

# **Multidisciplinary team members views about MDT working:**

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

## **Open question responses: MDT coordinators**

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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](mailto:cath.taylor@kcl.ac.uk)

## Introduction

This report provides the responses given by **MDT coordinators** 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	<b>MDT coordinators</b>	<b>302</b>
Other (admin/clerical and managerial)	Other (admin/clerical and managerial)	42
<b>Total number of MDT members who responded to the survey</b>		<b>2054</b>

## 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

<b>DOMAINS THAT ARE IMPORTANT FOR EFFECTIVE MDT FUNCTIONING</b>	<b>7</b>
What do you think constitutes an effective MDT?	7
<b>THE TEAM</b>	<b>14</b>
What qualities make a good MDT chair/leader?	14
What types of training do MDT leaders require?	18
What makes an MDT work well together?	19
<b>INFRASTRUCTURE FOR MEETINGS</b>	<b>23</b>
What is the key physical barrier to an MDT working effectively?	23
What impact (positive or negative) does teleconferencing/video-conferencing have on an MDT meeting?	27
What additional technology do you think could enhance MDT effectiveness?	31
<b>MEETING ORGANISATION AND LOGISTICS</b>	<b>34</b>
What preparation needs to take place in advance for the MDT meeting to run effectively?	34
What makes an MDT meeting run effectively?	45
<b>CLINICAL DECISION-MAKING</b>	<b>51</b>
What model of decision-making could be used for patients with recurrence/advanced disease if these patients are not discussed at MDT?	51
What are the main reasons for MDT treatment recommendations not being implemented?	54
How can we best ensure that all new cancer cases are referred to an MDT?	56
How should disagreements/split decisions over treatment recommendations be recorded?	60
Who is the best person to represent the patient's view at an MDT meeting?	62
Who should be responsible for communicating the treatment recommendations to the patient?	66
<b>MEASURING MDT EFFECTIVENESS/PERFORMANCE</b>	<b>70</b>
What other measures could be used to evaluate MDT performance?	70

**SUPPORTING MDTs TO WORK EFFECTIVELY.....71**

**What one thing would you change to make your MDT more effective?.....71**

**What would help you to improve your personal contribution to the MDT? .....73**

**What other types of training or tools would you find useful as an individual or team to support effective MDT working? .....76**

**Please provide details of training courses or tools you are aware of that support MDT development .....78**

**FINAL COMMENTS .....79**

**Please insert any final comments or observations on the characteristics or indicators of high-performing MDTs and appropriate measures of performance.....79**

## Domains that are important for effective MDT functioning

### What do you think constitutes an effective MDT?

218 MDT coordinators responded to this question.

1. Working well as a team and good support from all members of the MDT
2. When all depts; Nuclear medicine, Radiology, Histocytopathology, Consultants together make an informed choice of medical help to offer patient.
3. When all core members attend
4. When all core members are present, list of patients to be discussed was sent out in good time so all core members can fully prepare, the video conferencing equipment is fully functioning, patient notes are all available, history of the patient is well documented for the meeting.
5. Well structured, timely meetings where active discussion occurs and clear and concise outcomes decided and acted upon.
6. Well attended, by relevant attendees. Precise information
7. Well attended meetings that run in a timely manner with good effective communication between all core members. Providing the best MDT decisions for patients that are recorded accurately and distributed appropriately.
8. Valid patient discussion by core MDT members, covering diagnosis (with pathology review), staging, radiology review (where appropriate), recommended treatment plan including treatment intent. Referral to MDT should include patient previous history, current problem, comorbidities, local pathology, radiology and blood results (proforma designed for this purpose).
9. Up to date information at the meeting. Someone having seen the patient prior to the MDT
10. Up to date information and good communication
11. To make sure all notes are available, equipment is all in working order
12. The outcome of the meeting is passed on to all concerned asap
13. The MDT team members discuss cancer treatments for individual patients, to offer the best treatment options available given all of the patient's history
14. The MDT meeting's run on time. Information is correct and up-dated. Everyone needed for decision making is in attendance.
15. The discussion of diagnosed and suspected CA patient. To agree on treatment or further diagnostic tests with core MDT members.
16. The correct information collated so that doctors can discuss cases and make their decisions. A defined leader in the meeting to limit stalling, and a robust method of following up decisions, be it clerical or medical
17. TEAM WORK
18. Teamwork. Clinicians should involve the coordinators and all other MDT members in their discussion of patients. Any questions raised should be clearly answered..also effective data collection and preparation prior to the meeting helps a great deal.
19. Teamwork and mutual respect
20. Teamwork
21. teamwork
22. Team work. The entire tumour site must cooperate with each member working towards a common goal, each doing their own part but supporting one another, especially when one or more member(s) are absent.
23. Team work. Good communications. Preparation of documents. Good organisation.
24. team work with all involved with the MDT
25. Team work and communication by all team members.
26. Team work
27. Systematic and organised discussion of the facts relating to each individual case and a timely decision for treatment as a result.
28. Sufficient time to discuss patients along with sufficient information on the patient, the presence of the MDT member who knows that patient and then the presence

- of enough members of various specialities (i.e. Pathologist, Radiologist, Surgeon, Oncologist) to hold a full discussion
29. Strong leadership and good organizational skills
  30. Strong chair, well prepared diagnostics, videoconferenced links, real time recording of outcomes, well prepared, referral proforma including clinical and waiting times information, robust IT systems, team communication
  31. Starting on time, and keeping to the agenda
  32. Smooth running and a good attendance
  33. Sessioned time, adequately timetabled in order for all members to meet at a designated time and place without distraction for meeting. A strong and proactive lead.
  34. Sending out MDT list prior to MDT meeting Making sure all core members can attend Having a action list prepared Preparing for mdt meeting in advance making sure all patient notes scans etc are available at the meeting
  35. Respect and communication between all members allowing for a wholistic approach to patient management.
  36. Representation from all areas in which a patient wil come into contact during their investigations for cancer. Also input from areas which might have some input eg trial nurses.
  37. RELAXED ATMOSPHERE WITH EVERYONE HAVING AN OPPORTUNITY FOR INPUT. PREPARATION BEFORE MEETINGS. PROMPT ATTENDANCE.
  38. Regular representation by senior clinicians from all areas of the service, discussing patient care in an orderly and timely manner and achieving informed consensus of opinion, rapidly conveying these decisions to GP's.
  39. Prioritize,all members turning up on,all notes,proformas,list's and information being advalible.
  40. Preparation. Punctuality. Vigilance
  41. precise discussion, all relevant members attending.
  42. Patient pathway and effective timely treatment for that patient
  43. Participation, responsibility, enthusiasm, good organisation, clear communication, good outcomes, keeping the patient's best interests at heart, punctuality, attendance, good energy levels, good skill-mix, clinical experience,
  44. Participation and good communications of all core members.
  45. Participaion of all members present to confirm best care plan for patient
  46. Outcomes from MDT's that ensure the best possible treatment and care for patients being discussed.
  47. Organisation. Good Lean Clinician
  48. Organisation,communication, team work and commitment
  49. Organisation, efficiency, cooperation, effective communication, good attendence, time management, accurate collation and recording of information/data
  50. Organisation, effective communication, attention to detail, accuracy, experience, dedication
  51. organisation, communication, pre planning,
  52. Organisation is key. Having the same MDT co-ordinator each week helps as the co-ordinator gets to know the pt's and the team better and can spot ways to improve systems. The 'any other business' part at the end of our meeting allows people to suggest improvement ideas and has been a great success. We also hold a monthly journal club which medical student can attend where we discuss relevant articles to the cancer site of that MDT and have a talk and lunch provided by a rep. The rep MUST be relevant to that site and give an education based talk on the product.
  53. organisation and communication and ensuring as much information as possible is available at the meetings
  54. organisation and communication
  55. One where the discussion onpatient care is supported by the latest technology, the correct expertise and plenty of time.
  56. One that can decide treatment options in a timely manner with the relevant different disciplines involved in the discussion.
  57. Need all core members to attend and have all relevant information (results) at

- hand.
58. Members who are committed to making the best use of the MDT
  59. Making sure all equipment is available and in working order, all pt's are discussed with the treatment plans, all the data is updated correctly.
  60. make sure all notes and investigations are all there so they can make a decision on the patient treatment.
  61. Information, dedication, Equipment, support
  62. information and communication. information in that there must be a system whereby the key facts of each patient are readily available, where they are on their cancer pathway and where to go next can then be discussed and recorded. communication in that it is vital to have all of the above information, to have the whole team present and that the information is then easily accessible to see exactly, the treatment plan for the patient.
  63. Information and attendance
  64. If everyone works as a team, adhere to deadlines for adding patients so we have time to fully prepare the notes on each patient
  65. having as many core members attend as possible
  66. Having all the relevant information, complete core team.
  67. having all the members and all the equipment and all results there
  68. Having all the information required (radiology and pathology) available at the meeting and to have the necessary team members in attendance.
  69. Having all relevant information to hand at the MDTM e.g. Scans/PAC's worklist, Typing liver at the MDTM so that there is a clear outcome/plan for each individual patient, Data on the Cancer database PPM is up to date as much as possible and that core members of the team attend each meeting.
  70. Having all investigations completed before bringing the patient to MDT. Ensuring medical notes are present. Ensuring there is a clinician present who knows the patient. Ensuring there is at least one representative from each clinical group. Providing the coordinator with as much clinical information about patients as possible before the MDT takes place.
  71. Having all information readily available eg results/histo/xrays/casenotes, also having a radiologist/histology reporting in meeting
  72. Having access to all relevant sources and results, e.g. histology reports, or even a member of the medical team prior to the MDT in order to produce the most up to date and correct MDT discussion list. Also, ensuring any videoconferencing equipment is efficiently working.
  73. Having a list of patients to be discussed in advance. Communicating effectively between, team members of different specialisms ( surgeons, doctors, nurses, data managers, MDT coordinators etc) to ensure the relevant people are present to discuss each patient and all relevant questions about each patient is answered and treatment decision is finalised. All discussions and decisions should be thoroughly documented and filed in patient notes (electronic and/or paper) to ensure that everyone involved in the patient care is aware of the decision.
  74. Having a histopathologist, radiologist, consultants and core members to attend the MDT. Being able to show the images and slides on the screens without any hassle or having linking up problems.
  75. Having a good relationship with all members-communication. respect for each others jobs.
  76. Having a functional Multi Discipline Team
  77. Good working relationships between all team members in particular between CNS/Lead Consultant & MDT Coordinator. Accurate and comprehensive information.
  78. Good teamwork - every member of the team, from the clinicians to the administration staff play an important role to ensure that patient care and treatment management is managed effectively.
  79. Good team work, coordination across the three MDT units in our network, and ability to function under pressure
  80. Good team work and communication. Making sure that all results for patients are available to make a good decision about the patients.

81. Good Team Communications at all levels.
82. Good referral system. Effective discussion across the MDT.
83. Good organisation by the MDT coordinator and effective communication between the MDT coordinator and clinical teams and also effective communication with local MDT's.
84. Good Organisation is the main element i think. Along with the full support of your team.
85. Good organisation, team work
86. Good organisation, preparation, attendance of a wide range of clinicians. Good communication skills of members.
87. Good organisation and Planning
88. Good organisation and being able to maintain a high turnover.
89. Good communication.
90. Good Communication, Work well with other members of staff and alone, Organisational skills
91. Good communication, preparation and teams attending on time
92. Good Communication, Organisation, Full attendance, Access to information and a good Chair.
93. Good communication, keeping to time, discussing only what needs to be discussed
94. Good communication with the clinical team Good organisation by the MDT coordinator
95. Good communication is essential. Roles/responsibilities clearly defined including understanding the role of the MDT Co-ordinator. It is essential that the MDT Co-ordinator is seen as pivotal to the meeting and central contact for information gathering and reporting. Sufficient resources ie staffing resources. Robust data collection systems/processes. Robust patient tracking systems.
96. Good communication between team members at all times with efficient administrative support to speed patient diagnosis and treatment
97. good communication between all the members. excellent coordinator. good Lead/chairperson. everyones opinions are welcomed, listened to and respected.
98. Good communication between all members of the MDT. Respect for the role of each member.
99. Good communication and sharing of information both within the team and with other MDTs. Willingness to adapt to changing working practice as per guidelines.
100. Good communication and respect to every member of the MDT
101. good communication and rapport between MDT members, and robust administration
102. Good communication and attendance
103. Good Communication & clear plan
104. Good communication A good Chair to lead Effective equipment Complete information on patients
105. Good communication
106. Good communication
107. Good attendance of all core members at the MDT meeting were a discussion of all patients diagnosed with cancer or relapsed is carried out. Good communication between all members of the team and a common goal to agree on the best treatment for a patient in an efficient manner.
108. Good attendance from all disciplines. Weekly, structured meetings.
109. good attendance by all members, results and test ready on time.
110. Good attendance and good co-operation between all core team members. Clear plan of treatment for each patient discussed. Ensure all actions recommended in the meeting are carried out and speedy transfer of information by way of MDT proforma with treatment plan/outcome to all involved in patient's care.
111. Good and effective organisation. Punctuality and ability to discuss all patients on the list. Lunch provision for lunch time MDT meetings.
112. Good and clear communication throughout the whole team during the meeting. Data needs to be taken down precisely and if the actual wording is not communicated to the co-ordinator, then problems will arise further down the line.

113. Genuine commitment from consultants
114. Full support from all speciality's involved.
115. Full attendance from core members to activiley discuss pt diagnosis and treatments.
116. Full attendance by core members. Good preparation by an MDT co-ordinator in terms of patient history, results etc to aid members to make decisions on patient's care. Video equipment - it is essential that this is in full working order for the MDM to run smoothly.
117. Frank discussion, good equipment, needs to be well organised and effectively chaired
118. Focused meeting with all the relevant parties and all necessary information available.
119. Fair, equal and informed discussion
120. Exchange of valuable and accurate information. Clear decisions.
121. Excellent organisation, team working, effective outcomes and appropriate data collection.
122. Excellent comminication and good leader ship, good protocols and guidelines and data sharing.
123. Excellant communication
124. Excellant Commuication within the team, the arrangement of different speacialties who are patient focused and willing to support each other. Approacability of all team members
125. Everyone working together and easier use of finding case notes and investigation results.
126. Enthusiasm
127. Efficiently organised
128. Efficiency, Team work, communication
129. Efficiency and organisation. A good MDT co-ordinator. A chairperson.
130. effective organisation and just one person to officiate
131. effective communication between ALL core team members.
132. Discussing patients quickly, and being able to discuss all patient within the time given.
133. Discuss, diagnose, plan approriate treatment for cancer/suspected pts. To optimise hospital and pts time effectively. To keep all involved informed of plans including GP's and other care workers.
134. direct communication, visual diagnostic display
135. data, all members attend meeting
136. Data quality
137. correct data given to co-ordinators, accurate gathering of data by the co-ordinator, core members of the MDT having the correct information at the meeting
138. correct and clear information/data when requesting patients to be requested for an SMDT discussion all imaging made available on time quick turn around on pathology etc and a good communication between all core and clinical members.
139. CORE MEMBERES ALL IN ATTENDANCE AND GOOD PREPERATION ie ALL RESULTS TO VIEW
140. consultants appearance and knowing the patient that they are going to discuss, and having all the relevant patient information at hand
141. Consistency, team work, excellent communication, effective data capture
142. Communicaton
143. communication, patinet care, enough staff, correct treatment within correct tiemscale
144. Communication, organisation, preparation, prioritisation, committment, attendance, clear definition of roles, effective chair, information pathways clear (both in and out of MDT), annual operational policy review (full team encouraged to participate), audit, efficient data capture and actions met. It is important that the extended team and all dpeartments know how and how to contact when wanting to access the MDT - education is key.
145. communication, making sure all relevant information is available and good

- attendance by team members with cover for A/L sickness etc.
146. communication!
  147. Communication from all core members of the team
  148. Communication between members. Works as a team.
  149. Communication between members and MDT Coordinator. Early identification of patients for discussion to the MDT Coordinator, thus preventing last minute running around prior to MDT meeting.
  150. Communication and respect for other member's views
  151. Communication and organisation are the key issues. Team members must remember to work together and let each other know about patients and results, new investigations and procedures to be done. An MDT coordinator is the key person who brings all things together for the meetings and in order to do this effectively he/she must be organised and accessible to all team members and all information needed for the meeting. Regular meeting times and venues are vital.
  152. Communication and efficiency between the team and coordinator in particular the MDT Lead, CNS and MDT Coordinator.
  153. communication and committment from whole team
  154. Communication
  155. communication
  156. Communal database that imports letters, appointments, results communications etc. Achievable and trackable pathways. Enthusiastic team.
  157. Committment from all core members
  158. Comittment and consistency
  159. COHESIVE POLCIES; AGREED OPERATIONAL PLAN; CO-OPERATION BY ALL INVOLVED; REGULAR ATTENDANCE
  160. CLEAR, PRECISE PLANNING. GOOD PREPERATION FOR MEETING.
  161. Clear precise information
  162. Clear information and all relevant members available
  163. Clear guide lines and all staff involved working together as a team to reach our targets for PATIENT care.
  164. Clear and exact parameters established by the clinical lead and other core members
  165. Being precise when giving information at the MDT which is added to a patients form. Always have the correct NHS no.
  166. Being organised, friendly and reliable.
  167. Awareness
  168. Attendances by core members
  169. Attendance of all core members, correctand complete patient information.
  170. Attendance of all core members and input from all
  171. Attendance of all (appropriate) specialities All necessary imaging/investigations available Functioning equipment!!
  172. Attendance by core members
  173. Attendance by all core members. Good preparation on part of the MDT Co-ordinator and a CNS who is aware of all patients going through the MDT. A clear, concise treatment plan that is recorded accurately in the MDT and all the team are in agreement - if chnages occur to this plan then CNS, co-ordinator and data collector should be informed
  174. Attendance and decision making
  175. Attendance
  176. As many varied members of staff as possible for varied opoinions. Having all notes and up to date results available.
  177. An MDT Co-ordinator to ensure the admin side of the meeting works. Communication by all members of the team at the meeting. A positive attitude towards MDT's!!
  178. An effective team working together to achieve best patient care.
  179. An effective MDT: -Has a clear and effective leader -Meets weekly -Reviews cases prior to discussion -Has a designated tracker/co-ordnater -Has regular attendance from all core members -Has members who are all aware of cancer

targets -Has clear operational policies around everything from the time keeping and behaviour to the referral policies of the MDT -Audits their work as a team including the adherence to outcomes agreed in the meeting -Has clear and formalised patient pathways with key contacts identifiable to non-MDT members around the trust

180. An effective MDT Co-ordinator
181. An Effective chairperson, clear MDT plan/outcome, full attendance and clear and effective communication throughout the team
182. An effective Cancer Lead (Consultant)
183. All the relevant information and diagnostics available for the meeting and the core members attending on a regular basis
184. all team members present
185. All specialities covered. Organised/well facilitated meetings. Good discussion forum.
186. All relevant staff attending, especially consultants, radiologists and oncologists
187. All relevant information available and discussed in a clear and concise manner. All attendees to have an equal voice. Everyone clear on decision taken after discussion.
188. All relevant data available. All core members attending. Discussion between all members.
189. All members should attend every meeting and if they are unable to attend should send a representative. The MDT should include the lead consultant for the child, the team for the specialty as well as pathologists, radiologist and any other team member who would be valuable on advising on particular types of treatment e.g. surgeons or clinical oncologist. The meeting should have a weekly agenda, each patient on the agenda should be discussed in detail and the discussion and decision should be thoroughly documented for the purpose of good clinical governance and data collection e.g. Cancer Waiting Times or Clinical Trials.
190. All members present covering each field i.e: Surgeons, Clinical & Medical oncologists, Radiologists, Histopathologists, Dieticians, CNS's, Clinical trial nurses, Palliative care etc.. Being able to access all the information required easily + discussing patients on a weekly basis.
191. all members of the MDT have the same end goal for the MDT, to give fast effective treatment plan for the best possible outcome following a cancer diagnosis
192. All members being present
193. All members attending on a regular basis discussing patients they have at least some knowledge of with the appropriate patient information and test reports available.
194. All members attend MDT or a representative is on leave. Secretaries to be informed of outcomes.
195. All MDT members interacting with each other and ensuring what actions are decided at MDT are followed up appropriately and in a timely manner for the best interests of the patients.
196. All Core members being present
197. All core members present, equipment working and cover for specialities if on leave. Decisive outcomes.
198. All core members present, all imaging and histology available
199. All core members being in attendance and being able to review all patient diagnostic tests and agreeing on a treatment plan within patient pathway
200. All core members attending every meeting and all relevant information for each patient being available for the clinician's reference.
201. All core members attending and staying for whole of meeting.
202. Adherence to deadlines. Good communication between the team members. Usage of SCR.
203. Adequate training and support
204. accurate referral. Good team work.
205. A team where all members work together to reach a successful outcome in the best interest for the patient

206. A team that works well together, communicates well. MDT Co-ordinator who works closely with the team.
207. A team that understands everyone's responsibility and communicates regularly
208. A team that discusses all it's patients in a timely fasion, comes to good clinical decisions and implements them with clear lines of resposibility and communication.
209. A team consisting of all of the core members from the different areas, able to meet at regular intervals. Good channels of communication between all team members.
210. A smart relieable and goos person
211. A good team that works together effectively.
212. A good proactive team with effective outcomes making a steamline experience for patients
213. A good mix of people who can work well together and are well organised
214. A good Chair Person to ensure timely and effective meetings (which is not always the case). Good co-ordination.
215. A full team All relevant equipment ready set up and working
216. A full multidisciplinary team attending An organised MDT Co-ordinator A good chair person
217. A full comprehensive disscussion with all core members.
218. a concise, but comprehensive sharing of information between clinicians in order to effect the most appropriate treatment options for the patients.

## The team

### What qualities make a good MDT chair/leader?

120 MDT coordinators responded to this question. In addition, 1 MDT coordinator referred to the criteria in Q36 "all as above".

1. Would be a number of good quality leadership skills.
2. Willingness to listen and make effective decisions
3. Well respected and knowledgeable and knows when to call a halt to discussions and make a decision.
4. Unflappable, decisive and patient!
5. Understanding and decision making
6. To make sure everyone sticks to discussing the patient in a timely manner, make sure the patients agreed treatment plan is documented
7. To be assertive and champion the MDT
8. The MDT runs smoothly and all decisions are recorded by the chair
9. The chairperson runs the whole MDT, all decisions are recoreded by the chair in the notes and outcomes agreed at the MDT.
10. The ability to move discussion forward and summarise the decisions made.
11. The ability to listen to alternativer suggestions, to care about the patients as well as the targets and to ensure that actions are followed-up in a timely fashion.
12. Strong, knowledgable of MDT's
13. Strong, clear, concise delivery of treatment plan. Approachable, people person able to engage and provide an environment whereby any team member feels able to express their opinion.
14. Strong presence and respect of all members
15. Strong leadership. Good, clear communication. Able to bring the refocus the meeting if it gets off track. Manners - as team members may follow the Chair/Lead in their attitude.
16. Strong leadership qualities, ability to make clear decisions and communicate clearly
17. Strong communication skills, attention to detail, ability to maintain control of the

- meeting, good attendance
18. Sticking to discussing patient's, making sure MDT decision are noted.
  19. Someone with good communication skills able to maintain a high standard of team member participation
  20. Someone with authority who the members respect.
  21. Someone who values all members of the team, someone who speaks clearly and ensures agreement as a team, not just 'whose side he agrees with', someone who is organised and responsible and attends all meetings.
  22. Someone who listens Someone who is prepared to make a final decision where necessary
  23. someone who is very knowledgeable regarding the team and cancer site with good time keeping skills!
  24. Someone who is decisive, good communicator.
  25. Someone who is assertive and can move things along when the discussion becomes distracted or boisterous
  26. Someone who is able to make sure everyone turns up regularly, and can break a stalemate in the decision of treatment. Someone who promotes the level of debate surrounding different treatments.
  27. Someone who can take control of the meeting, discuss each case clearly and succinctly and ensure decisions are reached and recorded for each patient.
  28. Someone who can keep a room full of people in order, can be succinct without shortening discussion to impair patient care
  29. Someone who at the end of the discussion can quite clearly summarise the MDT outcome and someone who can keep a reign on the discussions and keep them on track.
  30. Somebody who is well organised, respected, fair and knowledgeable.
  31. Preparation before meeting and ability to bring meeting to order.
  32. Patience, friendly and knowledgeable
  33. patience, approachability, clinical experience, good relationships with other clinicians.
  34. organised, practical, knowledgeable
  35. organisational abilities
  36. Organisation, good time keeping, knowledgeable
  37. One who listens to all specialities and notes concerns for Pt if any. Decisive decision making and recording all outcomes clearly on Pr-formas
  38. one who involves and listens to EVERY member of the team
  39. make it clear what the patient treatment is.
  40. likable, knowledgeable regarding peer review process, good knowledge of cancer pathways, cancer waiting times, recognise relevance of network and locality issues
  41. Likable / charismatic. Highly regarded as being knowledgeable about the disease.
  42. Leadership. Practical thinking. Ability to co-operate and hear all views
  43. Leadership, organization ability, sound medical principals.
  44. Leadership and ability to keep everyone on track
  45. Knowledge of the site, respect of colleagues, excellent time management, good presentation skills, charisma
  46. Knowledge and understanding of the MDT. Good communication, enthusiastic about patients care.
  47. Knowing their patients well.
  48. Is respected by members and has good clinical decision making/control.
  49. Is highly respected by other attendees Can take on other points of view and weigh up best options for the patient Good time management. Approachable.
  50. High level of knowledge of the cancer site, assertive & authoritative.
  51. has command of the meeting.
  52. Has authority at the meeting and business-like attitude. Usually there is lots to talk about he needs to make sure everything is discussed and not sidetracked. I think they need to lead by example and allow everyone to speak up (often AHPs feel overpowered by consultants and for Head and Neck patients they are vital

- importance).
53. Good spokesperson with good ethical understandings
  54. Good presentation skills Understanding of patient's needs Authoritative
  55. good listening skills and good communicator
  56. Good listener, ability to make people pay attention
  57. Good leadership. Fairness. Good communication. Expert knowledge.
  58. Good leadership qualities and respect for all members
  59. Good leadership
  60. good leader, experience.
  61. good knowledge and skills working with patients in a clinical role
  62. Good interpersonal skills.
  63. Good communicator//ability to summarise treatment decisions//ensure the MDT remains focussed//positive approach
  64. Good communicator. Approachable. Clear speaker. Assertive.
  65. good communicator, tumour site lead and good patient skills
  66. Good communicator and team player. Assertiveness
  67. Good communication, respected by other team members and objective.
  68. Good communication skills, team work
  69. Good communication skills, organisational abilities, person skills, diversity and awareness skills
  70. Good communication skills, assertive,
  71. Good communication skills and a willingness to listen to other professional views.
  72. Good communication and someone who can keep calm and take control of the situation, who is respected by his colleagues
  73. Good clear thinking
  74. Friendly and easily approachable, vocal and clear in speech
  75. firm but fair approach, excellent communication skills and a leadership rather than management skills
  76. Fairness, good timekeeping, strong leader but not overpowering
  77. Fair, good listener, able to move on once decision made
  78. Expert knowledge of each individual patient's pathway that are being discussed and acting on the decisions made at time of discussion. A good rapport with colleagues and knowledge of subsequent requirements from any decisions reached.
  79. Expert clinical knowledge. Strong leadership qualities coupled with the ability to listen to and balance the views of other members; confidence to come to an informed decision on behalf of the team where opinion is divided. Approachability.
  80. Ensures everyone participates, sums up decision at end for the MDT co-ordinator, particularly where discussion is prolonged and many options considered. Makes sure the meeting remains focussed
  81. Ensures attendance, promotes clear presentation of each case and full discussion and clearly confirms agreement of decision
  82. effective team player, time management, organised,
  83. Dedication
  84. consistency and clear decisions
  85. confident, assertive, professional, good mannered, precise.
  86. Confidence. Willingness to ask for clarification from all members of MDT. Ability to summarise MDT decision in terms to be understood by all members of MDT.
  87. Confidence. Knowledge. Organised. Excellent communication skills
  88. Confidence, assertiveness, awareness of time, awareness to dissipate any arguments.
  89. compassionate able to listen
  90. communications between all members
  91. communication
  92. Communication, leadership skills and decision making. Typical skills of consultants.
  93. Commitment Enthusiasm Organisation

94. clear, precise, willing to listen, strong, time management
95. Clear decision maker, ability to keep the meeting moving forward without wandering from subject or rushing through patients.
96. clear and precise leadership
97. clarity, organisation, time to listen and explain
98. Calm and level headed Able to keep to the point being discussed
99. Being able to voice out their opinion and ensuring a decision is made before moving onto the next case.
100. Be clear concise and fully knowledgeable in decision making, taking into account and listening to points raised on behalf of the team or patient.
101. Aware of the tumour group, friendly, understanding, motivated.
102. Assertiveness.good people skills
103. Assertiveness. Approachability.
104. Assertiveness, unbiased, organised.
105. Assertiveness, good time keeping, someone who is open to suggestions
106. Assertiveness, familiarity with team members, knowledge of the subject being discussed
107. Assertiveness, being able to take control of the meeting
108. assertiveness directness and clinical understanding
109. approachable, good listener, calm,
110. An understanding of the aims of an MDT meeting. An understanding of the cancer waiting times and its relevance to the MDT.
111. An experienced consultant. Someone who can easily take control of a discussion. Someone who can decide when a patient's case has been discussed fully and the time has arrived to make a clear and definitive plan.
112. An assertive reliable person who is a good communicator and approachable person. Has good management skills.
113. able to understand what that person is going through
114. Ability to steer the meeting in the right direction with effective time management. Ensuring all get a say and all avenues of pathways are considered and all agree on the eventual outcomes for the patient discussed.
115. Ability to keep meeting on track and not go off at a tangent - encourage relevant discussion - good time management
116. Ability to guide patient discussion to ensure that all aspects of patient care are discussed, whilst ensuring that data collection criteria has been fulfilled.
117. A strong person who can take charge of the situation
118. A strong character who can pull the meeting back if sub groups discussing, who supports team and gives good decisions.
119. a good listener, decisive and in control.
120. A good communicator and educator.

## What types of training do MDT leaders require?

82 MDT coordinators responded to this question. In addition, 2 MDT coordinators referred to the criteria in Q36 "as above".

1. Would vary depending on skills
2. Workshops, and attending a professionally run MDT
3. Whatever they feel they need
4. understanding of patients pathway, how to make right decisions for the patient care
5. Understanding of all aspects of clinical care.
6. Training sessions of leadership skills and communication/meeting skills.
7. Training on programmes on the computer with the NHS, how to find medical records, how to track patients, what to listen for at an MDT meeting if you dont have help from a specialist nurse. Were to find information on treatment dates, etc.
8. This depends on the experience and job role the individual already holds.
9. the essentials of an MDT especially for Peer Review
10. Team work and leadership skills
11. People training
12. people skills,
13. people skills
14. people skills
15. People management, and patient understanding.
16. Not sure
17. Not sure
18. not sure
19. None.
20. None necessarily, i.e. formal. They need the abilities mentioend above.
21. none
22. none
23. none
24. Non as most of the time a Consultant is the leader and he/she counts on the MDT co-ord and other members of staff to ensure the MDT will run smoothly
25. N/A
26. n/a
27. Minimal
28. Meeting management skills, motivational skills, understanding of data collection
29. medical terminology, how to read slides etc
30. Man-magagement
31. Leadership, communication,
32. Leadership training together with 'How to chair an efficient meeting'
33. Leadership skills.Up to date treatments about the tumour site.
34. Leadership skills. How to chair a meeting, so people's opinions don't get missed. Just being loudest does not mean you are right.
35. Leadership skills.
36. Leadership skills, assertiveness, communication
37. Leadership and team building skills.
38. Knowledge of CWT and patient pathways. Communication and leadership skills.
39. Knowledge of cancer wait times, basic leadership skills are probably intuitive rather than trained
40. Knowledge of all areas of MDT - planning, investigations, treatment to ensure that all are fully available and discussed.
41. I have no idea.
42. i don't believe they need any training

43. I do not think that training is required for this role
44. I cant identify any that they wouldnt naturally already have.
45. How to treat others in the room
46. How to lead a meeting. They will know what they need as clinicians, but some may not be a natural leader. They may be in charge of the meeting even if there are many people at the same level.
47. How to control discussion to keep it accurate and relatively brief
48. Good communication skills, leadership training
49. Good communication skills including diffusing stressful situations
50. General leadership, good communication and interpersonal skills. My skin meeting has an excellent chair who involves and values not just the consultants, but the GP's, med students, oncologists, dieticians, myself! I honestly believe this promotes a better environment, encourages people to give their honest opinions and ask questions if they are unsure, and also encourages people to attend as they feel their opinion is valued and their being there is not a waste of time. This is reflected in the attendance rates of non-consultants when compared to my other MDT's.
51. Expert knowledge I should think
52. Enhanced communication skills?
53. effective communication skills.
54. effective communication
55. Don't know
56. don't know
57. Do not know.
58. Decision making skills and advanced communication
59. Control, listening and appreciation skills
60. communication, diplomacy, clear speaking voice
61. communication,
62. Communication skills.
63. Communication skills.
64. Communication skills, meeting management, listening skills and prioritisation skills.
65. Communication skills organisational skills and medical terminology
66. communication skills , diversity and awareness training, stress management
67. Communication and team working skills. Valuing each individual as equal!
68. Communication and interpersonal skills
69. Communication - managing people - tact and diplomacy !
70. Communication
71. Communication Skills.
72. Clear writing skills!!!
73. Change management & leadership skills.
74. Cancer Waiting training
75. Cancer Waiting Times.
76. Assertiveness Time management Chairing meetings
77. All types of Cancers and treatment types
78. advanced communication, chairing meetings
79. A good understanding of computer systems and record keeping. Training in how to get things done within the hospital regarding the actions decided in the MDT meetings.
80. A full understanding of the patient pathway and what it takes to keep patients on this path.
81. a course on effective fair leadership for a group
82. ?

### **What makes an MDT work well together?**

123 MDT coordinators responded to this question.

1. Willingness to make the patient top priority.
2. Willingness and a shared vision
3. When all core members attend and the meeting is chaired well
4. Valuing everyone else's opinions, listening to each other, being prepared for the meeting.
5. Trust in each other and respect.
6. to have the patient as the main focus, team members aware of other's roles
7. The MDT Co-ordinator
8. The Chair person involving all members in the decision making.
9. The ability to respect other's opinion and the ability to enjoy the meetings rather than approach them as a chore
10. the ability to listen to each other and respect each other's knowledge
11. Teamwork.
12. Teamwork and communication
13. teamwork
14. Team working and listening to everyone's opinions
15. Team working and communication skills
16. team work preparation
17. Team work
18. Team work
19. Team work - communication
20. Team-working Allowing others to voice their opinions Communication
21. Support and communication
22. Respecting each other and shared objectives.
23. Respectful communication.
24. Respect. Good communication. Patience.
25. Respect of all members, be they doctors, nurses or support staff.
26. Respect for individual's input to MDT
27. Respect for each other. Communication.
28. Respect for each other; continuity and stability of membership.
29. Respect for each other. Meeting running smoothly and effectively.
30. Respect for each other, shared goals/targets
31. Respect for each other and the patient pathway
32. Respect for each other
33. Respect between all members and their views and communication.
34. Respect and listening
35. respect
36. Reliance and appreciation of each other's input.
37. Recognising that we are all members of the same team.
38. Reaching agreement during the MDT.
39. organisation, communication
40. Openness and communication.
41. MUTUAL RESPECT/COURTEOUSY
42. Mutual respect. Shared objectives. Communication.
43. Mutual respect.
44. Mutual respect, commitment, dedication and acceptance that MDT's do work and are here to stay.
45. Mutual respect and team working
46. mutual respect and allowing each person to do their role effectively.
47. Members interact well and listen to each other's views
48. Lose personal agendas and work towards best policy for patient
49. Listening to all members' opinion and being able to agree on decisions
50. Listening to each other, recording of outcome & prompt fu & tx to pt

51. leadership. Good relationships
52. Knowing each others profession and understanding the person's role in the MDT.
53. i think it works well when everyone knows each other..but everyone tends to sit in the same seats .. I still dont know everyones name
54. Hoping that members listen to others as well as making suggestions. A good chair/leader.
55. having a strong lead and all members here tend to focus on the patient's welfare and agree on the best pathway for each patient, on some occasions there has been difference of opinions but by good communications it is worked out.
56. Having a sense of humour even though the work is often upsetting. No "them" and "us" and no prima donnas. Listening to all opinions
57. Good working relationships
58. good teamwork, willingness to listen & learn.
59. good team work, readily information available and attendance
60. good team work and communication
61. Good team work
62. Good team morale
63. good team members
64. Good team
65. Good leadership with a positive approach//efficiency and accuracy in prepping of the MDT with patient notes and information available //good communication between MDT members and good teamworking
66. good effective team working
67. Good communication.
68. Good communication.
69. Good Communication, patient centred views.
70. good communication, listening to others ideas & a common goal eg best interest of patient
71. Good communication between all members of the team and junior doctors. Respect for each member of the MDT (respect for MDT coordinators in particular)
72. Good communication between all parties, good working relationships
73. Good communication between all members who realise that there is a patient at the end of the registration number
74. Good communication at all levels
75. Good communication and good relationships between members of the MDT, members of other departmental teams and firm lines of communication of changes to decisions across the boards.
76. Good communication and respect for all levels
77. Good attendance at meetings, opportunity for everyone to give clinical opinions on treatment / diagnosis
78. Full attendance where possible
79. For the Doctors it is the ability to discuss, and also the ability to accept the decision made. From an administrative perspective, it is important to be supportive in terms of making sure information is available, and actions are carried out.
80. excellent communication, organised structure, aware of other department limitations and timescales
81. Everyone working together and respecting everyone's opinions.
82. Everyone working as a team in the patients best interests
83. everyone listening to everyone else's input and giving this due consideration
84. Ensuring the contributions of all MDT members are equally acknowledged and valued. Promoting patient centred management decisions and ensuring full participation.
85. Effective teamwork and coordination
86. Effective communication between members
87. Effective communication Group in-put
88. Direction Correlation of purpose

89. cooperation, compromise, good team building skills, communication, common goals to achieve, enthusiasm, attendance, dedication, hard work, patient centred views
90. communication
91. communication, organisation and working towards the same goals.
92. communication, cooperation, experience, willingness, preparation, support
93. Communication and working equipment and room being available.
94. communication and the ability to get along.
95. Communication
96. communication
97. communication
98. communication
99. communication
100. communication, clear decision making
101. Common goals, structure and set rules of engagement.
102. Commitment, understanding
103. cohesiveness
104. Cohesion and good team working
105. Co-ordination of all investigations and cooperation of all members for discussion.
106. Co-operation of all involved
107. Clear operational policy and shared purpose for what MDT hopes to achieve for patients and in developing the service offered
108. An understanding of each persons role, been able to bounce ideas off other members, the ability to get along with your work colleagues.
109. An MDT works well when there is a good team working together.
110. An effective MDT Co-ordinator who is at the centre of the communication wheel.
111. All working towards the same goal. All understanding that the central hospital will need to take the lead at times. Acting in the best interest of the patient can mean passing their care onto another Trust or consultant.
112. all members wanting to achieve the best possible treatment plan for their patient
113. all members turning up and being involved with SCR. I think if an Inspector from the PCT turned up say once every few months to make sure Consultants are meeting the requirements of an MDT and doing it the correct way.
114. all have the patients interests as a priority, and everyone has a chance to speak.
115. All core members working together
116. Agreement of clinical guidelines Respect for peer clinicians
117. Agreed treatment protocols. Agreement on how the MDT is structured.
118. Acknowledging each individual knowledge and skill base
119. a lot of communication with all team members.
120. A good leader. Respect for colleagues and their opinions. A willingness to learn from each other.
121. A good lead person at the meeting
122. a clear understanding of why they are there along with a 'tribal' pride in given specialty, robust and open communication
123. some members can be deliberately belligerent, awkward or cause unnecessary confusion. these members are not "spoken to" by the Lead for fear of losing their input.

## Infrastructure for meetings

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

153 MDT coordinators responded to this question.

1. When the consultants are uncomfortable they will hurry along the meeting and not have a proper discussion even if one is called for.
2. When notes cannot be found before a meeting, and when meeting rooms are not booked for long enough and the end of the meeting is either rushed or constantly interrupted
3. When imaging is not able to be viewed due to faults in the technology, or when the video conferencing system breaks down
4. When everyone speaks at once, the patients information can be lost in all the talking.
5. When core members can't attend
6. When consultants do not attend
7. when appropriate technology is unavailable - e.g radiology equipment faulty
8. video conferencing can be difficult as comments can be missed
9. Video conferencing breakdown
10. uncomfortable chairs. heating
11. Unable to see screens and therefore participate
12. Unable to hear the person presenting cases/outcomes and decisions made from that discussion.
13. too small a venue
14. Too much outside noise (building works) poor and ineffective and archaic equipment. Interruptions, bleeps and mobile phones.
15. Timeplanning - ability for MDT Members to understand the importance of having time to discuss patients and not carry them forward to the next meeting.
16. Time constraints, absence of core members
17. Time constraints and external noises
18. Time
19. Time
20. there are many eg.8AM start is sometimes difficult for those commuting/driving from a long distance. Location of meeting is also a factor - ie. when our meeting room changed attendance dipped due to member's having other scheduled commitments.
21. Theatre style layout or any other way when people cannot make eyecontact with virtually everyone easily.
22. The venue being too small.
23. The technology failing, the microphone not picking up clearly what is said, the team members arguing
24. The MDT coordinator not been given the correct information or referrals and being totally missed out of the MDT meeting preparation.
25. The control panel
26. The chair is always in control of the meeting, otherwise they get out of hand.
27. technological equipment
28. Sometimes the consultants - if there is disharmony it comes through.
29. Sitting arrangements
30. Room too hot or too cold. Cramped seating arrangement. Unable to see/hear speaker.
31. room layout, preference is boardroom
32. Room layout preventing being able to see other members and / or results displayed for discussion
33. Results and patients history not available.
34. Relevant members not attending for discussion of individual patients

35. Poor leadership. Members of the team not understanding their role and responsibilities. Members not understanding the role of the MDT Co-ordinator.
36. Poor facilities and room layout
37. POOR COMMUNICATION.
38. Poor chairmanship, people not being able to hear or take part properly. Also very important that the MDT Co-ordinator can see and hear everyone!
39. poor attendance, poor communication, poor organisation, poor cooperation or contribution, technology not working meaning hist/rad cannot be viewed
40. poor attendance, late attendance, bad preparation.
41. Poor attendance of core member, late arrival personality clashes, people talking over others, inadequate equipment and computer access.
42. poor attendance by core members
43. people's presentation skills/ clarity
44. People who aren't willing to take on or listen to other advice
45. People sitting in all different positions so they are not sitting near the consultant so cannot hear the decisions being made.
46. People not being there
47. People having their backs to the video conferencing screens. Need to treat the meeting as if it were in person.
48. Our particular room is very poorly ventilated and so gets very hot which can affect thinking processes
49. Organisation, Technology in good working order. Communication.
50. On screen display of details required.
51. Obtaining scans and reports from external referring hospitals and trusts. Also information not sent to the appropriate places.
52. Not having full results in time for meeting to fully identify patient diagnosis and treat.
53. not having everything ready and prepared
54. Not having access of the bare minimum to patient information, even a discussion list !
55. not having a venue!
56. Not getting the information early enough and having too many updates/amendments
57. Not eye contact between attendees if all sitting in rows facing forward.
58. Not enough room to be able to move around the room easily, ie when handing documents to different members, and when radiologists need to move to look at CXR's.
59. Not enough room - notes get mixed up, people eat their lunch over notes, people who should be sat at the main table move back because there is no space...
60. not being able to see each other, so people talk over each other. equipment not being sited properly
61. None
62. Non working technology where scans cannot be viewed or reports accessed, where the reports may not be in the patient's notes
63. Non attendance, equipment not working and information not being available
64. Non attendance of core team members.
65. Non attendance of core members or their representative
66. non attendance by key personnel
67. Non-communication
68. non-attendance of relevant care provider, lack of imaging, outstanding results, unorganised
69. no allocated time for all core members to be able to attend
70. More than one person chairing. Talking amongst members that others cannot hear.
71. Missing notes No histologies Lack of attendance
72. MEMEBERS WHO CANNOT ATTEND NOT GIVING PRIOR NOTICE.
73. Members turning up late, not having all the information required, missing team members.

74. members not valuing the importance of MDT for both patient care and data collection
75. Members not turning up on time meeting not being prepared in advance
76. Meeting room not having equipment to view diagnostics
77. making sure all the equipment is working.
78. Layout of the MDT room
79. late attendance results/tests not available
80. Lack of understanding of each member of the MDT and lack of communication.
81. Lack of time, appropriate environment, lack of facilities ie PCs, video conferencing, projectors etc.
82. lack of technology
83. lack of room/over crowding in meeting room
84. Lack of room availability and equipment.
85. Lack of preparation and interruption by mobile phones and inadequate facilities.
86. Lack of information and individual patient knowledge.
87. Lack of equipment or it not working at all
88. Lack of equipment - e.g. projection facilities, good quality computer equipment, simple and straightforward videoconferencing tools.
89. lack of effective IT equipment and small conference facilities.
90. Lack of communication
91. Lack of appropriate equipment.
92. Key personnel not available Patient information missing Insufficient clinical information being provided
93. IT equipment failure.
94. insufficient space
95. Information available to all
96. inflexibility
97. Ineffective conferencing kit
98. Incomplete or vague information when asked to add a patient to the MDT Meeting.
99. Inappropriate venue, bad equipment.
100. Inadequate facilities, hardware, software, time of meeting.
101. Inability to view information displayed, or inability to display information at all
102. If the meeting was not quorate or no notes, histology or imaging were available.
103. If MDT Coordinators are seated in the corner of the room - communication can be less effective.
104. If databases are not working correctly or the venue we normally use is out of bounds.
105. if computer systems are down the meeting cannot be held (eg videolink/PACS/etc)
106. I have attended other meetings where members coming and going is a distraction and the agenda has to be rearranged during meeting to accommodate
107. good core member attendance
108. Getting Radiology or pathology cover when core member is on annual leave/off sick.
109. Faulty computer and microscope
110. Failure of equipment or computer systems. Problems with room layout caused by previous users. Lack of participation/interaction between core members. Too many patients on the list to be able to discuss adequately, or concentrate on for extended periods of time.
111. Excellent communication skills.
112. Everyone being able to hear what each person is saying.
113. Equipments not working and lateness
114. Equipment. Space, temperature and refreshments.
115. EQUIPMENT!
116. Equipment not working.
117. Equipment not working properly
118. Equipment not working

119. Equipment not working
120. Equipment not in good working order
121. Equipment malfunctions.
122. Equipement slow or not working.
123. eqipment notworking correctly
124. Core members unable to attend. Diagnostic tests/results not available
125. Core members not being present and also their willingness to participate in open discussion of their patients proposed treatment plans.
126. Core members not attending
127. consultant input
128. Communication. Lack of process or protocols. Unclear roles. Lack of leadership.
129. Communication between all members
130. Communication
131. communication
132. communication
133. Comments from attendees not being heard/ overlooked if they are not directed at/ within earshot of the Chairman
134. Clinicians talking priavtely between themselves, so that the co-ordinator and other memebers cannot hear or contribute.
135. By sitting in rows in a meeting, many Clinicians are talking to someone's back.
136. being unable to see the diagnostic and staging tests
137. Badly chaired//IT equipment failing//indecisive treatment plans
138. Bad seating
139. Bad acoustics and poor display of information
140. Availability of imaging at the meeting if systems are not working properly.
141. Attendance & timing of the MDT
142. Attendance - core members unable to attend
143. Appropriate room availability. Time constraints across all MDT members
144. An ill prepared room and a disorganised MDT Coordinator.
145. All the team can sit together and view imaging and pathology
146. All members/representaivesand information available and co-ordinated by the MDT Co-ordinator.
147. all members are present to discuss pts
148. all information has been collected prior to MDT and prepared for MDT.
149. All core members turning up every week, not just when they feel like itor their patient is being discussed on that day
150. A small uncomfortable space which is often noisy makes and MDT more difficult to run.
151. A non-dedicated MDT room with no computer types.
152. A MDT needs to be inclusive for all members, any barrier that isolates or fragments the group fundamentally weakens communication within the group and makes it more difficult for the MDT to function as an effective , productive team.
153. 1 Lack of attaendees 2 Histologies not ready

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

153 MDT coordinators responded to this question.

1. You have to change the way you talk so not so spontaneous and clinicians have commented that they 'like to look members in the eye' during dialogue
2. you get to recognise other health care professionals
3. Works well if equipment working
4. Where we have referrals to our MDT from tertiary hospitals it would allow for their clinicians to present the cases that they have more knowledge of and for whom we have few notes.
5. When working efficiently, it has a massively positive effect. Clinicians have busy schedules and are unable to attend the meeting in person. Video conferencing allows the meetings to continue. But if the equipment is not working, then the meeting can not run and effectively is cancelled for that week.
6. When the video link does not work - most of the time.
7. When the technology all works it is great but even then some team members are reluctant to use the facilities that are readily available to them
8. When it doesn't work, it prevents patients from other sites being discussed. Also discussions can be muffled or unclear.
9. We manage very well without teleconferencing/video conferencing!
10. we have found our system to be very erratic and unreliable so it has been of no benefit
11. we find video - conferencing effective
12. We dont use this facility yet!!
13. We dont use teleconferencing at present
14. we dont use it yet
15. we dont do video conferencing in our MDT
16. We don't use it in breast at the moment as all members attend
17. we do not use this technology.
18. We do not use this in our MDT meeting, but I know that problems can occur when several people start talking at once and so the Chair needs to take a lead role.
19. We do not use this in our MDT however it is useful for members who cannot travel to MDTs
20. we do experience problems regular where the communication breaks down when another party call in. it is an ongoing problem which we are trying to stamp out with the IT dept.
21. We've never had to use but have access to it
22. videoconferencing does make MDT's slightly slower but is important for communication that the whole team are involved in the discussion of patient treatment
23. Video conferencing works well if there are no problems with the equipment- sometimes poor audio quality
24. Video Conferencing may be helpful to consultant's when they are at other site's.
25. Video conferencing can often stifle open conversation between sites as only one MDT member can speak at a time and be heard.
26. Video-conferencing benefits - ensures that all members can view histology & radiology results and are able to give a true objective view.
27. VCing always has positive impact! TCing is always a last resort
28. too impersonal
29. to enable patients to be discussed across different trusts
30. Time and attendance, as no member has to travel to participate and attend meetings.
31. Time-consuming. Prone to malfunctioning.
32. There is sometimes a short time delay which means that members may talk over one another which can be off-putting

33. The positive impact: being able to have a conference with more than one sight. Negative impacts: microphones not working, linking up problems, no quiet keyboards as other sites complain of hearing keyboard tapping
34. The person teleconferencing does not have any visual stimulus. Video conferencing needs a trained technician to get the most from the equipment - otherwise, it will be similar to teleconferencing. It is difficult, via video conferencing, to decide how to pass the discussion between the different sites.
35. The impact and benefits of video conferencing are enormous. However, technical difficulties and lack of technical support is a real hindrance and can delay the discussions significantly.
36. Tertiary centres can join in the meeting without having to travel
37. Teleconferencing is a positive way to co ordinate MDT meeting so we can jointly discuss a patients pathway and come to the best possible outcome
38. Teleconferencing can be confusing - doesn't allow people at one end to see radiology, histology, etc - which makes it difficult for them to make a full input. Often problems of feedback, cracking and general difficult to hear people through teleconferencing and videoconferencing facilities.
39. Technological problems often prevent efficient running of MDT.
40. Sound quality is not great at times - makes it very difficult to hear comments from outside the room. Picture quality is not always good enough (especially for lung where a matter of a few millimetres can make the difference between a patient being a surgical candidate or not).
41. Sound quality and delay in response can hinder the MDT . The positive aspect is that more clinicians attend
42. Sometimes it does not connect, it is a waste of time and efforts then. Also sometimes images that are showed in an MDT cannot be viewed by the other party who are being linked by video conferencing.
43. Sharing of knowledge. Ability to discuss treatment options.
44. Quality of sound and images can be poor
45. pt can be seen very quickly
46. Postive:Members are able to discuss and view reports of investigation with other trusts in regards to patients care. Negative:difficult to conclude on patient care without able to view reports or communicate if the networking system fails
47. possitive impacts are that all core members can attend and have their input on patients plan of action, only disadvantages are when the equipment is faulty which can result in patient not being discussed till the following meeting.l
48. Positive: it is an effective way of getting team members together accross different sities where travelling would have normally been essential. Negative: mute button used to often and Clinicians having seperate converstions whilst other side discussing patients.
49. Positive: Saves on travel. Negative: Can be time consuming.
50. Positive: improving attendance + reducing travel Negative: poor etiquette, poor quality sound and time delay
51. positive is that all cor members can attended where ever they are. Negative is when video conferencing is not working has a great impact on the mdt and patient being discussed.
52. Positive impact: Allows for throrough discussion of patients. Negative impact: Does not always work effectively due to service provider, equipment, etc.
53. positive impact, we have been TVC for many years
54. Positive impact
55. POSITIVE
56. Positive
57. positive
58. positive
59. positive
60. Positive - enables all members to be fully informed and take part in the managment decisions. Negative - the meeting sometimes feels dis-jointed, members video conferencing in sometimes do not fully engage in the meeting.
61. Positive - allows attendance from multiple sites for network level MDTs Negative -

- rarely works correctly, always wastes time, expensive opportunity for outside contractor work.
62. Patients can be discussed with the Centre and other local hospitals
  63. Patients can be discussed further by members who can not attend.
  64. Only positive
  65. not yet used
  66. Not yet available but planned for '09
  67. Not used in my meeting
  68. not tried yet
  69. Not enough. The meetings that need co-ordination are not Networked; where all patients' with the rarer or so called 'specialised' at 'Specialist Cancer Hospitals' are not discussed.
  70. Not all images project clear enough at video conference.
  71. None unless the equipment is faulty or not working
  72. Never used it However, consultants time across the County would benefit rather than travelling 30 miles plus
  73. never used it
  74. Neither of my two meetings use video conferencing
  75. Negatively the video-conferencing equipment often fails, usually due to the host and it can cause major break down in communication sometimes resulting in not being able to discuss patients.
  76. Negative: the system can go down and not able to use during the meeting  
Positive: being able to see other Trusts imaging via the link is easier, and quicker, than arranging a transfer of the images/histology
  77. negative
  78. negative-members dont seem to include the member who is video linked.
  79. need to dial in at a set time, if the other clinicians are not ready to receive you it is not time efficient
  80. n/a I have never attended and MDT where teleconferencing / video-conferencing was available
  81. N/A
  82. N/A
  83. Miscommunication. Signal loss. Inability to view images from other trusts
  84. Members can attend meeting without having to travel which saves time.
  85. Meeting feels fragmented. Cannot always hear comments from other venue clearly (mumbled). Images not always portrayed clearly - grainy.
  86. May be come over-dependent on it
  87. local teams have access to wider expertise and joint learning/educational aspects. Patients treatment plans are equitable across the patch
  88. Less travelling time so better use of time.
  89. it saves meeting having to be cancelled due to oncologists, radiologists etc being at another venue.
  90. It means we can connect with other trusts and have a network meeting to review all patients.
  91. it means that decisions will not be delayed by having separate meetings
  92. It makes it possible for all members to be involved in the meeting
  93. It is very effective when the v/c equipment is working, however when it fails there is no connection and the other party have no way of communicating with the other team.
  94. It is not something which is used at our hospital. If a Doctor is not present, patients are discussed, and they are informed, but can change or bring the patient back for discussion.
  95. It is harder for the co-ordinator as you do not know the other team, they are harder to hear, and you do not work so much as a team because you all sit in a line facing the TV. it causes problems, such as cancelled meetings due to technology not working, and discussions tend to be briefer as generally the 2 hospitals do not like to disagree with the other - it is much more polite rather than a team giving their honest opinions.

96. IT IS GOOD TO GET A 2ND OPINION ON THE COMPLEX CASES THAT ARE DISCUSSED.
97. It is a nightmare when the system goes down or does not work across all locations required
98. it helps when we need to discuss cases with the XX [area] thoracic team and HBP team. but when it is not working delays have been known to happen
99. it has a positive effect when it is working
100. It gives a wider opinion on patient treatments etc during live time.
101. It ensures all members attend but quality can be sometimes be poor and sound quality can be quite distracting
102. It enables us as a Unit to link with our Centre, enabling decisions to be made quicker with the aid of radiology images etc
103. it enables members to give their expert input without having to travel between locations.
104. It enables members to attend meetings when they are unable to be there in person. The bad side is that they often break down.
105. It enables core members to attend the meeting even if they are not on the premises making sure patient care is priority.
106. It enables all memebers to contribute to the meeting, even when they are on different sites.
107. It depends whether the equipment works when you switch it on the first time. This can cause frustration before the meeting even starts. It certainly slows things down even when it works well.
108. It can be disruptive if equipment is not working well
109. It can be a little confusing - but it is a welcome break in a long agenda. It can also be difficult if equipment is faulty but the benefits outweigh the disadvantages.
110. It allows core members to input in to MDT when they can't make it in person. Sometimes when videoconferencing voices aren't always clear to hear
111. It allows core members from several hospitals within a Network to come together for MDT with minimum inconvenience to core members.
112. it affords all surgical and oncology personnel to contribute towards a patients treatment plan. this is sometimes thrown into chaos by unreliable IT equipment.
113. is very good when it works, which thankfully most of the tome it does. Can bring different people in different places together
114. In my opinion it would slow the meeting down and cause more problems with trying to get correct utcomes. If a patient has to be discussed the relevant parties need to attend.
115. images & sound quality can be poor & so decisions can be missed or misunderstood.
116. Image quality (PACS or pathology) is not great, but at least people can link up with the specialist team to discuss their patient.
117. If the link is good quality this can be an adbvantage. If the link is poor quality then it can be frustrating and result in non attendance
118. if relied upon mdt will not funtion properly if technical breakdownhappens
119. If a core member hasnt the time to travel to the location of the MDT due to meetings it may mean that their case can be discussed earlier than planned if they can cut out the travel time and then present their case prior to any other commitments they may have.
120. I personally do not use video conferencing so do not have a comment.
121. I have not used it in my meetings yet
122. Have not currently used tele/video conferencing. I think it would be most useful if a patient has been referred and the meeting can update their progress
123. Have never used either so couldnt comment
124. Have clinical co-governance and input from specialist pathology so three centres videoconference-it works well.
125. Hard to see and hear, but saves travelling time
126. Greater input increases discussion therefore takes longer to discuss each case, but really this is a positive impact
127. Good

128. ensures those involved in the patient's care are all involved so that joint decisions can be made
129. Ensures regional clinicians can be 'present' when their cases are discussed; Allows managing clinicians input into their patients care; Can delay meetings with technical malfunctions/ temporary breakdown in audio/ visual connection; bad VC etiquette can cause confusion; low quality of projected images can be a barrier to effective discussion
130. Ensures more members of the team can attend meetings.
131. Ensures members of network MDT can discuss complex cases and means effective use of resources and core members time
132. Enables all to attend
133. enables all sites to communicate and decide pt care.
134. don't use so can't comment
135. Don't use it
136. Don't acutally attend such a meeting
137. Depends on the MDT
138. Cross site MDT's ensures all cancer pateints be discussed at MDT irrespective of Core Members duty rotas
139. could influence delegates not to attend for some meetings
140. Can take time therefore this is not used regulary and if the consultant is not around we defer the case until he is next present.
141. Can effect timing, ie one MDt may not be able to join until late, delays whole MDT.
142. Can connect with other sites so joint decisions can be made promptly. negative of it is when the system goes down
143. Can be useful when system is functioning properly
144. Can be disruptive if not properly available and lead.
145. Breakdown, People talking at a site when another site is trying to present a case.
146. better communication if it works!
147. bad reception can be a great disadvantage for speaking and viewing
148. Allows various people form other trusts to give an opinion
149. Allows people from elsewhere join the meeting and have input
150. All positive, team members raising patient health concerns, with view of other opinions.
151. All cases are agreed on.If a Consultant is at another hospital he or she can still discuss the patient,
152. Across site communication essential for us as 3 hospitals involved in V/C MDT meeting
153. Ability for whole team attendance.

### **What additional technology do you think could enhance MDT effectiveness?**

90 MDT coordinators responded to this question.

1. When the IT does not work properly, and imaging cannot be viewed, either on the computer, or projected. When the viewing of histology slides doesn't work and cannot be projected. These do not make for easy meetings or good discussions. Working IT would greatly advance effectiveness.
2. When a patient has an EUS ..the report should be available on a system somewhere rather than only in the patients notes
3. We would like the use of a microscope so we can review pathology, this is currently not available in the LMC lecture room and has been brought to the relevant peoples attention.
4. we use a modern touchpad system in RD & E - more funding should be given to other sites to have the same systems as remote control V/C is very complicated and corruptable and can lead to V/C difficulties

5. We have recently installed a printer in our MDM room to enable us to print outcomes and file in patients notes then and there
6. we have all available
7. We cannot currently project images - new database on order
8. up to date equipment
9. two screens for outcomes and rad/histo
10. There isn't any at present
11. The ability to view Somerset from other tertiary centres.
12. That all trust should have someone to make sure that video-conferencing is good working order. MDT Co-ordinators do not have time dealing with the equipment and run a mdt.
13. Technology that would enable connection to more than one site from more than two designated vc rooms.
14. superior IT equipment and support at MDT meetings.
15. Sometime better audio output so you can hear what everyone is saying.
16. Reliable technology is the key
17. Real time recording of MDT outcomes to go straight into patients records and access to GP's surgeries to email outcomes directly
18. Real time recording
19. Quiet keyboards.
20. quicker access to Network lines for radiology
21. Projection, so students can see what is being discussed.
22. Projection of decision to confirm agreement of all core members
23. Printer
24. ppm
25. PACS & ICS capabilities within the MDT room.
26. PACS !!!!
27. Not sure
28. Not sure
29. not sure
30. none really as long as the connections work effectively it is satisfactory.
31. None
32. new improved V/C!
33. National patient records
34. n/a
35. Mutual PACS visibility.
36. more up to date suite
37. More than one room equipped with the above
38. Microphones that work
39. microphone
40. Locally - real time recording of outcomes. Otherwise nothing.
41. Linking to the live patient record system would of course be the best option. that way all clinical staff involved in the pathway would be kept abreast of the decisions of the MDT.
42. laptops, good quality projection equipment, suitable projection equipment to enable the projection of proforma/database, radiology and/or pathology, other video conferenced sites
43. Laptops to document outcomes so that they can get sent out quicker, may decrease risks of mistakes, i.e. misinterpreted handwriting
44. Laptops for real time data collection rather than / as well as paper.
45. Laptop and separate projection for this
46. Keep additional AMX battery,
47. Improved reliability of videoconferencing equipment. Dictation/typing a record of MDT outcomes in real-time.
48. Improved image quality. Improved voice delay. Ability to provide multi-image views at the same time.

49. If PACS investigations have not been verified then they cannot be viewed in the MDT this can sometimes hold up a patients treatment. Being able to view unverified investigations would be of great benefit.
50. If i had a PC and a desk so i could input the data live and the members could then check the outcomes for completeness.
51. I think we have enough technology at our MDT's.
52. I THINK THAT WE HAVE ALL THE TECHNOLOGY TO SUPPORT OUR MDT ALREADY.
53. I think our technology equipment is very good
54. I feel all above works sufficiently
55. I cannot think of anything which would make our MDT run any better
56. Higher definition image projection, N3 connectivity based on IP addresses rather than ISDN line facilitating 'limitless access' to desktops/laptops from any location.
57. Having a plan B when the video conferencing isn't working. Always having someone to contact when the equipment stops working - maybe having someone test it every morning before the MDT starts.
58. Further enhancement of the video conferencing facilities would be beneficial to the MDT. The technology is not yet ready to project crystal clear images across different sites along with a high refresh rate.
59. Faster connectivity.
60. Faster connection speeds etc.
61. Excellent VC links with other Trusts including PACS link up. More robust and up to date IT equipment with improved IT support from VC company - consistent approach of equipment throughout networks ensuring that equipment is compatible with each other
62. Electronic Patient Recording system where we can view patients notes electronically.
63. Electronic access to patient's notes / clinic letters
64. Easier access to pathology specimens
65. Don't know
66. Do not know.
67. Digital photographs of pathology slides rather than the physical slides themselves may mean that images could be projected with little/ no pixellation while the slide is moved about and zoomed in/out on to show a specific area- if the specified image was already loaded up this could speed the diagnostic presenting process up and make images more immediately clearer.
68. Dedicated SDSL lines to give full strength images and clarity of sound.
69. Coordinator laptops
70. computere access so that outcomes can be recorded onto database immetiately
71. Computer to fill the outcome of the MDT direct onto the Patients electronic file
72. Can't think of any
73. can't think of any
74. Better sound and image quality for videoconferencing and reliable connection. Access to other trusts PACS would make adding patients onto MDTs quicker and easier (my MDT is a network MDT all clinicians attending a central meeting)
75. Beter quality video conferencing equipment.
76. being able to project via laptop photographs (ie. for skin MDT's).
77. An overhead microphone. A telephone with an outside line in the MDT room. An effective reporting system when the technology fails.
78. All of the above required for ideal discussion.
79. Access to PACS, Canisc MDT module.
80. Access to other Hospital systems ie PAS, Patient Tracking
81. Ability to project video, histology, radiology, proforma feeds all at the same time with no need to switch between sources.
82. Ability to document outcomes real time and for them to be viewed and verified in the meeting
83. Ability for inter hospital access to lab results and imaging.

84. A slightly bigger and more comfortable room
85. A reliable host and bridge during teleconferencing.
86. a good projector (ours is not great). the ability to project the outcomes on the screen. a telephone extension in the room, or close by) to answer bleeps.
87. A data base where the information is put straight on
88. 2 projectors similtaneously showing database (Canisc) and Scans or path reports. A phone in the room to get help with technical difficuties asap. Computers that are up to date and work efficiently, and that are up to the job.
89. ?
90. ?

## Meeting organisation and logistics

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

206 MDT coordinators responded to this question. In addition, 2 MDT coordinators referred to the criteria in Q13, stating “all of the above”

1. Verify and complie patient list, review history of care/investigations, review past appointment(s) note who has seen patient, when and what was decided, future investigation(s), future appointments and or procedures, note whether patient is new, known, recurrent Ca, time in pathway/care of patient.
2. Timely referrals to the agenda, agenda having a draft so that Radiologist.Registrar can view cases early, agenda vetted by Registrar to remove inappropriate cases, all members to be aware of their patients and deliver the medical history in an engaging way. Equipment check where problems have arisen (but this will fall to MDT Co-ordinator who may not have time)
3. The radiologist checks patients that are on the list who have had scans. The MDT Co-ordinators prepare the patient list, attendance lists etc, collect patient notes, prepare the room, collect any histologies. The pathologist should attend with any histologies to be discussed.
4. The names of patients to be discussed mst be gathered. The agenda prepared and distributed. Specialists presenting results must ensure that they are ready. Notes must be gathered and brought to the meeting place. People must be informed of any complications re attendance, venue or timing. Display equipment mut be in working order.
5. The MDT Co-ordinator needs to be fully prepared to support the clinicians, ensuring all results are available. Radiology and pathology results should be reviewed prior to the meeting.
6. The list of patients for discussion needs to be prepared and sent highlighting the exact reason for discussion in order for the people involved in that speciality to prepare in advance what is required for discussion.
7. The case history should be summarised clearly. It should be made clear what is being reviewed and why. The MDT list needs to be clearly laid out. Any OPAs should be booked prior to the MDT when possible. Investigations from outside trusts should be requested as soon as possible to ensure they are present at MDT.
8. Staging info and medical histories need to be available, doctors involved in presenting patients need to have studied the cases, MDT coordinator needs to have comprehensive info on patient
9. Retrieval of casenotes, imaging reports and pathology for each patient. Preparation of lists and patient information.
10. Results of test, patients notes, and letters from clinic. Help from Consultants sec to up date us on patients if they are on the MDT list to be discussed.
11. Requesting x-rays, scans, requesting and collecting notes or paperwork,

photocopying paperwork, filing in BAUS forms, adding patients and all investigations, histology reports to the MDT meeting agenda, entering all the patient information onto the database and worksheets. Finding out future dates for appointments and investigations, completing MDT proformas and ensuring histology reports are attached.

12. Requesting of patient case notes//preparing proformas on each patient//preparing and distributing agenda beforehand//ensuring that all information is available for the meeting//ensuring catering is ordered//IT equipment is set up & working//venue available
13. requesting of histology and imaging adding data into Somerset, requesting notes
14. requesting imaging, path reports, sorting out where pts path has been sent, finding out which hospitals pts have been referred from
15. Requesting appropriate pathology/radiology case notes requested or clinical information collected. Radiology loaded onto PACS system.
16. Regional MDT. Track treatments. Dates. Demographics etc. Collect histology and Radiology and relevant information
17. referral form to be completed in detail list of patients with investigations for discussion - and copies available for all attending collection of all patient notes request for histology slides room and equipment set up
18. Receipt of appropriate and accurate data Collation and summary of results Appropriate timing of pt discussion. Dissemination of information
19. Pull Notes, create discussion list, check appointments, Import imaging from other trusts (where applicable), Send off radiology/pathology reports for review by appropriate team members, arrange for review of appropriate slides\sections, e-mail/fax out discussion list, arrange transfer of notes from foreign trusts for discussion, check audio-visual equipment before meeting.
20. Print report and get slides ready for consultants. The list of patients to be included needs to arrive in time for the preparation of the co-ordinator, sufficient time for the consultant to review the slides
21. Presentation of all relevant patients request for their imaging and histology and case notes.
22. Preparing the list of patients and their summaries to be discussed, checking that all recent investigations are up to date and entered on CaNISC, sending the list around to MDT members by email, setting up radiology images on the Web 1000 and preparing MDT forms to be filled up by relevant consultants.
23. Preparing & circulating agenda, collating case notes, histopathology & imaging for presentation.
24. Prepare MDT list with patient details scan dates histology, surgery dates any O/P appointments Circulate MDT list Make sure you have all patient notes prior to meeting Prepare action list send out mdt list prior to meeting
25. Prepare & distribute an MDM list containing patient names & brief history to all members prior to the meetings. Ensure patient medical notes are available. ALL results relating to radiology & histology are available. All slides are available where required.
26. Preparation, review and distribution of Agenda. Checking patient information on Agenda. Collection of medical notes. Extraction of cancer waiting time data from notes. Chase/collate test results, pet scans; ensure imaging is loaded onto discs for Radiologists. Liaise with Clinical Nurse Specialists, secretaries etc to clarify any queries. Preparation of notes with MDT labels, proformas and extra stationary that might be needed in the meeting. Chase histology results.
27. Preparation of running list and submission to x-ray and path. Preparation of patient proformas with all relevant information. Collection of patient notes, test results, films for meeting.
28. Preparation of minutes, agenda, attendance lists, tests, OPA's. Who is going to attend i.e radiologist, pathologist
29. Preparation of MDT list, proformas and patient notes. To make sure report, imaging, pathology and lung function. Sending MDT list to core members. Ensure reports from tertiary hospital are available.
30. Preparation and distribution of the agenda(s), at least two days in advance of the meeting- a separate agenda is created for the pathology dept on their request.

Summaries are prepared for each patient (including, but not exclusive, clinic letters, theatre letters, referral letters etc). Requesting pathology slides and Scans for those patients that have been seen outside of the trust. Preparation of the database and data collection forms. Identification of target patients and days remaining on the target. Identifying which patients already have appointments/tests booked post meeting. Checking availability of theatre slots and appointments so that these can be booked in the meeting when the management plan has been decided.

31. Patients who are referred to the MDT need adding to the database, also patients with positive histology available is added for discussion if not discussed. Notes are requested for the meeting and chased up when necessary. Diagnostic imaging and histology is chased up, recorded onto the database and printed if necessary for the meeting. Agenda's are sent out prior to the MDT and additions are notified to appropriate core members in good time. Catering is ordered. Venue is booked in advanced (block booked). Equipment is checked in advance before meetings start. MDT room is arranged accordingly and the notes/proformas/agenda's are all distributed.
32. Patients to be discussed must be identified to the MDT coordinator Patient notes need to be collected Histology slides need to be ordered from pathology Scan reports need to be printed Agenda needs to be prepared and sent to core members Proformas need to be produced for each patient
33. patients details, faxing to histology and x-ray and ensuring received, collecting notes and late add ons
34. Patient notes need to be collected, scans need to be recorded, pathology needs to be gathered, Agenda's need to be created, circulated & printed. Information needs to be entered into somerset for CWT's & NOGCA. Appointments need to be noted etc..
35. Patient names; clinical question, diagnostics to be reviewed, Adittional information important to the individual patient.
36. Patient names and details need to be put on the agenda as soon as possible, notes to available for the meeting, all results printed and ready for viewing. Radiologist requested for image update. If required, the video link up between sites should be prepared. All members should be sent an agenda in case of any add ons. The attendence list should be printed and checked prior to members arriving.
37. Patient lists and patient summaries need to be done. Ensuring radiology, casenotes and histology are available. Ensure all equipment will be available and in working order and that the room is available.
38. Patient lists and agenda. Getting patients notes ready, circulating agenda.
39. patient list prepared, notes collected, meeting room set up, collection of data from other sites, notification of agenda sent out, proformas completed
40. Patient list prepared and circulated by email Checking that imaging and procedures have taken place prior to adding patient to list List copied and attendance register prepared for meeting Patient notes collected and proformas attached Ensuring histology reports from other Trusts are available Taking notes to meeting and collecting inpatient notes
41. Patient Information, Images and Pathology, pre-paring notes, liaising with consultants, pathologists and Radiologists ensuring that all information and Equipment are available.
42. Patient information to be collected, all results of scans and pathology need to be identified, communication between other sites should be effective
43. Patient info to be collated. All notes, histology, images etc to be available for discussion as nec.
44. Pathology, notes and full questions/presentations from consultants.
45. Organising Agenda, inputting all info onto Haema Database. Requesting casenotes, xray results, histo results, PET scan results, emailing info to Consultants.
46. Organisation of Notes xrays Reports summary of patients treatment.
47. once we have all the information of patient to be discussed we place them onto a list which is circulated one day before the meeting so that all core members know

- who is to be discussed and reasons why, all imaging and pathology is requested and notes are collected and set out prior to members arriving at the designated conference room.
48. Obtaining notes, results from five different sources and summarising information on to the agenda. Send out provisional list as early as possible so there is time for outstanding reports to be chased. Send out final list for members to work from during the meeting.
  49. Obtain casenotes and any external imaging/results. Establish why patient is for discussion to ensure results of any tests are available for the meeting. Confirm which clinician is to present the case. Check to ensure imaging from external trusts has been received and is on the hospital system or in a suitable format to review at the meeting. Send e-mail prior to formal agenda, to Histopathologists and Radiologists to allow them maximum time to prepare their reports. Prep the MDT proforma with brief patient background, summary and history to date. Provide Agenda to cover summary and background and circulate to all team members.
  50. Notification to members of patients to be discussed. Pathology and radiology available prior to the meeting to enable pathologist and radiologist to prepare for the meeting.
  51. notes, slides, letters sent out, lists ready, print outs done, ppm updated
  52. notes, presentation and imaging review
  53. Notes to be got and prepped. Patients pathologies & imaging chased and printed. Patients asked for listing to MDT need to be ensured all results available and chased up if not. List typed and distributed.
  54. Notes collection, lists, results, room prep
  55. Notes collected & refilled correctly, asses IP notes - availability. Reports & test results up to date and filled correctly
  56. Notes available at the meeting, histology results readily available, equipment fully up and running especially when video conferencing.
  57. notes and results available mdt sheets filled in by relevant clinician , room and equipment prepared
  58. more help & support
  59. MDT co-ordinators need to collate an accurate list that is easy to understand. Clinicians should be aware of the patients and have looked into history and current issues for discussion.
  60. MDT co-ordinator should ensure availability of all necessary notes, reports etc. X-rays should be reviewed where necessary, pathology the same. Clinicians should be aware of the patient's history and not have to spend time leafing through notes.
  61. Making sure PACs are accesible to tertiary Hospitals if not Disks sent prior to meetings
  62. Making sure notes,results are available for Consultants.My consultants go through the notes a day or so prior to the MDT so they are familiar with what needs to be discussed about the patient as they may not have seen the patients themselves.Making sure that patients have appointments to come back to clinic with the MDT decision after the MDT.Communication with other trusts that may have performed tests that we need the results for.
  63. making sure all relevant patient information is available ie post op hx. further OPA dates futher Diagnostics already planned
  64. Make sure the room is booked.Make sure equiptment is working.Collate who is to be discussed. Send patient lists in advance with an explanation as to reason for discussion and by whom. Alert Path and Pacs in advance to compile reports on Pt's. Inform the group of changes/alterations. Ensure proforma's are compiled in a concise but comprehensive manner with all applicable and relevant info, treatment dates, PMH, previous discussion and outcomes, OPA's ranges, findings.
  65. Make sure all the images required for the MDT are downloaded onto the laptop. All notes are avaiable. All relevant paperwork is ready for the MDT. MDT lists sent out to all teams prior to meeting.
  66. IOCATING AND MAKING AVAILABLE ALL UP TPO DATE RESULTS AND PATIENT NOTES
  67. Lists need to be made of the patients to be discussed and circulated to the team.

Any additions to this list should be circulated as they come in. Notes have to be accessed from medical records or from secretaries and departments.

Summaries on each patient written and stored on relevant database or document to be used in the meeting. Registers need to be prepared. Results of histology need to be recorded and chased if necessary. Reports on imaging need to be recorded and chased if necessary.

68. Lists need to be compiled of all patients to be discussed at MDT, stating reason for discussion. List need to be sent out to all Core Members. Notes, histology, radiology reports all need to be gathered for MDT, An MDT proforma needs to be filled out giving relevant information on each patient. Following MDT all recommendations need to be typed on to the MDT proforma, filed in clinical notes and sent to GP. A Post MDT list is sent out giving recommendations on patients discussed to all core members.
69. Listing of patients, booking room equipment, catering, arranging slides, films and correct personnel to attend.
70. list preparation. paperwork preparation
71. list of what needs reviewing. proformas completed effectively by each person adding to the list. notes. chance for histology and radiology to be reviewed.
72. List of patients to be discussed sent out in good time so all core members can know who is to be discussed and fully prepare, access to full history of the patient, often requiring speaking to the referring clinician about the case. Radiologists and Pathologists must review the material prior to the meeting, allowing them to summarise it in meeting. Consultants need to have some awareness of patients wishes, ie wanting to preserve fertility, as this can effect the treatment decision.
73. It is important that the agenda is compiled with all the relevant information relating to each patient for discussion and that it is emailed out to the team members in a timely fashion. It is also important that any team members that are required to input to the discussion ie: radiology histopathology are available to attend. it is essential that the team is emailed about any any core members non attendance as this could hinder the patients treatment and also wastes time. It is also essential that all case notes are available and if not that the relevant information is available ie: clinic letters radiology/ histopathology reports
74. information of pts to be discussed, pts notes. list of pts circulated prior to meet, reports images available
75. Images downloaded Patient notes available
76. Image and pathology review.
77. I spend between half a day and a whole day depending on how many patients are being discussed
78. I compile the list of suspected or proven cancer patients for discussion. I then find out where on their pathway they are, and what investigations have taken place. I find the notes of all of the patients for the meeting, and follow up any decisions afterwards as necessary.
79. Histology, Notes, Imaging, list's, filled out proformas,
80. Having all patients on the MDT list with correct information. Being sent the information at least 2 days prior to MDT so that it can be included onto the list. Everyone who adds a patient to the MDT list should be present as those present may not see the patient and they cannot be discussed.
81. Have the MDT List ready, the Video Equipment ready, the Images uploaded onto the Hosp Systems to review, and the Pathology slides ready for the Histopathologist to review.
82. GETTING ALL CASENOTES, REPORTS, IMAGING CIRCULATING MDT LISTS. ARRANGING CLINIC APPTS
83. GET NOTES, TYPE AGENDA, INVITE, PROFORMAS AND GET X-RAYS
84. Full clinical history for each patient. Preparation of outside imaging. Circulation of MDT list to histopathology. Ensure all patient's investigations/reports/notes are available.
85. From an MDT Co-ordinator perspective: Referrals, review material and associated reports need collating- discussion lists need preparing and disseminating and medical notes need tracking down and obtaining
86. Finding patient notes and putting in order. Preparing discussion lists. Preparing

- relevant histology and imaging for discussion. Clinical staff should prepare proformas for each patient.
87. Finding patient's notes and collating all test results. Presenting cases in orderly and understandable format. Forsee any tests that may need performing and have relevant request forms to hand.
  88. Everything, the compiling of the list, Requesting histology & scans, obtaining patient history. Collecting notes.
  89. Every one informed so that they can do their part of the preparation ie radiology etc
  90. everthing making sure notes , histology reports, scan results, appt booked, equipment works
  91. entering patient details onto dedicated MDT database, finding reults and entering details onto database. Finding casenotes, producing agenda and sheet for front of notes. Transporting casenotes to MDT venue.
  92. Entering all appropriate info on Cancer database, collecting notes and tracking, preparing meeting list and distributing, checking for radiology and histology results, making team members aware of any deviation from normal routine
  93. Ensuring that test results are made available prior to the meeting, colating missing information, chasing notes etc.
  94. ENSURING NOTES/SCANS/HISTOLOGY ETC AVAILABLE. COMPUTERS WORKING. PEOPLE ATTEND ON TIME. PEOPLE BRING INFORMATION WITH THEM AND CIRCULATE IT BEFORE THE MEETING.
  95. Ensuring all results/case notes and summaries are prepared prior to the meetings.
  96. Ensuring all results, scans, notes etc are available at the MDT to discuss the treatment pathway fully
  97. ensure all referrals are accurate and cut off time known. Get notes . Produce list. Circulate list . Ensure x ray and path can report . ensure all relevant personnel are available.
  98. Ensure all notes, histology slides and reports and radiology images available Book and set up room Prepare agendas and collate information Send out agendas in good time Chase results where necessary
  99. Ensure all diagnostic tests have been - a performed and b results are ready all concerned parties know their role and what is expected of them in any given meeting Lists are circulated to all those involved
  100. Effective selection of patients. Catering preparation. Gathering of relevant notes and results. Distribution of list of patients to be discussed to relevant parties. Preparation of room.
  101. Correct patient & clinical infomation given to consultants in charge, histopathology & radiology. All casenoted need to be located. A suitable venue for meeting to take place. Our MDT's are mainly during lunch so food being there before everyone turns up is always helpful!!
  102. Considerable data entry on to Somerset database. Prepping and finding clinicial notes. Collation of historic imaging
  103. Comprehensive list of all patients to be discussed, with all relevant information collated and resultts made available.
  104. Completion of Pro Forma forms to be inserted into patients notes after meeting. Collating all hospital notes, test results etc Emailing out list for discussion to all relevant members. A list for Diary meeting (which takes place the day before the actual MDT) prepared and emailed out.
  105. Compiling list. Checking pathology reports prior to meeting to assess how many referrals. Checking notes and x-rays available. Checking radiology has been reported.
  106. Compilation of list of patients for discussion List to be sent in advance of MDT An indication of what is to be discussed Gathering of notes, imaging, histology samples Relevant paperwork in place to ensure data capture can take place Ensure IT/PC/on line technology is in place Prior knowledge of who is attending to ensure meeting cover for absent core members
  107. collection of results. Preparing notes, preparing a list of patients.preparing pro-forma's for each patient.Preparing an action list.Seting up of meeting room, lap top, video conference ect.

108. Collection of referrals for MDT including all points of discussion for Meeting
109. Collection of patient notes, adding patients to the MDT list and emailing of the list prior to the meeting to appropriate members, then emailing the list to core members 2 days before the meeting. On the day of the MDT printing of agenda's, proforma, attendance list, relevant patient information ie, blood test CT U/S ect, printing of outcome sheets.
110. collection of notes, treatment plans, reports - ct, histology etc.
111. Collection of notes, referral details, imaging results, histological results, operation dates, creation of proformas, uploading of tests, diagnoses, previous treatments if applicable.
112. Collection of notes, patient history, treatments they have had, the preparation of the agenda. updating on somerset
113. collection of notes confirm histology and radiology tracking, present any potential breaches Agenda distribution
114. Collection of information regarding each individual patient and presented in a clear format. Ensuring that all case notes are available.
115. Collection of discussion data, collection of notes, collection of previous/ongoing investigations.
116. Collection of case notes: Imaging transfer from referring units: Room prepared for meeting: Notes collected from wards: Histology from referring units and reviewed: Database prepared with as much information as possible: List managed and circulated: All patients with imaging and histology ready for review, added to list
117. collection of all required notes, histology & radiology reports. proformas completed
118. Collection of all data, results and patient information including all patient's notes and documents.
119. Collecting patients notes. Printing all relevant pathology and imaging reports. Ensuring all images are available on the radiology system to consultants can view them.
120. Collecting of notes. Preparation of lists in correlation to patient care and pathways. Clinical summaries available to ensure efficient time management. Information to all members of the team.
121. Collecting of notes. Collating of ALL investigation results (including other hospital histologies - slides, formal reports; radiology images, reports. completing proforma's on all pts to be discussed, checking F/U appts, chasing tests dates and results in time for MDT.
122. Collecting notes, filling in proformas making sure all tests have been done and reports available
123. Collecting notes, histology and radiology results
124. Collecting medical notes and collating results, printing patient list and MDT forms
125. collecting casenotes, histology, any test results, sending out up to date agendas, room ready to start meeting
126. Collect patient information by phone, email or from consultants, formal requests for outside imaging & histology, patient history from other Hospitals. Ensuring all relevant data is available prior to MDM and on system. Team members are sent provisional & Final lists with correct information with location details, if linking with other hospitals patient lists have been emailed for patient outcomes. profoma's filled out properly with patients summary and plan and copy faxed to patients GP if requested. All equipment for MDM meeting is in working order and attendance outcome is kept.
127. Collation of up to date information on the patient
128. Collation of results, patient case notes and room/equipment organisation. Distribution of agenda to team members.
129. Collation of patient history, tests and results. Requesting of patient's notes, collating list and distribution to all members.
130. collation of list which is circulated, proformas collated with appropriate history
131. Collation of list of patients to be discussed sent to core members for review, including histology and radiology for preparation of slides and films. Completion of a proforma for each patient to include all history on patient including breach dates, co morbidities and investigations etc. Ensure all outstanding investigations are

- complete and reported
132. Collation of list of patient's to be discussed. Attaining Scans, results & reports from various hospitals. Information on patient history and presentation of symptoms.
  133. Collation of case notes/imaging/pathology. Preparation of acetates. Compilation of database records - Summary of patient pathway. Liaising with other Trusts regarding video-conferencing. Familiarisation with events in patient pathway. Previewing radiology.
  134. collation of all patients information is available, eg notes test results etc. getting lists prepared and distributed in plenty of time before the meeting. Making sure all patients are registered on to the cancer system.
  135. Collation of all notes, reports, proformas. Distribution of patient lists
  136. Collation of agenda list, email to all concerned collecting all relevant data for meeting, ie notes, reports, imaging, OPA's, nursing notes, etc + any additional data required by others
  137. collating patients inputting onto system and distribution to all mdt
  138. collating of patient information eg history, investigations undertaken etc, relevant imaging and histology organised, background from doctors on each patient as an introduction to each specific patient on list.
  139. Collating note, results, imaging, typing of case summaries
  140. Collating a list of patients for discussion. Preparing case summaries. Requesting imaging to be available electronically, particularly from other hospitals. Requesting histology review. Tracking, collating patient notes and investigation reports. Adding late additions to the list of patients to be discussed (agenda), if urgent.
  141. Collate patients for weekly list (from clinic lists, post-ops, staging etc. ); find notes, histologies and x-ray bags; Update pathology and Cris information on MDT sheets. Review notes for previous treatments. Assess stage of treatment, recurrence.
  142. collate list new & ongoing patients, check patient details, distribute list, retrieve individual casenotes, correspondence, relevant imaging, print attendance register,
  143. Clinicians needs to remind themselves of cases. Proformas need to be produced to show what the clinicians need to see. Notes, scans and histology needs to be available.
  144. Clinicians need knowledge of the patients they are to present. Radiology and pathology need availability of reports and images.
  145. clinical summary available, waiting times targets reviewed, fitness of patient status for first and subsequent treatments, histology and imaging reviewed reported and available, notes (can be electronic) prepared and up to date, staging information, conferencing equipment checked
  146. Circulating the agenda at least 24 hrs prior to meeting, all case notes available for MDT. check equipment is working, ie projectors, video conferencing, P.C's. Make room available for all MDT members in meeting room
  147. Checking histologies, imaging results, blood results, collecting casenotes, collecting data and preparation of MDT discussion plans. Preparation of MDT list of patients to be discussed.
  148. Check all histology/cytology results are available. Scans are reported on and available. Notes are available. Agenda sent out in time. Proforma's completed. Other hospital MDT Coordinators contacted to confirm final list of patients prior to video conference. Target treatment dates identified. Video conference system check.
  149. Casenotes, scans,
  150. Casenotes to be acquired, relevant test results to be available. Agenda prepared & updated as applicable, then distributed to people attending
  151. casenotes requested reports and images available for the meeting. Clinical profomas filled out.
  152. Case preparation, summaries made, images reviewed, slides reviewed
  153. Case notes not always necessary if there is a good prepared MDT sheet with patient background collected within
  154. case notes need to be available as this is dangerous to try and discuss pts without the correct information. xray cards imaging cards must be available to improve

- speed from meetings and all proformas with all pts details discussed dealt with and typed within hours after discussion.
155. Caenote retrieval, data collection. Ensuring all results available. Provide up to date and accurate informatin on all patients discussed.
  156. Availability of notes, results and personell
  157. As the MDT co-ordinator my entire role evolved around the MDT. Making sure everyone is on the list who should be on it and all informations, scans, histology slides are available for the meeting.
  158. As the MDT Co-ordinator I need to prepare the list prior to the MDT and send out a fax or email to the relevant core members so they know what cases are to be discussed at the meeting. I need to collate a list on PAC's also so that whilst we are in the MDTM the Radiologist has instant access to films on the list I have collated.
  159. As MDT Co-ordinator, to receive patients for MDT via proforma\*, entered onto MDT management system. Provisional MDT list circulated week before MDT. Patients accepted up to lunchtime of day before Final list circulated. \*Proformas are completed by Consultants & CNSs prior to MDT giving full information as extracted from patient casenotes - this substitutes for need to take casenotes to MDT.
  160. As MDT co-ordinator I compile the patient list for discussion, create patient summaries, collect casenotes and circulate information prior to the MDT and colelct any relevant data
  161. as an MDT Coorindator the majority of my role is within the preperation of the meetings. preparation of forms, reports, collecting notes, preparing agenda's and completing proforma's as a patient summary are very important to ensure that all necessary material and information is readily available in the meeting without delay. consultants need to be very aware of the patients stage/progress and options before the meeting to present their patient at MDT. Radiology and Hilstology also need as much time as possible to carry out theri functions and report on the patients in readiness for the meeting.
  162. As an MDT coordinator, lists must be prepared, we must make sure imaging and slides are available and ready before the MDT date and ensure a small summary is placed on the list. Also ensure there is an outpatient appointment available to the patient afterwards.
  163. As an MDT Coordinator where do I begin!
  164. As an MDT Co-ordinator/Data Manager/Patient tracker i prepare all the case summaries for all of the patients discussed at the MDT meeting, this is a Network MDT and we discuss anything between 35- 50 cases per week.
  165. As an MDT Co-ordinator/Data Manager i prepare all the summaries for discussion at the MDT meeting though I feel there should be input from the clinical team. Although I have been co-ordinating the MDT for 7 years it we are now a network MDT and discuss between 35-40 patients weekly from 3 seperate trusts and I feel preparing the summaries is very important and should be done with the help of a clinician
  166. as an MDT Co-ordinator its getting the notes, films, slides prepared along with the admin.
  167. As a Co-ordinator, it is key that all relevant paperwork, radiology and clinical information is available for the MDT meeting and relevant information is circulated beforehand. It is important that the Clinicians prepare beforehand so that each patient can be discussed in a timely manner.
  168. As a co-ordinator I recieve a pile of histology reports at the start of the week. I then seperate these into the different types of tumour (i.e. malignant melonoma's, SCC's, BCC's etc). I then decided (using guidelines) which need to be discussed, and which are to be registered only. The relevant histologys along with other pt information, such as pas number, DOB, GP, consultant, excision date, referral date, relevant history, future appts, are all typed up into the agenda (excel sheet). The pt's on the agenda are then all added (if needed) onto the cancer database for tracking. The agenda is checked, and then a copy sent to all the MDT memembers, their secrateries and all GP's of pt's to be discussed and the 3 trained community GP's. A list of GP excisions that week, and the Pt and GP details are

then send to the cancer lead for monitoring. I then find out where all the pt's to be discussed notes and any other relevant material is, and arrange to collect it the day prior to the meeting. Once collected and booked to myself, I add an MDT sticker, dated and timed in the relevant section of the medical notes, a email or fax receipt as proof that the GP for the pt was contacted and a 'key worker checklist' for the CSN to fill in - this ensures pt's do not get missed by her. The notes then have a sticker to mark the correct place in the notes, and are sorted into piles for each consultant. On the day of the MDT copies of the agenda are printed for everyone attending and a register drawn up in the log book. All those unable to attend are recorded in the 'apologies' section with the reason why. I go down to the meeting room 30-40 minutes before the start of the meeting and ensure the room details are showing at reception. I then arrange the room and bring in extra chairs/set up tele-conferencing/x-ray machines etc and put the notes for each consultant in front of where they sit and put out the register book and an agenda on each chair and water for the members to drink. After the meeting the room needs to be put back to how it was and the equipment away/keys returned. All the notes are returned to the secretaries/medical records/clinics (where ever I got them from the day before) and as soon as I get back to the office I track them out on ipm and in our log book. I then type up the minutes of the meeting, add the list of attendees and send out a copy to everyone as well as any requested information (such as a breakdown of targets, copies of a journal article etc). A copy of the minutes are then saved on the hard drive, one files, and one kept in the mdt box for reference. data sheets are then completed for each patient and the mdt outcome for each pt added onto the cancer database. Any pt's to be re-discussed are then added to next week's agenda.

169. arrange images/histology to be sent. update MDT list daily. collect patient notes. Make sure all images/histology are available for MDT and if not have reason why. Find out target dates of patients. Prepare to type minutes up after MDT. Book patient notes out to MDT. Distribute list to all MDT members.
170. An agenda/ patient list should be compiled before the meeting including all patients who require diagnosis, staging, restaging or change in treatment for that specialty. The agenda should be send to all members of the MDT. All relevant scans and or pathology results should be loaded to accessible machines in advance and the radiologists and pathologists should review them and be ready to present them at the meeting. Each patient should be reviewed by a core team member who should then be ready to present there case history and questions at the meeting.
171. All test results need to be available, and the MDT agenda needs to include details of follow-up appointments and tests already booked
172. All results, radiology, annotations and reason for discussion need to be in place prior to the meeting.
173. All results to be easily assessable. Correct input of Data. Note collection. Efficient running of Technology input
174. All results reports etc to be in patient notes. Case history +/- referral available with Jr Dr to present. Time to review patient notes before MDT
175. All results have to be found and transferred on to the database for the reports for the meeting. Case notes need to be found. Referrals have to be clear or they have to be called back to clarify the referral.
176. All reports should be available including short notice ones if they are urgent.
177. All relevant information needs to be collected for patient and radiology needs to be available on the appropriate system
178. all patients case notes have to be collected and relevant info concerning patient details, diagnosis, stage and grade of cancer, which consultant patient is under and all information typed into MDT form which is then distributed by email round everyone attending meeting. All case notes then have to have an MDT Discussion Form attached so that consultant can record treatment plan on this and it is then placed in patients notes. Previous to each meeting video conferencing has to be checked and if there are any problems IT contacted
179. all patient notes, imaging, letters and summaries to be tracked. Surgeons to be present to represent their patient. Patient details uploaded onto Infoflex data

- collection system and a summary overview of the patient to be printed off for each member attending the mdt. Bone scan, imaging request forms should be available for completion at the MDT and submitted immediately post MDT. CNS input needs to be represented to update the MDT of the current emotional/psychological status of the patient.
180. all patient information to be available, i.e. histology radiology medical notes and additional information usually exchanged via CNS
  181. All patient details, medical and clinical history needs updating on the acetates. Any histology or radiography reports need adding to the acetate. All patient notes need collating for the meeting. Discussion lists need finalising and distributing. Any external patient information and reports need chasing from the relevant trust.
  182. All patient case notes and reports should be available.
  183. All notes to be got ,MDT forms completed, results requested, agendas prepared and distributed, check venue, prepare attendance list
  184. all notes and investigations to be ready. My mdt has over 45 patients a week. there is a lot of preparation to be done
  185. All information should be presented at the meeting and a summary of the patient should be circulated to all core members before the meeting
  186. All imaging/investigation results available and having been reviewed prior to MDT by the appropriate speciality. Collection of all notes or if notes not available sourcing as much PMH on patients.
  187. All histology to be available. Notes to be available. Any further imaging, e.g. MRI provided.
  188. All clinical reports need to be available All casenotes need to be available equipment checked and working If video conferencing confirm link meeting list circulated apologies and if necessary deputisation organised Meeting room organised, information assembled, equipment switched on - stage set!
  189. All clinical details to be accurate, all notes/reports and imaging should be available and agendas should be distributed
  190. All casenotes to be available, all investigation to be made assessable, especially if they are from another hospital
  191. All case notes and reports to be available before the meeting.
  192. all case notes and imaging needs to be to hand and an up to date agenda
  193. all case files are needed, pro formas to be completed, histology reports to be printed and collated, MDT list to be created and updated, attendance to be confirmed
  194. ALL admin regarding the MDT meeting - data entry, summaries, meeting lists, requesting and collecting casenotes, reports, images, preparation of room and equipment, much of which is done within a 24 hour period pre meeting.
  195. agendas written and circulated, notes, reports and images collected, images prepared for report, samples analysed for report,
  196. Agenda, documentation being available, equipment working and all specialist being available
  197. Agenda sent to histology and radiologist for their preparation of cases. Notes to be collected on all patient, unless inpatients and team to bring on day. MDT forms to be completed - with presenting symptoms. PMH and current investigations
  198. Agenda prepared and circulated with correct pt details & brief summary of what is to be discussed. Any additions to be added then circulated again. Collation of notes and adequate prep done. Notes in order of agenda. Attendance register prepared. Any reports or information that is requested to be available at the meeting etc. Wherever possible lunch arranged.
  199. Agenda and patient list Collation of patient info + imaging & pathology availability Attendance of core members Room and equipment preparations
  200. Advance notice of additions to the MDT agenda in order to advise the radiologist or pathologist and to obtain the patients medical notes. Only urgent additions to be added passed the agreed deadlines. Patients should have completed staging rather than be discussed one week for imaging and the next for pathology.
  201. Accurate patient info - correct spelling of name, registration numbers, correct reason for why on the list, i.e. histology, imaging or discussion. Accurate complete list emailed out to team members at the deadline No unnecessary

- additions to the list, which can be very annoying Booking a venue which fits the purpose of the MDT and has enough space for all members to fit comfortably
202. 3 to 5 hours
  203. 1. Compiling a discussion list from a variety of sources. 2. Distributing the discussion list to MDT team. 3. Collecting (or arranging for) the hospital notes for each patient on the discussion list. 4. Preparing proformas for the consultants to complete during the MDT for each patient. This includes collecting and presenting information for each patient such as imaging and histology results. 5. Ensure each patient on the discussion list is treated before their Cancer Waiting Times breach date.
  204. 1 Make sure all patients are added on to the list 2 Lists are sent out to the teams 3 Notes are all prepped for the meeting 4 Images have been downloaded on to the laptop 5 Check equipment is in working order 6 The meeting room is available
  205. 1 Collection of all patient names post-op, diagnostics & reviews. Also rollovers from previous MDT 2 Compilation of lists all sent out to MDT members 3 Collection of notes 4 Preparation of notes
  206. \*Having the patients who are being discussed in advance preferably by a few days. \*Having the medical records available as some can go missing this causing problems. \*Effective communication between different depts such as radiology and the MDT. \*Being aware of who is attending the MDT meeting, in case of absences or annual leave. Knowing this in advance is a big help. \*Having a list of patients who are going to be discussed prior to the meeting, therefore this list can be distributed to consultants and radiologists. \*Also having a specialist nurse helps a great deal when being an MDT coordinator. The special nurse who is aware of the patients and who can help with new patients will be able to translate information more effectively. Currently the specialist nurse takes time every week to discuss the outcome, then the outcome is sent to the referring trusts etc and appointments are booked etc.

## What makes an MDT meeting run effectively?

179 MDT coordinators responded to this question.

1. Working as a team and good organisation prior to MDT.
2. When all core members attend, names of patients circulated prior to the meeting, patient notes available during the meeting and the chair summarises the plan at the end of each patient and has input into Somerset data being input during the meeting.
3. Well organised. Members turning up on time. Strong chairperson. Access to any technology required.
4. Timely attendance of core members All information on each patient available Effective visual aids Good chairing Seating plan
5. time management. ensure accurate discussion. good team work
6. Time management and co-operation
7. The Team working together and everyone understanding their role and whats required during the meeting.
8. The team sticking to the agenda and not getting side tracked with other issues not appropriate for MDT meetings.
9. the smooth running of the MDT. focusing on the patients on the meeting and not deviating onto other matters that can be discussed outside the MDT
10. the organisation prior to the meeting and attendance of all core members. Working and upto date technology.
11. The meeting should start promptly and only one person should speak at a time. It is important that the MDT Co-ordinator is clear on the decisions made for each patient and that he/she has enough time to record these before the next patient is discussed. All too often the Clinicians move on without a thought for the Co-ordinator.

12. the MDT Co-ordinator
13. The co operation and team work of all the MDT attendee's
14. The appropriate person taking the lead in the meeting to ensure that it is kept on track. The MDT facilitator ensuring that all resources are available where possible. Communication between all members in a respectful manner.
15. team work, consultants must know the patients they are presenting and moving to non paper patient notes would streamline MDT
16. team players all with a good working relationship sympathetic to individual timetables and lunch provided !
17. strong leadership. good communication. effective MDT coordinator. Supported IT links when tele-conferencing.
18. strong leadership
19. Strong admin skills on the part of the coordinator, delegated meeting 'chair', any technological equipment being in full working order
20. Standard operating procedures. All information required is available. Input from relevant clinicians
21. Someone to take charge of proceedings.
22. Respect for the opinions of others, allowing a full and frank discussion. Clear decision making, based on agreement of the group rather than one strong personality.
23. Relevant people in attendance, casenotes/results available, agenda up to date with as much detail as possible
24. Punctuality. Complete organisation of meeting. Equipment that works.
25. Punctuality, work as a team. All have input. All information is available to make a clear decision.
26. proper planning
27. Prompt attendance, preparation done.
28. Prior collation of as much information as possible. Not having lists that are too large to complete in the optimum time, before members start to flag. I find the best time is no more than two hours, however our meetings sometime last three hours if there is a very large list
29. Presence of the relevant doctors, esp. an oncologist. Also, the opportunity for the doctors to look at the patient's history is very important. On one of my sites, the agenda is grouped according to what is happening to the patients, but that is not the case on the other site. I think that the ability for each meeting to decide what works for them is important.
30. Presence of all core members. Availability of pertinent information/results. An effective chairperson to control discussion and make decisions about when to move on to next case.
31. preparation by the MDT admin if all the necessary information is provided the clinicians can agree a effective plan of action for the patients care.
32. preparation. secretarial attendance. notes/x-rays presented in orderly manner
33. Preparation, leadership and information running through the MDT coordinator.
34. Preparation, good leadership, prompt arrival and start. Clear summary of discussion including PS and Staging
35. Preparation prior to meeting. A good chairman.
36. Preparation prior to MDT is key. Effective chairmanship to lead MDT discussion and encourage full participation is essential. Reliability of video conference equipment extremely important. Logging an accurate record of MDT discussion essential.
37. Preparation and attendance. Strong lead by Clinician (Chair)
38. preparation and attendance
39. Preparation Planning Attendance Leadership
40. preparation
41. people attending on time, not going of the subject in hand. Having a chair that can keep control of the meeting
42. organization in the meeting people turning up at the start and not in drips and drabs, which makes the meeting disorganized. having all information available. and having allocated time in their job plan.

43. organised information available, relevant case notes available, consultant treating available to discuss care, IT system working effectively, room available if meeting longer than anticipated, communication
44. Organisation, Technology in good working order. Communication.
45. organisation, preparation, cooperation, planning
46. Organisation of the agenda, notes, room and any reps booked. Notification asap to the GP's so they have adequate time to arrange to attend. Good communication between the consultants and the co-ordinator. Working as a team.
47. number of cases is more greatly determined by the complexities of the cancer site, for example Breast can get through 60 patients in the time it takes Head & Neck to discuss 10.
48. Notes available, results available and as many members attending to discuss the various issues for each patient. Patients for the meeting to be sent to the MDT Co-ordinator promptly to allow time for notes etc. to be found and input done.
49. not having too many cases to discuss (otherwise meeting becomes sloppy), having all core members attend, having all correct information to hand, having food!
50. More than 45 cases because we tele-link with another hospital. Ensuring that all investigation results and casenotes are available for the meeting as well as prompt attendance. Good and efficient presentation skills of doctors. Efficient equipment.
51. Meticulous preparation, Effective chairperson
52. members work as a team with good communication to all parties involved
53. Members arriving on time and having prepared the relevant information for discussion and all members having a good working relationship and a brief Knowledge of each others duties.
54. Meeting starting on time, particular if there are many patients. Sticking to the agenda and knowing the patient you are to present. Focus on the patient. Focus on the patient.
55. me!
56. mdt lead, co-ordinator having everything ready, notes, slides ect, all drs arrive at correct time
57. MDT chair moves discussion on and keeps things moving. V/C System is running efficiently. Relevant documentation available. Clear instructions to MDT Coordinator following each patient discussion.
58. Making sure it starts on time
59. Making sure everyone arrives on time and the equipment is working. All relevant information is available.
60. Making sure all diagnostic information required is available in advance. A strong chair to make sure each case gets an adequate amount of time and a clear decision is reached. Doctors reviewing cases in advance to ensure they are ready to present the patient information at the meeting.
61. Leadership during the meeting.
62. Knowledge of patients by presenting Consultants - effective technology to display radiology - results of investigations available
63. KNOWLEDGE OF PATIENTS ALL RESULTS AT HAND TIME MANAGEMENT
64. knowledge of patient, correct running order with everything to hand
65. Information on each patient being readily available. Strong chairperson to lead meeting.
66. If majority of diagnostic tests have been completed before hand, tumour markers are back, around 20 cases are discussed in a 1 hour period. This on average gives enough time to each patient to be fully discussed. MDT chair and MDT co-ordinator work closely together to manage the timing of the meeting and the information presented to the meeting as a group.
67. if everyone participates. If the lead clearly states the outcome at the end of each case..this doesnt happen in mine that often
68. If everyone arrives on time
69. Having the requested information in place for the MDT. Good organisation before, during and after the meeting. Good communication. A strong leader.

70. Having an Agenda and someone chairing it
71. having all the required information at hand and all relevant people attend
72. Having all the relevant information available along with all the relevant people Not having too many on the list
73. Having all the information need, ie histology, radiology, notes, all core members
74. Having all patient's records ready for discussion Ensuring all relevant paperwork is prepared in advance of the meeting Working technology! Having a chair person is a good idea
75. Having all information available and the right people
76. Having a sane amount of patients to discuss - too many and members tend to start arguing about who is more appropriate. radiologist can become, understandably, fatigued after 2.5 hours of looking at images. Good equipment. Good training on video conference equipment. Tea/Coffee to keep awake!
77. Having a chair that ensures the pts are discussed, decisions made and that the meeting does not revert to other discussion.
78. Good time management, listening to other team members, ensuring all info present at start of meeting
79. Good team work and relevant information
80. Good structure and following a pre determined Agenda in order
81. Good preparation from the MDT Co-ordinator by ensuring we have a paper record sheet so the consultant can document on paper and this can then be filed in the patients notes for use in clinic. Also live typing at the MDTM by the Co-ordinator so we have a clear plan documented on the database. PAC's worklist prepared prior to meetings to radiology can access films there and then on the database and a note of when each patient is coming back to clinic so the consultant knows when to expect the patient.
82. GOOD PREPERATION BEFORE AND DURING THE MDT MEETING.
83. Good preparation, good leadership, attendance of all members required to make the management decisions.
84. Good preparation, communications, team work. Reliable technology. Room availability.
85. GOOD PREPARATION
86. Good organisation. Clear discussion of patient.
87. good organisation, relevant information and communication.
88. Good organisation and well represented
89. Good organisation and preparation by all members attending the meeting. Equipment which works.
90. good organisation
91. good organisation
92. Good list planning, only discussing relevant patients, members arriving on time so that meeting starts on time. Breach dates clear
93. Good leadership/chairperson. Good time-management. Focus. Commitment. Good team relationships. Respect.
94. Good leadership, good communication and good organisation, having all required information to hand.
95. Good leadership from the chair. Good relationship between the chair and the MDT Co-ordinator.
96. Good database to produce documents with results already entered and CWT breach dates noticable for planning of treatment
97. Good communications across the whole MDT team
98. Good communication between the MDT co-ordinator and core members.
99. Good communication between all members.
100. good communication and team work, preparation of patient data before the mdt
101. Good communication and relationships between members
102. Good communication
103. Good Communication, with clear outcomes given.
104. Good co-ordination between the team. Ensuring all relevant documentation is available to discuss each patient. Fully operational video conferencing equipment.

- A good/firm Chair person.
105. Good co-ordination and communication skills.
  106. Good clinical judgement. Co-operation from team who relate well to each other. Each and every core member being totally committed.
  107. Good chair, organisation. Good MDT co-ordinator
  108. Good chair, notes prepared, contribution from all core members
  109. Good Chair plus attendance by all team members when possible. Recording of MDT discussion and decisions
  110. Good attendance Enough time to discuss each patient fully Fast and efficient follow up after the MDT e.g. booking investigations/appointments/surgery. Close working between clinical nurse specialists and MDT coordinator and clinical teams.
  111. Good and complete preparation prior to the meeting. Good communication between the team, and a good chairperson during the meeting.
  112. Good chairmanship, effective equipment, good organisation
  113. Full preparation and organisation. Ensure all necessary information is available for the meeting, notes, mammograms, pathology reports and other results.
  114. Full attendance Available and working equipment
  115. FULL ATTENDANCE
  116. Firstly making sure the MDT meeting starts on time.
  117. Excellent communication
  118. Everyone is there on time, knows their stuff, and speaks clearly. Relevant materials and results are to hand.
  119. everyone getting to meeting on time.
  120. everybody arriving on time, radiology and pathology available, properly working technology, everything at hand that the core members need
  121. Ensuring everyone is present and give appropriate information on patients.
  122. efficient preparation full team compliment interchange of ideas
  123. Efficient co-ordination by the whole team.
  124. Effective working and contril by the MDT lead and it's core members
  125. Effective leadership to push meeting forward. Communication of all the members.
  126. Effective data presentation and coordination among the MDT members
  127. Effective Chairmanship, ensuring brief discussion takes place and is adequately summarised in a timely manner; Ensuring that all required discussion material is available and has been reviewed by the relevant specialist
  128. effective chairing, relevant documentation and attendance
  129. Discussion of the correct patients in the correct order - i.e. new presentations, then further staging, then post chemo review, then late additions and then the post resection. If more than 25 patients going forward meeting would need to be extended from 1.5 hours to 2 hours to ensure that patients are given appropriate consideration.
  130. Direct discussions regarding patients care.
  131. Core members being present and discussing cases within a maximal time of 5 minutes per patient or less.
  132. Core members being on time. All the relevant information to be discussed being available at the MDT. An MDT member taking the lead.
  133. Core member attendance. All notes, scans and pathology available. Equipment in good working order.
  134. Consultants getting on with the next patient instead of talking amongst themselves
  135. concise history of pt being completed on proforma, concise feedback of histology and radiology results. only 1 person talking at a time. ensure that discussions are completed and everyone knows the outcome before moving on to next patient.
  136. COMPUTER ETC SYSTEMS WORKING. ALL INFORMATION NEEDED BEING AVAILABLE.
  137. Communication. Accuracy and availability of information & results. Good attendance from core members.
  138. Communication, information, preparation, attendance
  139. communication, hard working, planning and management.

140. communication, good preparation, respect within the team
141. communication and attendance from all core members.
142. Communication and adhering to cut off points
143. communication
144. commitment and team 'buy in'. Clear definition of roles and responsibilities. strong chair and good working relationships. Agreed deadline for inclusion of cases and agreement for urgent cases and process to add to list (retrospective discussion in some cases)
145. Co-ordination, timeliness, respect for others views and a good Chair to keep things moving
146. Co-operation from all core members etc
147. co-operation between all members
148. clear presentation
149. clear decisive outcomes for each case
150. Chaired efficiently//discussion re each patient with clear treatment plan decisions and recording data realtime//IT equipment working efficiently//mobile phones switched off!
151. Cases should be reviewed and discussed without running off at tangents - e.g. far too often when a patient is suitable for a trial a discussion ensues about what the trial is about. The radiologist and pathologist should have reviewed the scans and path in sufficient detail to be able to answer any clinical questions.
152. Case study preparation, good attendance and excellent facilities including viewing equipment for diagnostics
153. Attendance of all core members, all of the information available for all patients, the equipment needed is available.
154. attendance, punctuality, all info being present for the meeting
155. As said previously attendance by core members and all data and histology and pathology available for review
156. appropriate levels of preparation, diagnostics available, leadership, robust comms systems, attendance, video connectivity, structured outcomes eg what is going to happen, where, by whom and when
157. all the relevant people should be at the meeting each week and turn up on time.
158. All reports being available, the MDT coordinator been given all information on time, no add ons being discussed at the meeting with no paper work. And generally all professions working together and with the MDT coordinator.
159. All information is available ie X-rays, path results and patient medical notes. Also the attendance of Consultants, Radiologists and pathologist at every meeting
160. All information is available for discussion of each case so that outcomes and decisions can be made at the meeting.
161. All core members to attend and come on time make sure all prep work is done in advance a good mdt co-ordinator team working sticking to discussing the patient
162. all documentation of pts are there, all reports and images are available
163. All core members present
164. All core members in attendance from all departments, all notes for each patient, adequate preparation
165. ALL CONSULTANTS TO ATTEND
166. A strong chair who can control the conversation and keep the discussion to what is needed and little more. An MDT Coordinator who can use the technology available to ensure that it does not get in the way adding time to the discussion rather than reducing it.
167. A reasonable number of patients over a certain time (too long and the team start to become tired and irritable and lacks concentration)
168. A preprepared list of patients to be discussed. A preplanned method of running through the patients on the list, eg. alphabetical Everyone taking their turn to speak and not to speak over someone else All members attend and if not possible to send a representative to speak on their behalf and relay the outcome back Equipment that works A nice cup of tea
169. A good leader and excellent co-ordination and preparation prior to the MDT
170. A good chairperson. Members being attentive and respectful when the patients

- are being discussed and not talking to their neighbour.
171. A good chairperson and good organisation of the meeting
  172. A good chairperson and effective MDT co-ordinator
  173. A good Chairperson An organised Co-ordinator Prompt arrival of all Core members!! Reliable and equipment Well prepared radiologist and pathologists
  174. A good chair person, and availability of information. Equipment in good working order.
  175. A good Chair person and communication amongst the team
  176. a good chair and good equipment!
  177. A friendly & positive interaction between core and extended members, that will facilitate good and useful decision making for each patient discussed.
  178. a clear and concise chairman
  179. 1. Having readily accessible information for each patient on the discussion list, including hospital notes, histology, imaging and appointment schedule. Also, proof of why the patient is being discussed, e.g. email printout to MDT coordinator from requestor. 2. Having efficient working videoconferencing equipment.

## 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?**

73 MDT coordinators responded to this question.

1. with patient and specilaist team
2. With oncology colleagues or with original referring clinician
3. We have always followed the protocol that all patients with recurrence/advanced disease are discussed at MDT prior to any treatment plan been discussed with the patient therefore I am unable to comment
4. very difficult question. If patient don't go to MDT it will be difficult to track these patients on the 31 day pathway.
5. Unsure
6. unsure
7. Through out-patient appointments with their clinicians.
8. They must be discussed at the MDT, unless they need emergency treatment before the next MDT. In effect these are like new cancers, with more co-morbidity. This is the case in Head and Neck at least, other tumour sites may have more straightforward treatment plans where an agreed protocol may be sufficient.
9. They must be discussed at an MDT!!
10. They can be discussed between the Consultants themselves and a decision recorded on a proforma.
11. These patients need to be discussed in the whole pathway setting as each element of the team needs to be aware of the MDT outcome in case that patient presents through A&E or similar while they are on call.
12. These patients are often followed up by the oncology team and treatment has most certainly already commenced, before discussed on MDT
13. There should be protocols set up for these patients and a clear pathway for all clinical teams and patient trackers
14. There must be clinically agreed guidelines if cases are not discussed at MDT.
15. the mdt co-ord and lead should be informed so that patients can be tracked and treatment data can be inputted
16. the information should be faxed thought to mdt- co-ordinators.
17. The clinicians would best answer this question
18. talking between consultants outside the meeting.

19. should be discussed at MDT
20. relevant core /extended members should meet or communicate outside MDT.
21. Question not applicable to myself.
22. Pt seen in clinic with decision made should be presented to the next mdt.
23. protocols should be agreed within the mdt for use when discussion at the meeting is not possible
24. protocols
25. Protocol for decision making
26. Protocol
27. patients with recurrences/advanced disease especially need to come back through the MDT so there treatment can be planned and reported on through the Cancer Waiting times
28. Our patients are discussed at MDT meetings
29. Oncology specific meeting for recurrences/advanced disease.
30. Oncologists will Know their patients by the time they have a recurrence so should not need to discuss these at MDT unless there are other issues affecting Tx
31. Not sure
32. not sure
33. Not qualified to answer - they should just go on an MDT - it is the patient's right
34. not known
35. None the whole team need to be made aware of recurrences
36. None
37. n/a
38. n/a
39. Meetings between oncologists.
40. MDT should always be involved although this amy not always be possible if it is derogatory to patient care.
41. liaison with all relevant health professionals inc scc
42. liaison between the consultant and cns
43. Joint Surgeon/physician and oncology clinics.
44. It needs to be discussed with a number of clinicans. MDT is ideal.
45. information on the pts pathway, or histopath list
46. In house collaboration with key personnel and telephone advice from oncology specialists.
47. If first recurrence and thought to be either unusual or unexpected or earlier than normal should be discussed at MDT. If thought highly likely patient would recur after first treatment when first discussed at MDT a plan for a likely recurrence could have been outlined at the first MDT presentation with a proposed treatment plan should this happen.
48. I think we need to make sure that all patients wether new or recurrence/advanced disease need to be discussed at an MDT. May be if the patients have recurrence or metastaic disease they can be discussed via a supportive care MDT and a GP/Community palliative care team MDT could be set up and these decisions could be sent to the Managing Consultant/CNS/Oncologist so that they know what is going on with the patients
49. I think they should be discussed at the MDT but it's not always in the best interests of the patient to wait for the MDT discussion to have taken place before the oncologist can see them
50. I think they should be discussed at MDT! Occassionally we plan ahead, i.e. say 'if it reoccures we should...' in which case it does not need discussing, but i feel otherwise it should be to ensure the best outcome for the pt.
51. I think that the MDT is the best forum for discussion of these patients - it would be silly to have seperate meetings for essentially the same discussions.
52. I think it is vital all recurrences should come through an MDT
53. I feel all patients should go through MDT especially if they have recirence/progression
54. I don't know

55. I do not feel that this group of patients can be discussed outside the MDT. These patients are by definition more likely to require the expertise of the MDT
56. I am not a clinician so cannot make an informed decision about patient treatment
57. Have a formal protocol and patients must be discussed at MDT if varying from this.
58. Don't know enough about this
59. don't know
60. don't know
61. Don't know as we discuss all recurrences and advanced cancer.
62. Don't know
63. Decisions would be made in clinic or on the ward and the information passed to the MDT coordinator in order that the patients are recorded as having a recurrence and are tracked in the new Cancer Reform guidelines
64. Consultant could discuss outside of MDM with key people if discussion needed.
65. Clinical decision
66. Case discussion with consultant / palliative team
67. As each case is different it would be hard to adopt set procedures.
68. All patients should come through the MDT if they have a recurrence or advanced disease and a representative of that team should present this case if that person is unable to attend or postpone it to the following week before making a final decision to treat unless it is an emergency procedure for an acute onset following complications of recurrence or advanced disease. These such patient will/should come to the MDT at the earliest opportunity to discuss further management.
69. All patients should be discussed at an MDT
70. all our patients are seen at a post MDT clinic where all clinicians are present, so a joint discussion would be held in clinic.
71. all decisions should be documented so it can be followed
72. A joint clinic appointment with Consultant and Oncologist
73. ?Common sense- if patient 'A' relapses and there is only one logical course of onward treatment then perhaps MDT review is a nonsense, however, if there are several options available (as there nearly always are) then it should be standard practice to discuss at the MDT

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

112 MDT coordinators responded to this question.

1. Where treatment plans cross organisational boundaries there is no evidence by audit that recommendations are acted on
2. When patient is assessed they are found not to be suitable for the proposed treatment.
3. When coming to the staging laparoscopy there is another complication or difficulty which may result in a change of treatment plan or the need for further consideration.
4. unavailable clinic/treatment slots because of consultants cancelling clinics or because the clinics are so overbooked
5. The patient's choice
6. sometimes MDT decisions are made before the consultant has assessed for fitness of the treatment. This is because we are working to such tight deadlines
7. Sometimes clinicians have failed to document accurately the MDT outcome. In cases of MDTs which use paper proformas sometimes the notes are not available in clinic (and therefore the proforma), and the clinician seeing the patient may not realise they have been discussed at MDT and may simply do whatever they feel is appropriate.
8. Self opinionated consultants
9. Rarely happens as far as I can recall. There was a huge debate at the MDT too and clinicians disagreed there too. The more senior member of the MDT had the final say then and the other delivered the treatment.
10. Rare for this to happen
11. pts choice, pts not suitable
12. Pt does not want the treatment/dies.
13. PT CHOICE
14. Poor performance status or patient choice
15. poor communication
16. Patients reviewed in MDT prior to the patient being seen by the clinician in clinic ie circumstances may have changed.
17. Patients reject proposed treatment Patients condition deteriorates and they are no longer fit
18. Patients may refuse treatment or opt for something else if they have been given two choices (ie clinical trial). A patients condition may deteriorate soon after the MDT and require emergency intervention by surgery/other treatment.
19. Patients choice.
20. Patient wishes
21. Patient unfit for treatment or patient choice
22. patient unfit for the treatment on review by the treating doctor
23. patient to ill for procedure or patients choice
24. Patient too fragile to have treatment
25. patient refusing the option
26. Patient refuses treatment, or suddenly changes and the decision is modified accordingly.
27. Patient refuses treatment or Deceased
28. Patient refuses the decision made in the MDT. They may want to seek a second opinion.
29. Patient refusal or patient performance status deteriorates.
30. Patient refusal
31. Patient not being fit for recommended treatment.
32. Patient non compliance or change of mind, or severe deterioration of health
33. Patient might go against decision and refuse treatment
34. Patient may not wish to proceed.

35. Patient health & choice
36. Patient fitness. Funding by PCT.
37. Patient fitness
38. Patient died. Patient performance status changed such that treatment plan not suitable. Patient declined.
39. Patient declining suggested treatment; emergency admission overriding original treatment decision
40. Patient choice. Patient is seen in Surgical/Oncology clinic and due to patients health may need to revise treatment plan.
41. patient choice. deterioration in patient health. Further INX show mets/other tumour
42. Patient choice.
43. Patient choice.
44. Patient choice.
45. Patient choice.
46. Patient choice, condition of patient changes, something was missed from the history of the patient outlined in the meeting.
47. Patient choice or patient not being fit enough for initially proposed treatment
48. patient choice and or suitability to recommendation agreed at mdt
49. Patient choice ..Hormone status
50. Patient choice
51. Patient choice
52. Patient choice
53. Patient choice
54. Patient choice
55. Patient choice
56. Patient choice
57. Patient choice
58. Patient choice
59. Patient choice
60. Patient choice
61. patient choice
62. patient choice
63. patient choice
64. patient choice
65. patient choice
66. Patient's health/choice
67. Patient's declining treatments, DNA's or poor performance status.
68. Patient's decision not to have treatment/choose a different treatment Change in patient's clinical status Not having sufficient patient information at time of MDT and therefore patient may not be fit enough/suitable for certain treatments
69. Patient's choice.
70. Patient's choice can influence/override MDT decisions
71. patient not well enough, too many cases discussed at any one Mdt meeting
72. Once treatment recommendations are made and offered to patients sometimes pt's decline's and pt's then are offered different options
73. None that i can think off
74. No one is sure who should be following up a patient's treatment.
75. no comment
76. n/a
77. Mostly patient choice.
78. Medical occurrence or history that was not previously known when decision taken
79. MDT not being fully appraised at the time of the patient's state of health/ co-morbidities that may prevent the MDT recommendation being carried out
80. Making a decision in the MDT prior to having met the patient.
81. Lack of communication
82. lack of communication

83. Information not available to MDT
84. Individual patient choice or perhaps pt is medically unfit for a certain type of treatment
85. If the incorrect information about the patients history was communicated at the MDT, which changes what treatment they could or could not have.
86. I think I am right in saying that patient fitness is an issue and patients declining treatment
87. Dont know.
88. Dont know
89. Don't know
90. don't know
91. Disease progresion and patient choice.
92. Discussion with patient
93. disagreements/ standoffs
94. Death of a patient.
95. Conditions that are not relevant at the meeting that are met when treatment is undertaken
96. Communication between teams after MDT
97. Co-morbidities of patient, deterioration - patient choice
98. co-mobidities
99. Clinically re-assessed patients - not fit for treatment Patient refusal to treatment
100. Changes in patient health.
101. Change of situation / information not up to date at MDT.
102. Change of circumstances
103. change in patients health
104. change in patient status / patient choice
105. Change in patient circumstances, patient not suitable for surgery, patient declines treatment
106. change in patient's status
107. Change in patient's condition?
108. Change in clinical state
109. Change in circumstances of patients' condition/decision.
110. Capacity
111. capacity
112. Based on our audit results, this usually results in not having enough clinical information available when the patient is discussed at the MDT meeting.

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

112 MDT coordinators responded to this question.

1. with data colection
2. We have a robust system with proformas which the physician seeing the patient ticks if the patient is to be discussed at MDT. For added failsafe measures the secretaries put any new cancers on meeting automatically. MDT Co-ordinator receives copies of malignant histologies which is the 3rd failsafe mechanism
3. We don't have a problem with this. All procedures carried out in clinic are added to a list which is produced once a week prior to the MDT - this is then used as a basis for discussion of patients, cancer and non-cancer
4. We do very well, i.e CNS plays huge part in notifying MDT Co-O of PT to be discussed, also Consultants and rediology highlight Pt to MDT Co-O.
5. We are not aware of the new cancer cases until they reach the hospital/ MDT coordinator.
6. Various methods need to be used, but mainly through cancer tracking.
7. Use of the secretary is the key as they are the ones who type letter/receive

- reports.
8. Use of all available resources and communication to MDT Coordinator
  9. Updated and efficient referring protocols that are adhered to.
  10. training all the Doctors
  11. Tracking all Suspected Cancer patients from date of referral received until the day treated
  12. To ensure that all members have a thorough understanding of the pathway and what it takes to keep it going and in a timely manner.
  13. The tracker usually highlights this information and we pick it up from the pathology report. Unfortunately because of the way in which the MDT is currently managed it is rarely the coordinator who does this due to time limitations which reduces job satisfaction.
  14. The referring doctor needs to ensure that these patients are passed over to MDT as soon as possible. Rather than thinking that somebody else already has.
  15. the doctors should take responsibility for doing that.
  16. Talk to the clinicians!
  17. Systems should be in place to capture and identify all new cancer cases. Liaison with Endoscopy, Radiology and Pathology Units
  18. Source of diagnosis should import into relevant MDT
  19. Single Point of Referral, clinician awareness
  20. Robust systems of referral, via GPs and a working relationship between the CNS and co-ordinator means that all patients can be referred to the MDT efficiently.
  21. Referral from radiology, pathology and endoscopy when new cancer diagnoses are made would ensure all patients are discussed at the relevant MDT.
  22. Raising profile of MDT.
  23. PPC's/MDT Coordinator's provide a link between diagnostic clinical teams and MDT and can assist in this area.
  24. policies and protocols in place through the co-ordinators role to ensure this is achieved
  25. More data staff
  26. MDT pro formas should be done as soon as new patient is processed
  27. MDT Coordinator needs to track referrals from point of entry
  28. MDT coordinator checking all discussed via database collection
  29. Maverick clinicians who find MDTs unnecessary should be pulled into question about their decisions and be requested to present their patients case at the MDT as a learning process for others - and hopefully themselves!
  30. Making all tests available so results can be checked.
  31. Make sure that after rapid access clinics all diagnostic tests are faxed over
  32. Make sure teams know how to contact MDT co-ordinator
  33. Local protocols which ensure 'tagging' possible or confirmed cancers for referral to the MDT
  34. Just to remind the doctors that patients who are diagnosed with cancer must be referred to the MDT coordinator for inclusion on the next meeting
  35. Inter-trust referrals being completed and passing through MDT team. MDT liaising with Secretaries to 'catch' all new referrals
  36. Inform all Clinicians of protocol surrounding MDTs
  37. Improve resources/training
  38. If all team members do their bit by ensuring new patients get on to the appropriate list for discussion, regardless of whether this means duplication in names Histopathology & radiology should also be encouraged to generate names for discussion as these are the patients most at risk of missed off The data co-ordinator should also put names forward for discussion
  39. Hopefully by a Fast Track system and good communication.
  40. HISTOLOGY AND RADIOLOGY DEPTS SHOULD INFORM MDT COORDINATOR OF ALL SUSPECTED CASES OF NEW OR RECURRING OF CANCERS
  41. Highlighting access of MDT to ALL hospital staff ie: non tumour group professionals - ward staff, A&E, out patients, radiology, pathology. Should all be

- able to highlight pts to MDT although some should be reviewed by tumour group member first.
42. Have an effective Cancer information team
  43. Have a standard pro forma which can be electronically accessed within the Trust
  44. Have a central point where all cancer cases are referred within your organisation as well as on to relevant tumour site
  45. have a better training for doctors to ref to mdt and not waste money on things like onoalert
  46. Good working team,Histology,CNS,Consultant in put and GP input.
  47. Good team work & communication between the team particularly between the Co-ordinator and the CNS
  48. good links between secretaries/nurses and coordinators
  49. Good internal systems for referring patients to MDM co-ordinator
  50. Good cummunication between clinicians and MDT coordinator
  51. Good communication between data collection officers and MDT coordinators on diagnosed cancers
  52. good communication between Coordinator and the clinical teams
  53. for the mdt co-ordinator to have a pivotal role within the team who is 'on the ground'
  54. extra training and more staff in histology and imaging to highlight any cases coming via these areas
  55. Every member of the MDT needs to contribute
  56. Ensuring that clinicians refer all new cases to the MDT
  57. Ensure the histology is received by the MDT co-ordinator who can then put the patient on the next meeting.
  58. Ensure all specialities know the rules. Co-operation between MDT and diagnostics, CNSs and med secs
  59. Ensure all clinical staff are advised of referral processes/ best practice when starting their rotation
  60. enable tracker to refer
  61. Effective patient tracking by MDT Co-ordinator/Tracker, ability to add patients withoout consent of clinician.
  62. Education of ward/accident and emergency staff
  63. Educating all members to understand that all new cancers need to be communicated to MDT coordinator
  64. educate consultants to put the patients names forward to be discussed
  65. direct emails from pathology and radiology results to the MDT co-ordinator
  66. Develop a formal procedure for referring patients for MDT discussion that is common across all MDTs in a hospital.
  67. database fast track system and via histology
  68. Data capture is sole person
  69. copies of all relevant pathology reports are sent to mdt coordinators
  70. continued effective working between CNS and MDT co-ordinator. Good liason with radiology/pathology/oncology
  71. Consultant inform the MDT
  72. Compiling a database specifically for this purpose.
  73. Communication from clinic via cancer nurse specialists and clinicians
  74. Communication between all members of the Colorectal Teams eg House Officers, SHO's
  75. communication
  76. communication
  77. Close co-operation between MDT Co-ordinator & Consultants & Cancer services
  78. Clinicians/other MDT members must inform the MDT Coordinator
  79. Clinicians need to inform MDT Coordinators of any suspected cancers. GP's to make furhter use of suspected cancer referrals. Histology/Radiology to notify MDT Coordinators of any cancer reports.
  80. by tracking the 2ww referrals dilligently so none are missed.

81. By submitting an EPR request form after surgery or during an outpatient appointment
82. By randomly checking a newly diagnosed patient
83. By proforma
84. By placing protocols & procedures in place to ensure referral including the training of relevant staff
85. By patient pathway tracking by MDT Co-ordinator and also communication by team members to the MDT Co-ordinator
86. By making the MDT a useful place to bring patients for all clinicians.
87. By making the co ordinators aware with communication when possible
88. By making sure that junior doctors are aware of the MDT process and the cancer waiting times.
89. by making all core members and their secretaries aware of this, having copies of referrals from GP's, pathology reports and xray reports
90. By liaising with the clinicians
91. By letting people know how to refer to an MDT and easier access to doing this.
92. By implementing standard practices and pathways
93. By good communication within the core members of the MDT.
94. By ensuring that all SHOs and above are aware of the processes to get a patient discussed on MDT, to instigate the consultant to consultant referrals systems and to involve histology and radiology in the referral process.
95. by ensuring all clinicians are following a universal referral system that is stuck to by all
96. By educating the consultants and having a fail safe process in place to ensure it happens
97. by a data team managing new refs
98. Build up the faith in the MDT's of the clinicians. If they don't feel that the MDT can be of help then they will not use the facility.
99. better systems of initial referral/guidelines for consultants
100. Better processes - less paper - streamlining - better systems
101. Better induction for all new staff to make them aware of the importance of MDT's
102. An effective system of ensuring that any pt with a clinically proven or highly suspicious lesion is highlighted by the team on the day of the appointment and as such, the name of the patient given to the MDT Coordinator.
103. All staff working together and sharing patient information with each other
104. All relevant information is communicated to the MDT co-ordinator who will ensure that the patients are discussed at the appropriate stage within their pathway.
105. all our positive biopsies are sent on a computer printout weekly. the only time the patient isn't discussed in our MDT prior to treatment is if they were an emergency
106. All histologies which identify cancer should be sent (we do on a weekly basis) to the cancer co-ordinators for them to sort through themselves.
107. All histologies reported with cancer, the secretary's should inform the MDT Co-Ordinator.
108. All histologies of diagnosed Cancers to be collected daily from the pathology lab by MDT co-ordinators
109. All core members have the responsibility of adding patients to the MDT on the first suspicion of cancer or diagnostic test. Thus ensuring from all angles that patients are not missed in the system or delayed which will help with the management in the longterm.
110. Again good team work, all non MDT members should be advised if a patient has suspected or even confirmed cancer to refer to that specific MDT ASAP. If you have a good team this should already be in place, and monitored you will already know if you have put into place which consultant, Dr's, staff and not referring.
111. access in every dept in all hospitals here and local to the MDT proforma and Coordinator contact details.
112. ?

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

101 MDT coordinators responded to this question.

1. Very carefully
2. unknown
3. This should be recorded in the patient notes as a % but on the MDT outcomes should be recorded as 'so and so' believes this should be done and the rest of the MDT disagree
4. This should be recorded in the clinical notes if the split decision is not resolved by the majority.
5. This should be recorded by the MDT co-ordinator and documented on the outcomes
6. This should be recorded by consultants with options offered pros & cons
7. This should be noted correctly in the patients treatment decision of the database.
8. This has not as yet happened but should this take place, then further outside (other hospital treating for same cancer) should be asked to join the MDT, and the consultants not agreeing should write reason of the disagreement which should be attached to patient record, also the patient should be advised and sound arguments given to the patient for discussion. It may be that the patient makes the decision and requests a further opinion or referral to another NHS cancer unit
9. They should be recorded on the patient proformas.
10. These should be recorded on the patient's MDT paperwork, together with the ultimate decision/treatment
11. These should be recorded on the mdt proforma that is put into patients notes
12. These are usually agreed within the MDT and recorded verbatim
13. there usually are none
14. The majority decision should be recorded
15. The consultant who is in charge of the patient should have the final say. I have never come across a split decision
16. summarised by the MDT coordinator and also stored by them so that they can be referred to for audits etc for improving the system
17. Split decisions should always be recorded in the MDT minutes and in the patients notes.
18. Should be recorded separately, made notes of.
19. Should be noted on P/F. Noted on Post outcome list and should be discussed fully at another opportunity to ensure a plan is formatted for future similar patients
20. Should be included on the relevant patient's MDT summary.
21. Send to SMDT
22. Rediscussion at the MDT
23. recorded in patient notes
24. recorded on mdm minutes of meetings
25. Recorded as two options to be discussed with the patient in Clinic - entered into notes via an MDT letter to the GP or referring Clinician.
26. Record all suggested treatment options, ultimately for Consultant to discuss/agree with patient
27. Overall consensus should be used
28. on the proforma and then discussed at the next business meeting/tssg meeting for further review
29. On the patient sheet that is filed in the notes that details all from the meeting
30. On the minutes from the MDT meeting and on the proforma which is added to the patient notes
31. On the minutes
32. On the MDT proforma's and in the case notes.
33. on the MDT Outcome sheet
34. On the individual patients MDT decision record sheet, options can then be

- discussed with the patient
35. On that patients record from the MDT
  36. On proformas??
  37. ON PROFORMA IN NOTES
  38. on proforma
  39. on pro-forma
  40. on ppm
  41. on paper and electronically in the MDT minutes
  42. On outcomes on agenda
  43. on a live system
  44. Noted down exact details i.e. what was discussed & who was involved then forwarded to the relevant management
  45. Not sure if it should. Decision should be recorded of majority.
  46. Not sure
  47. not sure
  48. Not in the treatment plan but recorded in the MDT comments for all to see.
  49. No comment
  50. N/A
  51. n/a
  52. Minuted that there were several possible recommendations for treatment
  53. Minuted in patients case notes & patient choice
  54. lay out the relevent options and state clearly on record - to be discussed with patient and final decision at the discretion of the managing consultant.
  55. Just minuted and decision left to treating consultant
  56. interesting - not sure, as the Lead records his final decision as an outcome. our Lead is quite open-minded and usually states that there are two ways of treating a patient, or that opinion was divided.
  57. in Writing
  58. In the minutes of the meeting
  59. in the minutes of the meeting
  60. In the minutes
  61. In the minutes
  62. In the meeting minutes
  63. In the MDT minutes
  64. in the mdm module via chair person.
  65. In patient outcome/clinic letters to GP
  66. In patient notes,recorded in proforma's
  67. In notes and on MDT minutes
  68. In letters to the GP so they are aware there was not a majority decision. However, it has been my experience that a good discussion will not lead to a split decision, as a consensus is reached between all surgeons and nurses with the help of effective leadership.
  69. If high contention the split should be recorded.
  70. I think it should come down to the Lead Clinician to the final say is there is a different of opinion.
  71. Honestly
  72. have never come across this scenario.
  73. Fairly
  74. everyone who is involved should have the right to go on the database and change the details.
  75. Electronically by the individuals concerned.
  76. documented in notes
  77. Documented in meeting minutes.
  78. Diplomatically
  79. data base, and in pts notes
  80. Clinic letters

81. By recording the argument of each recommendation, mainly the evidence and reason for that opinion. 99% of the time, consultants agree on a treatment course.
82. by both parties recording their opinions in patient notes
83. by a specialist extra meeting with different impartial members
84. BOTH views should be recorded, but state which is the 'overall' (majority) decision, and if possible give the pt both suggestions, but explain to them which is the preferred option and the reasons why, thereby giving the pt the choice.
85. Both views should be recorded with party names and reasoning in the minutes
86. Both should be recorded on the same document/database and this should be stated in the outcomes and distributed to the MDT team.
87. Both options outlined in the discussion part of the MDT proforma.
88. Both decisions recorded and presented to the patient.
89. As they occur- accurate reflections of the nature of decisions are as important as the content
90. As they are said with the persons name against their decision/opinion and the person shown the outcome and agreeing to the recorded information.
91. as all details are electronically recorded at the MDT.
92. as accurately as possible
93. Annotated on current management systems during time of meeting by clinician who should be taking notes and recording.
94. along with everything else on the proforma
95. All treatments discussed should be recorded including split decisions. These should be relayed to the patient for consideration.
96. All treatment options should be recorded, with the rationale for implementing the chosen treatment decision noted.
97. all recommendations should be recorded on the outcome, patient reviewed in clinic for their views and then rediscussed at MDT
98. add to agenda of team meetings
99. Accurately, any treatment decisions should however be finally made between consultant responsible and patient
100. accurately in outcomes
101. ?

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

180 MDT coordinators responded to this question.

1. whoever is in charge of the patients care.
2. Whoever has had informative discussion with the patient ie: The clinician or CNS
3. Whoever has dealt most with patient at a communicative level
4. Whoever has assessed and spoken to the patient.
5. Who ever has seen them in clinic or spoken to them on the phone.
6. Wherever possible the Consultant who has hopefully met the pt.
7. Treating clinician
8. Their key worker and/or BCN
9. their key worker
10. Their Consultant or Keyworker
11. The treating doctor, or a member of their team. As long as the presenter has a reasonable knowledge of the patient.
12. The treating doctor or specialist nurse
13. The treating consultant or CNS
14. The team as a whole, although primarily appropriate consultant/nurse specialist. We are ALL meant to consider the pt when discussing their care.

15. The specialist nurse as they work closely with the patient and the patients family and form a relationship.
16. The specialist nurse
17. The referring consultant
18. The person who knows them best, but not to discuss a patient purely on the basis that they are not known by a team member maybe detrimental to patient care
19. The person who knows the pt and who the pt is under the care of.
20. The person who is treating/caring for the patient. i.e. the Consultant or member of his/her team or the Clinical Nurse Specialist
21. The person who has assessed/examined them in clinic.
22. The person most responsible for their care up to the point they are being discussed. This may be the CNS if on MDT after first appointment or consultant after that point. Depends where the patient is on the pathway
23. The patients consultant
24. The patients clinician
25. The one who knows them best
26. The MDT coordinator
27. The lead consultant and/or specialist nurse for the patient
28. The Key Worker, CNS or Surgeon
29. the GP in an ideal world, or the clinician/AHP that has had the most recent dealings with the patient in relation to the case. Patients should NOT attend MDT meetings.
30. The doctor who saw them last either in the clinic or on the ward.
31. The Doctor who has been seeing the patient.
32. The doctor that has met the patients
33. The doctor or one of his/her team caring for that patient
34. The core member who has been overseeing the patients care either on an outpatient or inpatient basis and has had regular contact with the patient.
35. The consultant/registrar who will have seen the patient in clinic/ward
36. The consultant who is seeing them or there registrars.
37. The consultant who is in charge of the patient
38. The consultant who has met the patient
39. the consultant or nurse specialist
40. The consultant or CNS involved with the patient
41. the consultant in charged
42. the consultant in charge of the patients care - however in reality this is not always possible which is why it is important for meetings to be prepared and there be full patient information at the MDT.
43. The Consultant and/or CNS who has seen/reviewed/assessed/diagnosed/counselled the patient
44. The Consultant
45. the consuktant they are under
46. The CNS/assigned key worker
47. The clinician/CNS involved with the patient.
48. The clinician with the most contact with that patient
49. The clinician who is caring for the patient or CNS
50. The clinician under who's care the patient is as they often build a strong rapore with the patient.
51. The clinician the patient saw or who knows them.
52. The clinician or CNS who has been involved with the patient from the on set of the diagnosis
53. The Clinical Nurse Specialists
54. The clinical nurse specialist would be the best person, however not all patients have been seen by the CNS.
55. The Clinical Nurse Specialist
56. The clinical nurse specialist
57. The Cancer Nurse Specialist

58. The breast care nurses spend the most time with breast patients and understand their views and feelings
59. Specialist nurses
60. specialist nurses
61. Specialist Nurse. BCN
62. specialist nurse who knows the patient better than the consultant
63. specialist nurse or GP
64. Specialist Nurse ?
65. Specialist Nurse
66. Specialist Nurse
67. Specialist Nurse
68. Specialist Nurse
69. Specialist Nurse
70. Specialist Nurse
71. Specialist Nurse
72. Specialist nurse
73. Specialist nurse
74. specialist nurse
75. specialist nurse
76. specialist nurse
77. Someone who is involved with patient's treatment
78. someone who has seen them and is involved in their care
79. someone that has met them and discussed what they want
80. someone clinical who has spoken to the patient
81. Nurse specialist
82. Nurse specialist
83. nurse specialist
84. nurse practitioner or whoever has spoken to patient
85. normally keyworker/CNS
86. lung nurses
87. Key worker/someone who has met the patient
88. Key worker, CNS
89. Key worker and consulting clinician
90. Key Worker
91. Key worker
92. Key worker
93. Key worker
94. key worker
95. It is preferable that the clinician in charge of the patient's care should represent the patient however if the clinician is unable to attend this should not limit the discussion of the patients case
96. It is generally the specialist nurse who has had the most contact with the patient, so could have in depth knowledge of the patient's thoughts and wishes
97. i do think the clinician/Dr who has seen the pt initially in a clinic/ER dept etc would be the best person to represent that pt.
98. Head of consultants
99. Either the consultant who has seen the patient or the CNS
100. Either Macmillan nurse or the clinician who last saw the patient
101. Either a nurse or doctor who has met the patient.
102. Consultant/Specialist nurse care for the patient
103. Consultant.CNS.
104. Consultant, registrar or clinical nurse specialist who has met the patient.
105. consultant, nurse or someone who has seen and knows of the pt
106. Consultant, CNS or one of the AHPs
107. Consultant which has seen and followed the patient through their pathway and

- valued input from Key workers/CNS
108. Consultant under whose care the patient is or a specialist nurse who has assessed the patient before and knows about his/her views and preferences
  109. Consultant or Tenovus/Macmillan nurse
  110. Consultant or SpR who has assessed the patient
  111. consultant or specialist nurse
  112. Consultant or named CNS
  113. Consultant or CNS who has met the patient
  114. Consultant or CNS
  115. Consultant of CNS, someone with knowledge of the patient
  116. Consultant and the CNS.
  117. CONSULTANT AND NURSE WHO PATIENT SEES IN CLINIIC / HOSPITAL
  118. Consultant / CNS
  119. Consultant & clinical nurse specialist or anyone who has met the patient
  120. Consultant
  121. Consultant
  122. Consulatant who is caring for the patient and the CNS.
  123. Colorectal Specialist Nurse
  124. CNS/PAEDIATRIC ONCOLOGY OUTREACH NURSE
  125. cns/consultant
  126. CNS/Clinician.
  127. CNS who has usually spent more time with the patient after consultation
  128. CNS NURSE
  129. CNS Key Worker or Consultant
  130. CNS and consultant that has seen the patient in clinic
  131. CNS
  132. CNS
  133. CNS
  134. CNS
  135. CNS
  136. CNS
  137. CNS
  138. CNS
  139. CNS
  140. CNS
  141. CNS
  142. CNS
  143. CNS
  144. cns
  145. Clinician/CNS who has assessed & seen pt
  146. Clinician who initially saw the patient or Nurse specialist.
  147. Clinician who has spend time with them.
  148. Clinician the patient has been referred to and who is seeing the patient and offering treatment.
  149. clinician or specialist nurse
  150. Clinician
  151. clinician
  152. Clinical Nurse Specialists.
  153. Clinical Nurse Specialists.
  154. clinical nurse specialist.
  155. Clinical nurse specialist or Keyworker
  156. Clinical nurse specialist or consultant
  157. Clinical Nurse specialist in most cases
  158. Clinical nurse specialist and the person who saw them recently.
  159. CLINICAL NURSE SPECIALIST

160. Clinical Nurse Specialist
161. Clinical Nurse Specialist
162. Clinical Nurse Specialist
163. Clinical Nurse Specialist
164. Clinical Nurse Specialist
165. Clinical Nurse specialist
166. Clinical Nurse specialist
167. clinical nurse specialist
168. Cancer nurse specialist or someone else who has discussed the diagnosis with the patient
169. CANCER NURSE SPECIALIST
170. Cancer Nurse Specialist
171. Cancer nurse specialist
172. Cancer nurse specialist
173. Breast care nurse
174. Breast care nurese
175. Any member of the team who has had personal contact with the patient
176. A member of the treating clinical team
177. A Consultant or Cancer Nurse Specialist who has met the patient
178. A combination of their consultant, GP and key worker, possibly even dietician.
179. A CNS
180. a cancer nuse specialist and consultant/dr

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

173 MDT coordinators responded to this question. In addition, 8 MDT coordinators referred to the response they had given to the previous open question (Q32).

1. Whoever next sees the patient next - CNS, Surgeon etc
2. Where Breast is concerned, it would normally be one of the Breast Care Nurse Specialists, although sometimes the pt will come back to clinic and discuss thing with the Consultant.
3. Treating clinician or specialist nurse
4. This would depend on the circumstances.
5. this person
6. their key worker
7. Their consultant
8. the specialist nurse or specialist registra
9. The specialist nurse as they are about to speak on a medical level and answer questions accordingly.
10. the relevant consultant
11. The person or a designated medical member of their team who was involved in presenting their case to the MDT.
12. The patients Consultant
13. The patient's consultant
14. The next doctor to see the patient along with the specialist nurses' help
15. The lead consultant for the patient
16. The Key Worker, CNS or Surgeon
17. The Doctor/team that will be treating the patient.
18. The doctor that has met the patients
19. The doctor or nurse specialist who is involved in their care.

20. The core member who the patient is under the care of at the time of the management decision of the MDT.
21. The consultant, who is able to present the decision as something they consider to be the best option.
22. The consultant with a CNS if possible
23. The consultant who is in charge of the patient
24. The consultant who has already met the patient, or the CNS
25. The Consultant which has seen and followed the patient through their pathway.
26. The consultant under whom they currently are.
27. The Consultant responsible for their care
28. The consultant responsible for care
29. The Consultant or Keyworker
30. The consultant involved in their care
31. The consultant and the KW
32. THE CONSULTANT
33. The Consultant
34. The Consultant
35. The Consultant responsible for the patient or the keyworker.
36. The clinician/CNS involved with the patient, whoever will see them next
37. The clinician who the patient saw (ideally in clinic, or by phone if it is something that will not unduly concern the patient)
38. The clinician who has presented the case on behalf of the patient and who knows the patient
39. The clinician
40. The clinician
41. The Clinician
42. The Clinical Nurse Specialists
43. The clinical nurse specialist or the patients' doctor
44. The Cancer Nurse Specialist
45. Surgeon's.
46. Specialist Nurse / Key worker
47. Specialist Nurse
48. specialist nurse
49. specialist nurse
50. specialist nurse
51. Physician initially seeing patient
52. personally, I feel for pre-cancers, the co-ordinator could do this, therefore giving the doctors (who are paid more!) more time for seeing other pt's. For more serious cases - i.e. non-curative/malignant melanoma's etc, the consultant with the SCN present for emotional support and I always make sure the pt's GP is aware if this is going to happen.
53. Patients clinician or CNS
54. Nurses or Consultants
55. nurse specialist
56. Named consultant or nurse - whoever has spoken most to patient and developed rapport
57. mdt co-ordinator or secretary
58. Managing consultant or their key worker, depending on the recommendation
59. Keyworker ie Specialist Nurse
60. key worker, consultant
61. Key Worker
62. Key worker
63. Key worker
64. Key worker
65. it should be done in an outpatient setting, or if, the patient is from another hospital, by the local hospital in an outpatient setting. unless the mdt is happy that it could

- be done over the phone.
66. In Dermatology we have 2 meetings one for pathology review and one which the patient attends is assessed and treatment options are discussed and agreed with the patient.
  67. Ideally the Clinician looking after an individual patient but sometimes this could be the Clinical Nurse Specialist
  68. Either the Clinician or CNS
  69. Either clinician or CNS
  70. doctors
  71. Doctor or Key Worker
  72. Doctor
  73. depending - clinician
  74. consultant or clinical nurse spec
  75. consulting clinician where treatment is radical
  76. consultants and support of specialist nurse
  77. Consultants
  78. Consultants
  79. Consultant/Specialist nurse caring for the patient
  80. Consultant/Oncologist.
  81. Consultant/CNS
  82. Consultant/CNS
  83. Consultant.
  84. Consultant, SpR or CNS
  85. Consultant, registrar or clinical nurse specialist
  86. consultant, nurse or someone who has seen and knows of the pt
  87. consultant with oncology nurse
  88. CONSULTANT WHO SAW PATIENT
  89. Consultant who is directly responsible for the patient's care.
  90. Consultant team/nurse specialist.
  91. Consultant or SpR
  92. consultant or specialist nurse
  93. Consultant or specialist nurse
  94. Consultant or specialist nurse
  95. Consultant or representative
  96. Consultant or registrar.
  97. Consultant or Nurse specialist
  98. Consultant or named CNS
  99. consultant or known specialist nurse
  100. Consultant or CNS
  101. Consultant or CNS
  102. consultant or CNS
  103. Consultant or Cancer nurse specialist
  104. Consultant or by the CNS
  105. Consultant or Breast Care Nurse
  106. Consultant or BCN
  107. Consultant in charge of care
  108. Consultant and CNS together at a clinic appointment.
  109. Consultant and the Nurse specialist.
  110. Consultant and the CNS.
  111. Consultant and Cancer Nurse Specialist
  112. CONSULTANT AND NURSE WHO PATIENT SEES IN CLINIC / HOSPITAL
  113. Consultant / Surgeon / Clinical Nurse Specialist Team looking after patient
  114. Consultant / Specialist Nurse
  115. CONSULTANT / DOCTOR / CNS
  116. Consultant & Specialist Nurse together

117. CONSULTANT
118. CONSULTANT
119. Consultant
120. Consultant
121. Consultant
122. Consultant
123. Consultant
124. Consultant
125. Consultant
126. Consultant
127. Consultant
128. Consultant
129. consultant
130. consultant
131. consultant
132. consultant
133. Consultant's
134. consultant and spec nurse
135. Consulatnt/key worker
136. Colorectal Specialist Nurse
137. cns/consultant
138. CNS/Clinician.
139. CNS or the clinician involved with the patient
140. CNS or consultant
141. CNS or consultant
142. CNS or consultant
143. CNS
144. CNS
145. CNS
146. CNS
147. cns
148. Clinicians
149. Clinician with care of that patient.
150. clinician or specialist nurse
151. clinician or clinical nurse specialist
152. Clinician in charge of the patients care.
153. Clinician as above or Cancer Nurse Specialist.
154. Clinician and CNS
155. Clinician and breast care nurse
156. CLINICIAN
157. Clinician
158. Clinician
159. clinician
160. Clinical Nurse Specialists
161. clinical nurse specialist, however consultant if inpatient
162. Clinical Nurse Specialist or Consultant
163. Clinical Nurse Specialist or Consultant
164. Clinical nurse specialist and the person who saw them recently.
165. Clinical Nurse Specialist
166. Clinical nurse specialist
167. cancer nurse specilist, consultant Dr
168. Cancer nurse specialist / other designated clinician
169. Cancer nurse specialist
170. Any clinician.

171. a member of the treating team or CNS
172. a core MDT member
173. A clinician/AHP who has been in contact with the patient prior to the news breaking point.

## Measuring MDT effectiveness/performance

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

32 MDT coordinators responded to this question.

1. Unsure
2. Turnover of staff/ attendance of key individuals/ services
3. The number of attendees to each MDT. Whether students attend. How diverse the team is.
4. Standardised protocols for all MDT's nationally so that responsibilities are the same throughout
5. Regular business meetings to ensure that everyone is happy with the treatment of cancer patients.
6. Questionnaires to core members. Personal evaluations about how the meeting is conducted. Feedback at the end of the meeting, co-ordinators/navigators to write up
7. questionnaires to all core members and the patients
8. Number of difficult cases discussed and treated. Accessibility of other specialists when necessary.
9. Not sure.
10. Not sure
11. Not sure
12. Not sure
13. No comment
14. n/a
15. n/a
16. it is very important that MDT's remain flexible and are not bogged down with too much performance ratings that people are deterred from using them or tied down in audits etc
17. Individual and speciality attendance levels. Audit treatment recommendations against actual treatment given.
18. how often the meetings are fully attended and if any are ever cancelled
19. How effective they are for tracking patient pathways
20. Have meetings with core members.
21. Do not know.
22. Difficult to measure how effective an MDT is, I think the best way to see how good or bad an MDT is to watch one. Quantitative measures may not reflect the effectiveness of an MDT. Having said that I put survival rates as the best indicator.
23. Dedication, taking pride in a job well done.
24. Comparison with like for like centres in other parts of the UK
25. Auditing MDT outcomes (which has already been completed by my team)
26. Audit of how many times in one month the same patient is discussed at MDT to avoid repetition and make best use of the time available
27. Attendance
28. Attendance
29. Are all patients discussed and at what stages are they discussed - e.g. are they discussed before treatment and after every treatment type. Attendance of MDT members.
30. AGM for general discussion

31. A general survey of all members of an MDT
32. %age of patients discussed at MDT Meeting.

## Supporting MDTs to work effectively

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

109 MDT coordinators responded to this question.

1. we needed a new location for the past 5 years but have just gone into a dedicated MDT room that has great equipment
2. Videoconferencing for all members to be able to be present.
3. To make sure it starts on time.
4. To make sure it starts on time
5. To be given more information prior to the meeting and for professionals to contact me with referrals or emails regarding the MDT as being the MDT coordinator just now I feel that I am missed out a lot of the time.
6. Timeplanning
7. Time of the meeting
8. The time Consultants are rushing to get off and start clinics.
9. The team dynamics
10. The seating arrangement should be changed to around a table.
11. The room that we currently use.
12. The referring consultant does not always sent all the required information such as profromas, scans, reports etc therefore the coordinator has to chase the information up and this can be time consuming.
13. the number of patients that is discussed.
14. The meeting currently takes place in the late afternoon - it would benefit from dedicated session time
15. THE IT WHICH NEVER WORKS PROPERLY!!!! And sometimes the Oncologist is not available and patients are put off for another week. Other than that it runs quite smoothly.
16. The attitude of consultants who won't accept the advise of other medical professionals, will not present full cases as they know the details themselves and do not believe they should have to pass o the care of their patients to more experienced and qualified clinicians.
17. That all decisions made are documented clearly and appointments are made straight away to highlight and problems
18. Support for core team members to attend or their cover
19. Summarise outcomes to predetermined format and content
20. Sufficient time to meticulously review all prior to meeting.
21. Standard information regarding the patient to ensure that I get out the right slides and reports for the meeting. eg Operation date/OPA
22. reduce lateral discussions
23. Projecting name on to separate screen of patient to ensure everyone is talking about same person. Laptop accessibility
24. Possibly have the histology's back earlier so that there aren't as many rollovers
25. people to speak clearly and not mumble
26. People being able to put aside personal and clinical differences to consider the patient
27. People arriving on time
28. Outcome of MDT documented clearly. Equipment & room always functioning correctly, notes availability and filled correctly.
29. Nothing.. I work with an excellent team of professionals, whose main objective is patient care of the highest calibre.
30. Nothing, both my MDTs are run very effectively

31. Nothing
32. nothing
33. not sure
34. none
35. no more case notes as in house data system holds all informationn.
36. No change required
37. My MDT's run perfectly
38. More training for the MDT co-ordinator (me)
39. More timely discussion, members have a tendency to get side-tracked.
40. More time/resources
41. More time to discuss patients
42. more time to discuss all patients fairly. sometimes get rushed at the end because of pressure to get to clinic
43. More time in meetings
44. More time for the meeting
45. more time for core members to review present cases in their job plan
46. More respect for non-clinicians.
47. More regular attendance
48. Meetings between consultants, MDT coordinator and CNS on a regular basis
49. making sure that equipment is regularly updated and checked
50. Make sure that everyone arrives on time and concentrate on what is being discussed without being distracted by bleeps and other doctor's wishing to talk to Consultants.
51. make sure all consultants attended
52. Make it shorter, have smaller mini meetings if and where possible
53. live outcomes
54. limit the number of cases discussed
55. Limit patient numbers in order to prevent clinicians becoming bored
56. LESS ARGUING/BICKERING!
57. length of the agenda!
58. Insisting that all preparation has been carried out & is available before discussing a patient.
59. Increased participation of all attendees
60. Increase the time allocated for the MDT
61. Improvement of IT equipment including software/data collection to avoid repetition of information between different systems
62. Improved communication with MDT coordinator prior to MDT meeting. MDT Training.
63. i wuold ensure that all forms are available and ready for completion off the back of the meeting to move the patient forward on their pathway as swiftly as is possible.
64. I would incresae the amount of time allocated for the meeting
65. I feel that our MDT is extremely effective. Although ocassionally time is limited.
66. How all the information is presented to the team via the agenda etc
67. Histology reports authorised and typed and imported into database for meeting.
68. Having more time to discuss the patients, or less patients to discuss, but that is not going to happen.
69. Having a chair person to be in charge of everything - someone with knowledge and experience of chairing difficult meetings
70. For the MDT chair to value the MDT Coordinator!
71. Everyone talking at once
72. equipment, summarisation
73. Equipment
74. Ensure that all members of the team can attend
75. Encourage core members to be up to date on the progress of their patients through the system rather than relying entirely on the MDT Coordinator
76. electronic pro-forma

77. effective technology that always worked to assist the discussion eg displaying the relevant scans and histopathology to confirm diagnosis leading to accurate decisions made for the patients care pathway.
78. Dont know enough.
79. Digitalise path slide images
80. Dedicated, uninterrupted time.
81. correct information given to MDT co-ordinators by the team before moving on to the next patient
82. compulsory team building exercises..paintballing..a social event every three months
83. Communication to be improved.
84. Communication involving ALL members of team regarding a patient's journey
85. communication before and after MDT's
86. clear speaking
87. change some of the personalities
88. Breast MDT: nothing. Gynae MDT: nothing.
89. Better time keeping
90. better technology
91. Better leadership/chairperson.
92. better IT equipment....and a less stressful clinician.
93. Better input from clinicians as to why they want a particular case added to the MDT list - sometimes all I get is a name and a hospital number.
94. Being more selective regarding the patients listed, many patients turn out to be benign
95. Being able to use a laptop to type outcomes during meeting so that it can be viewed at the end of the meeting to the team.
96. Be able to use the database within the MDT.
97. Attendance of experienced surgeon/physician
98. Attendance of all core members
99. attendance
100. Ask each member to stay for the duration of meeting instead of staying for just their patients
101. Allow preparation radiologist and pathologist enough time to prepare for the meeting in their job plans.
102. All using the same software.
103. all core members to be able to attend the meeting from the beginning
104. Access to PACS!!!
105. access to computer system to record data
106. Acceptance by everyone, no matter how important they think they are, that it is important they attend in person or provide cover if they are unable and never, ever, do not appear without advising the MDT co-ordinator that they are not attending.
107. A radiologist who is willing to commit to a decision.
108. A bigger, better room - currently trying to sort!
109. a better venue with better equipment!

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

81 MDT coordinators responded to this question.

1. Upgraded IT equipment & software for preparation and recording of data
2. unsure
3. understanding of medical conditions, terms etc
4. understandin terminology , site specific training , radiology training , path training
5. Training. A better understanding of my pathway - more clinical understanding of

- the pathway and more time
6. Training and getting the consultants on board to use SCR
  7. To gain more understanding of clinical procedures
  8. To develop more skills and knowledge with medical terminology.
  9. To be more assertive with regards adherence to SOP. Technical training with softwares
  10. To be allowed to speak! As a non-clinical member of the team i get little opportunity to discuss the problems with the pathway and it would help if this opportunity was given.
  11. The ability to type up the patient proformas as we go along (hopefully we will start this in the near future now I have a laptop).
  12. That names are given earlier in the referral process
  13. Terminology training in different types of cancer and treatment types
  14. support from the team
  15. space allocated for accurate data collection
  16. Some further clinical training in my tumour field.
  17. Skills training, ie. more up to date knowledge of tumour site(s), more medical knowledge (more than basic).
  18. Recognition from management as MDT co-ordinator. CPD work.
  19. Recognition
  20. projection equipment for proformas
  21. Performing MDT duties in the department applicable to the MDT that I cover to ensure knowledge of a patients pathway from start to finish.
  22. PACS
  23. Nothing
  24. Nothing - excellent relationship with team.
  25. Not sure, as I am not just MDT coordinator I also data capture, audit, track, cover for other MDT, and so much more
  26. Not having to check and set up equipment for most meetings as other people move things about when they use the room.
  27. n/a
  28. More understanding of the MDT Coordinator role
  29. More training, especially basic clinical training
  30. More time/resources
  31. More time to do the job - I have to meet the increasing demands of the post in 30 hours a week and work unpaid overtime to maintain my standards.
  32. More time for preparation
  33. more support from peers, especially line managers who don't seem to have a basic understanding of the demands of the role. Also adequate cover of the MDT co-ordinator role during times of absence as this is severely lacking!
  34. More support from Cancer Services for cover for annual leave/illness. Currently if I am not there there is no adequate cover
  35. more resources
  36. More notice of patients for discussion (one hour before the meeting is not acceptable) and it should be understood that although patients can be added late not all the documentation may be available. Clearly state why the cases are for discussion and if any recent tests have been done, particularly if these have been done outside the Trust.
  37. Inputting data during the meeting straight into our database
  38. If other external trusts/ hospitals sent over the correct information.
  39. I learnt alot from the TME training done by the Pelican centre. I'm sure alot of the Consultants didn't need this training, but as a co-ordinator it was very useful especially seeing a live operation. I went straight into co-ordinating without any knowledge of what an MDT was, I didn't have any knowledge of the tumours or treatment. This learning has been ongoing for 5 years but I think a basic overall knowledge is now essential.
  40. i feel i have gained enough as i have been given lots of opportunity to do training, such as customer care skills

41. I feel happy with my contribution at MDT and feel that I am valued at the meeting
42. I am quite happy with my personal contribution to the MDT.
43. I am new in my post so I am still learning, but I think non medical staff would benefit from medical terminology and tests/imaging knowledge relating to the department to which they work
44. I am hoping to go on the medical terminology course and watch some of the con's in theatre -this way I can have a better understanding of the procedures they do. I have found my clinical degree, and previous work as a HCA invaluable. I think having a specialist area helps, My skin, specialist skin and breast all link together (members of the teams cross over, similar pathways, similar types of treatment etc) and so work well, but I also do leukemia - which is completely different and not an area I am experienced in, which is why I wish to take the medical terminology course, but managers never seem to keen to support us in courses - last year I asked if I could do a team leadership course, but was told we didn't really have time to let me go on it. I disagree with this and think managers should encourage further learning.
45. I am happy with my level of contribution. The meetings run well, and I think all of the members are taught effective teamworking skills in other areas which means MDT meetings are just another way for them to practice their teamworking skills.
46. Having the appropriate information available prior to the meeting. Being accepted as a valid and valued member of the team. Having the clinical teams accept that part of the role of the MDT is related to waiting times tracking as well as best patient care.
47. Having basic clinical training i.e. watching staging investigations being performed & spending some time with each core-member.
48. Having a one to one with the leads every so often
49. further clinical training to admin personnel
50. Full and proper training - I had approx 3 hours and then had to learn on the job. The team are highly critical and do not work well together anyway which is not a good environment for a new starter
51. For all members to respect co-ordinators and see them as important members of the team
52. Ensuring appropriate infrastructure in place to support (I am not clinical)
53. Due to only recently starting, more knowledge of the breast cancer, i.e. research
54. dont know
55. Develop skills, learn more about medical terminology
56. Data collection in a more organised and timely manner
57. Confidence to actually contribute in the meeting
58. communication skills
59. Clinical members of the team understanding the role of the MDT Co-ordinator.
60. clinical knowledge of some aspects of cancer
61. Clearer understanding of medical terminology
62. Better understanding of treatments and pathways.
63. Better medical understanding, such as a basic course.
64. Better medical knowledge
65. Better Management Support
66. better equipment
67. Better cover for annual leave etc
68. Being more supported as i have to do everything.MDT's,tracking data collection and also holiday cover for myself and other MDT co-ordinators.
69. BEING MORE ASSERTIVE
70. Basic training in anatomy and treatment regimes. It's a case of "pick it up as you go along" at present.
71. Basic cancer training and experience.
72. As MDT coordinator, some input into the actual disease and treatment would be helpful.
73. An explanation of what was going to happen and an understanding of new MDT co-ordinators needing additional help

74. An assistant to help with finding patient notes and filing of MDT proformas. This would give me more time to prepare the MDT and communicate with referring hospitals/GPs/patients.
75. already very active in discussions where appropriate.
76. All latest mdt information,training day's
77. admin support and help
78. Additional medical terminology training/courses.
79. Acknowledge by the consultants of how important my role is
80. A wider knowledge of the different illness's and help to understand them which will come in time. Sometimes explaining things in laymans from helps.
81. A better medical understanding of anatomy

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

38 MDT coordinators responded to this question

1. Working along side another MDT.
2. unknown
3. twinning with another organisation
4. Training the team as a whole. There is training available for individuals/specialities but it would be very useful to have training as a team.
5. Training for core members to share/understand importance of data collection/cancer waiting times
6. To visit another Trust's MDT
7. Team building
8. team building
9. Shadowing other MDT Co-ordinators would be a useful learning tool
10. Shadowing another MDT's equivilant MDT member. Being present in the meetings before you start in post, to gain a understanding of the meeting without the presure of having to participate.
11. Review by another successful team to point out any possible areas for improvement
12. Regular MDT Coordinator support/training/ meetings within networks and nationally
13. Raise profile of MDT's to engage clinicians more to accept the MDT as an important and necessary part of the patients treatment.
14. Opportunities to discuss and compare the running of the MDT with other colleagues in other areas of the country.
15. Not Sure
16. Not sure
17. Not sure
18. None.
19. non clinical staff to have appropriate terminology training/knowledge
20. No others
21. Networking with similiar teams in other hospitals, learning how they run their meetings
22. National Tools for tracking patients pathways and recording outcomes.
23. n/a
24. More understanding at my level re: staging, treatments (chemo, Radiotherapy, trials etc)
25. monthly evaluation of MDT's involving all core members, constantly thinking of ways to improve that have to be formerly recorded and assessed
26. Meeting between coordinators from different hospitals
27. medical terminology course, shadowing days I have had have been great as you understand other's roles and input better and increases the closeness of working and appreciation for each other. I have shadowed the SCN, physio's, dieticians,

nurses, and have been offered a 1/2 day with a consultant.

28. Medical terminology
29. MDT specific course
30. In the role of MDT Coordinator - medical terminology training with an oncology bias would be useful//
31. I don't feel i now need training but general knowledge of tumour sites, cancer in general, cancer pathways ,how the technical equipment works would have been really useful when I started
32. Dont know
33. Awareness of Cancer waiting times Familiarity with the MDT meeting databases
34. Any training whatsoever would be good.
35. An MDT Bible - saying what tracking the co-ordinator is responsible for. Video Equipment training and manuals. perhaps team-working to build trust.
36. An effective induction and list of local people to contact in case of problems. I think team training and away days woould merely waste valuable time on things which are learned in situ anyway.
37. All the tools in the world don't help if there is existing friction between the core team members and their secretarial support staff. It is a difficult situation.
38. A specific course for MDT Co-ordinators

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

50 MDT coordinators responded to this question.

1. YCN MDT Co-ordinators meetings.
2. Working a few days in the clinic info dept. and an away day for the new national cancer times other things have to just been picked up.
3. West Midlands Cancer Intell.Unit
4. we have an away day booked in March - I am struggling to wait that long to be able to discuss MDT's with the whole team - there should already be many systems in place but unfortunately they aren't.
5. We had MDT coordinator induction and bi-annual forums for MDT coordinators as well as attended workshops for tumour site specific training usually for national cancer databases
6. unknown
7. The MDT Co-ordinator forum is good for new MDT co-ordinators but there is nothing for established co-ordinators who have progressed through the initial set up, having been doing the job for some years and are ready to move on to next stage.
8. Teams Talking Trials
9. Some annual MDT meetings.
10. oncology course, video links, team meetings
11. oncology course, mdt time training
12. Oncology awareness workshops
13. Oncology Awareness Workshop.
14. Not sure
15. Not sure
16. Not aware of any.
17. not aware of any.
18. Not aware of any
19. Not aware of any
20. Not aware of any
21. None.
22. None.
23. none.
24. None that i am aware
25. none known
26. NONE
27. None
28. None
29. None
30. None
31. None
32. None
33. none
34. none
35. Network Workshops. Cancer and Anatomy study days for non clinicians
36. Network MDT Forums - once a year.
37. n/a
38. Medical Terminology
39. MDT co-ordinators conference.
40. MDT Co-ordinator workshop
41. MDT Co-ordinator Conferences. Communication skills workshop.
42. manual of cancer services IOG

43. I shadowed the previous MDT coordinator for 4 weeks, and was able to pick up the processes from her. There was also a hospital specific instruction file which allowed me to find out processes when I was not sure.
44. I previously mentioned, the medical terminology course, but I believe all the modules in the cancer care BSc (hons) degree run by the hospital benefit all cancer team members. I would very much like to do the modules on palliative care, chemotherapy and RT. I believe the more you understand everything the more you can be involved, help and write better notes.
45. From MDT Co-ordinator point of view am not aware of any training courses.
46. don't know of any
47. don't know of any
48. Don't know of any
49. cannot think of any.
50. cancer intelligence unit malignancy training days, in house pathology training

## Final comments

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

19 MDT coordinators responded to this question

1. there should be a cancer tracker and mdt co-ordinator as two separate roles.
2. The training and backup we receive is non-existent. If you are lucky enough to work with a forward thinking consultant then the job can be satisfying - if not it's a slog!
3. The centralized Head and Neck MDT at the XX [hospital] was excellent. Not just because I did a good job, but I felt that everyone wanted to make it work and provided support and information to have full discussions. The joint clinic straight after the MDT allows MDT members to discuss plans with patients and their carers. It also allows surgeons and oncologists to see patients together. So patients can hear from a surgeon what the surgical option is and from the oncologist about chemotherapy and/or RT.
4. Some MDTs run smoother than others, due to the hard work and dedication on the part of the MDT coordinator.
5. Some MDT's work together as a team much better than others.
6. proper session time should be given to mdt not just lunch time or first thing in morning before clinic etc
7. Not aware of other MDTs
8. n/a
9. It would be beneficial if doctors were not booked to do other things that would encroach on their arrival at an MDT on time ie, theatre list, clinics, on call. Also as an MDT co-ordinator you sometimes feel under a lot of pressure and undervalued as you seem to be the hub of making sure things happen but do not always get appreciated. The general attitude is the co-ordinators can do that. As we are only Grade 4 at XX [hospital] but we have a lot of responsibility with targets day to day running of MDT's, waiting lists and investigations. Audits and data collection. I don't know about other trusts but at XX [hospital] we have to do everything. I am not sure if this is the appropriate forum for this but to me it adds up to Job Satisfaction and appreciation for hard work and making sure the trust does not incur breaches on targets.
10. it has taken 5 years but I now have a great MDT lead, dedicated room and fully functioning equipment (and I don't have to find xrays anymore!)
11. I think there should be an agreed induction, training process for all MDT co-ordinators. I was expected to take on board the role, fully within 3 weeks of

being employed and it is not enough time. There should be guidelines for each pathway on treatments, pathways etc as these should not differ from trust to trust.

12. I think MDT coordinators work extremely hard to ensure the smooth and effective running of decision making along the patient pathway. I feel they are unappreciated and thought of as one of the less valued members of a team. I think more emphasis needs to be put into how important MDT's are and joint decision making is a proved method of effective patient centred care.
13. I strongly recommend more secretarial input as they are pivot to the patient pathway.
14. I do not attend MDTs but do prepare the information required by the consultants in Histopathology
15. High performing MDTs are to a great extent a function of the inter-personal relationships of the members, a measure which is difficult to quantify. The work of a good MDT with dedicated members can be and increasingly is negated by the wider framework it works in; eg by staff shortages and low morale across the Trust as seen by the implementation of the recent Agenda for Change.
16. high performing MDT's have good communication both inside and outside of the meeting. and established proforma's readily available to all to view outcomes of the meetings.
17. Bringing the patient early to the MDT. Ensuring that protocols are in place to arrange further investigations.
18. As a new Cancer Patient pathway Co-ordinator, in a large hospital on a large cancer site I am finding it difficult to breach the barriers between clinical and non-clinical staff. For me to manage my role effectively I need to be heard and understood in relation to cancer targets and the changes to the dataset and WTAs. Our role needs to be clarified to clinicians and how important it is that they support us.
19. All MDT will run smoothly as long as the people use the resources available to them, but when teams do not work together no MDT will function effectively.