made by colleagues in diagnostics. These are inteprretations - not tests.

34. Greater secretarial support More CPD funding & time
35. Generate more hours in the week!
36. Due to lack of time several members have left by the time pathology review is done. There should be more time alloted to the mdt
37. chocolate and beverages
38. Better organisation; less "finger pointing" when there are delays
39. Being based in the same centre as the cancer surgeons, oncologists, palliative care physicians etc to facilitate the establishment of a meaningful working relationship with colleagues, not simply restrict exposure to a weekly encounter at MDT meetings.
40. Attending courses and sharing the experience of other MDT lead pathologists
41. Attedance to national multidiciplinary meetings
42. Adequate time to prepare and adequate time to present the case. Currently there is neither.
43. A megaphone

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

16 histo/cytopathologists responded to this question

1. We try to socialise as a team at least once/year
2. We just need more TIME!
3. Visits to Australasia, North America, Carribean
4. visit other MDMs
5. Training to use an AK47 to get rid of some of the team members
6. This is all very managerial - NO TIME FOR TRAINING + have been doing MDTs for last ?5 years - bit late now. Sure tweak things - can always improve, but training courses tend to be for lowest common denominator and waste a lot of time. Should be available, but not compulsory.
7. There is a lot to be said for just doing it.
8. Team training within the team itself - I am not sure that "generic" training would work.
9. Specilaity based training. Peer based from othertrusts or royal colleges
10. Routine visits to other mdts
11. None.
12. None
13. NO VIEWS
14. In my experience many of the problems associated with MDTs are due to the clinical staff having little or no understanding of what takes place in pathology departments, and how we go about MDT review. The induction/training process for staff involved with MDTs should include some cross-speciality work.
15. Facilitated role play & discussion
16. e-learning modules are most cost effective

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

16 histo/cytopathologists responded to this question.

1. thames cancer registry provides training courses for MDM coordinators
2. pelican programme
3. Pelican MDT course
4. Pelican courses for colorectal
5. Not interested
6. Not aware of any for pathologists
7. not aware of any
8. None known
9. NONE
10. None
11. None
12. none
13. none
14. I am not aware of any.
15. I am not aware of any.
16. Communication.

Final comments

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

18 histo/cytopathologists responded to this question

1. Use of management protocols - with audit against protocols. Good team working.
2. The personality & skills of the MDT chair is the most important factor.
3. The highest-performing MDT's depend on individuals and their specialist knowledge, and their ability to communicate. If these characteristics are absent, the MDT does not work so well but may still function effectively. Success does NOT depend on 'tools' nor technology, given a basic minimum. Nor does it depend on specific MDT training or courses - these are peripheral. However, it is important that individual members feel part of the MDT and respected for their own contributions.
4. Survival outcome does not necessarily reflect the effectiveness of an MDT. Cancer makes up its own mind and time to presentation is everything and not always in our hands.
5. Our MDTs have been transformed by the provision of a good room, admin staff and electronic recording systems
6. Moves to create multicentre/regional MDT meetings are detrimental
7. MDTs are very different: in some most cases are pretty routine and need little discussion (eg. colorectal cancer), in others a lot of discussion comes up for most patients (eg. pancreatobiliary cancer). The latter is fun, the former utter boredom (and to some extent, a waste of a pathologist's time).
8. MDT meetings are extemely expensive in staff time, there should be cost benefit analysis.
9. MDT is useful only in a very small proportion of patients where difficult nature of

the case will benefit from a multidisciplinary input. In most patients, MDT adds very little in way of management as most treatments are protocol guided and therefore decisions can be made by individuals, if required after discussion with relevant speciality member. By discussing all cases at the MDT and insisting on attendance of core members through the entire MDT, many professionals are actually wasting their time that could have been more appropriately used for genuinely deserved clinical care elsewhere outside the MDT.

10. MDT has been the best and most effective tool of communication between professionals involved in patient care in the last 30 years of my consultant post. Its benefit to patients is beyond any doubt. All other things will come as a side result.

11. In my experience the best performing MDTs are where all core members not only attend all meetings but are also on time.

12. I have a distinct impression having attended many MDM's since 1982 that these are not necessarily effective. They are often used to rubber-stamp decisions already made - not necessary. The upshot is that the meetings are now too long with too many patients to be effective. Small MDT's who work in harmony are best. Why measure performance and ignore workload and logistics?

13. I AM FORTUNATE TO BE A MEMBER OF HIGHLY PROFESSIONAL MDTs WHICH SEEM TO ME TO BE FULFILLING ALL REASONABLE EXPECTATIONS. IN PATHOLOGY WE ARE CHRONICALLY SHORT OF STAFF TIME TO MEET OUR OBLIGATIONS BECAUSE OUR NEED FOR APPROPRIATE STAFFING LEVELS IS GIVEN LOW PRIORITY BY MANAGEMENT WHILE OTHER DISCIPLINES RECRUIT ADDITIONAL STAFF AND GENERATE STILL MORE WORKLOAD FOR THE UNDERMANNED PATHOLOGY DEPARTMENT.

14. From the point of view of a histopathologist, attending MDT meetings is generally a waste of time (in my case = one working day wasted per week)

15. find the best chair from within the membership.

16. Effective chairman; excellent MDT co-ordinator; systematic preparation; clinical knowledge of individual patients; to focus on cancer and suspected cancer rather than use the MDT as a results service for all patients.

17. Any training must not eat into Study Leave allowance

18. A high performance MDT requires full support from the employers. For many staff MDTs are "bolted-on" to their current jobs, without proper assessments of the time requirements or resources needed.