

Multidisciplinary team members views about MDT working:

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

**Open question responses:
‘Other’ team members
(admin/clerical and managerial)**

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Introduction

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

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

Open questions

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

1. Domains that are important for effective MDT working

What do you think constitutes an effective MDT?

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

- Who should be responsible for communicating the treatment recommendations to the patient?
- 2. Measuring MDT effectiveness/performance**
- What other measures could be used to evaluate MDT performance?
- 3. Supporting MDTs to work effectively**
- What one thing would you change to make your MDT more effective?
 - What would help you to improve your personal contribution to the MDT?
 - What other types of training or tools would you find useful as an individual or team to support effective MDT working?
 - Please provide details of training courses or tools you are aware of that support MDT development.
- 4. Final comments**
- Please insert any final comments or observations on the characteristics or indicators of high-performing MDTs and appropriate measures of performance.

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

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

Method

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

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

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

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

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Domains that are important for effective MDT functioning

What do you think constitutes an effective MDT?

34 'other' team members responded to this question.

1. Where cases are discussed in a logical, thorough manner and the decision of the MDT is clearly pronounced
2. When all the relevant information can be reviewed and discussed in a timely manner
3. Timely decision making regarding the treatment of cancer patients with contributions from the appropriate personnel
4. Staff from pathology, radiology, surgery, oncology, specialists nurses, advanced practitioners in speciality, MDT & data collector involved at meeting. Also important Medical PA's to type outcomes during meeting for patients individual hospital notes. Manager of service to ensure patients kept within pathways, all investigations are actioned, discuss op / treatment dates and provide back up for MDT staff. Junior doctors should attend for experience, radiographers and research nurses to discuss appropriate trials patients can be entered into. Patients notes should always be available for MDT meetings, PACS imaging and for breast analogue projection available on full screen for all members to view. Projection of pathology slides onto screen, so a microscope is important within the MDT for breast and skin. Also the patients personal datasheet needs to be projected onto a screen so that all staff present can see the relevant information and management agreed and make comments during the meeting. A really effective MDT would have session time allocated say 1400-1600hrs or whatever is most convenient for the core members of staff, instead of having to be held during lunchtimes and over running causing afternoon clinics to run late.
5. Right people, right information, at the right time with swift, accurate communication within the MDT and to referrers and ensuring that decisions made are acted upon.
6. Patients are discussed , ongoing problems, treatment and management. If there is deviation form protocol, palliative , care social problems. Service development
7. One where clear treatment plans are decided and relevant data is easily collected
8. One where answers to data questions are given in a constructive manner - from a purely selfish point of view as the data collector!
9. One that has formal processes in place. Values and respects individual's opinion.
10. objectives of the MDt clearly defined. Attendance from all parties Time Keeping
11. Multidisciplinary team, preparation, data collection, follow up actions
12. Membership and attendance by all professions who have relationship with patient. Preferably at least half of the MDT should have actually met the patient
13. Input from all relevant clinicians to make the best joint clinical decisions for the patient
14. Having a forum whereby everybody's views and opinions are valued and respected. Having the opportunity to learn from other mdt members Having all necessary information to hand.
15. Good team working and effective communication
16. Good organisational skills commitment of clinicians
17. good leadership good radiology support good time keeping interactive
18. Good communication, MDT well prepared will all relevant info available. Members arrive on time
19. Good communication and respect between colleagues
20. Excellent clinical leadership, engagement and commitment to the MDT.Lead clinician role key to effectiveness of service provision. Good managerial and clinical relationships with pt focus/input on service provision via MDT

21. Effective team working relationships, ability for all mdt core members to attend, organised and knowledgeable MDt co-ordinator. Having designated MDT co-ordinators for each speciality
22. Effective pre-meeting planning. Strong clinical leadership during MDT to keep meeting 'on-track'. Adequate IM&T systems to ensure MDT runs effectively and is productive (e.g. Video Conferencing, live data collection etc.)
23. data preparation prior to MDT with all disciplines involved in decision making process to optimise individual patient care
24. Comprehensive membership and teamwork
25. Communication, humility, patience and a good pair of ears.
26. Commitment and attendance by all members and good communication
27. Clinical 'buy in'; administration and clinical prep prior to meeting; 'real time' data entry; validation of data by MDT members at MDT meeting;
28. Clear structure and defines responsibilities of each member of the MDT. Working across several networks this is really important.
29. Clear plans for patients to be discussed and well documented evidence of discussions that took place.
30. Agreement of management of the patients treatment. Consistent data collection on MDT and good communication between core members
31. A small group of knowledgeable individuals
32. A meeting where all clinicians can input their knowledge to discussion of a patient pathway. The discussion should take place with all data present from different recording systems ie Radiology, pathology, oncology. The meeting will need administrative support.
33. A good sensible team of clinicians, radiologists and pathologists with the appropriate IT and infrastructural support.
34. A forum in which all participants are given the opportunity to share their knowledge of the patients and therefore contribute to the development of their care.

The team

What qualities make a good MDT chair/leader?

16 'other' team members responded to this question.

1. someone with good communication skills, well organised, able to allow everyone to contribute in a timely manner.
2. Someone who will ensure all views are considered
3. Someone who respects and has the respect of their colleagues, clinical and non-clinical
4. Precise; easy going; inclusive; good communicator; makes non clinical staff feel at ease and valued
5. Personable manner who ensures the list is discussed logically and in a timely fashion. Prevents agenda being taken off track. Encourages advice from members of the team.
6. One who is able to direct and lead. Remain impartial. Promote good communication between members and encourage multi-disciplinary discussion and decision making.
7. Listening, discussion, being open minded, keeping the MDT under control to allow good interaction between members
8. Knowledge and experience.
9. They must be concise, clear and highly motivated.
10. Decisive words and actions to keep the meeting focussed and moving. Knowledge of that Cancer site!
11. Consistent; respected; attendance

12. Clear objectives for the meeting Good communication and involvement of all members of the team
13. Being prepared, objective, patient
14. being concise in summary and keeping to the point in discussions
15. ability to keep consultants to time to move process forward
16. ability to hear every view but keep focus and to time

What types of training do MDT leaders require?

15 'other' team members responded to this question.

1. Team leadership skills; shadowing to understand others' roles
2. none
3. managing meetings
4. Leadership skill and organisational skills
5. Knowing how to effectively chair meetings, including how to summarize.
6. Interpersonal skills training.
7. how to move people off of contentious issues
8. How to identify and promote good patient centred and evidence-based management decision that all members have contributed towards
9. How to handle professional people with integrity and diplomacy
10. Facilitation skills; they also need to be empowered by organisation
11. Communication, awareness of national cancer requirements - cancer waiting times, IOGs etc
12. Communication skills.
13. Communication skills are required so this could be a possible area for training and also cross organisation working is required so understanding of external pressures on other Trust, Social Care Departments etc.
14. Communication and leadership.
15. advanced communication skills

What makes an MDT work well together?

18 'other' team members responded to this question.

1. team work and effective communication
2. structure, coordination, consideration, having a question that needs answering
3. shared goal
4. respecting each others opinions
5. Respect for the reason MDT are in place;
6. Respect for others' views and roles
7. Patience and respect. The ability to listen to one another and take time to consider the professional opinion of another. An ability to keep ones own prejudices out of the decision making process.
8. Mutual respect, good communication, everyone works as hard as the next person
9. Mutual respect of individuals. Well organised processes. Good communication between members.
10. mutual respect for members
11. Mutual professional respect between members and the willingness for team participation.
12. humour
13. Having the same objectives

14. good leadership and valuing all points of view
15. Formal approach to meeting
16. Everyone has a contribution to the meeting
17. Ensuring that the focus for the collective group is the patient.
18. All members know that they will have their turn to discuss the treatments offered and any suggestions will be decided upon there merits

Infrastructure for meetings

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

22 'other' team members responded to this question.

1. Video Conferencing facility
2. The lack of resources to provide electronic mdt facility because of ICT issues!!
3. technology breaking (v. rare)
4. Room not big enough to accommodate all participants comfortably.
5. Rom availability- only 1 room with vital equipment available
6. Participants squeezed into an unsuitable room
7. Participants not able to be heard or not seated so they can see the imaging etc
8. Not respecting other people input and opinions
9. Not being able to review all results simultaneously, not being able to fit the MDT in the MDM room
10. Not being able to hear people speaking
11. Not being able to hear conversations well
12. Lack of systems so that radiology /systems cannot be viewed
13. Inadequate space (within meeting room) + lack of appropriate IM&T resource.
14. Inaccessibility to visual and audio presentations
15. I would class technology as an issue, if this does not work well, it can hinder an MDTs ability to work well.
16. Having the passwords to access I.T. of other hospitals to check for results of tests done elsewhere
17. Equipment failure.
18. Electronic equipment failure
19. Cramped MDT room
20. Chairperson not speaking clearly or listening to other members with their point of view on treatments/patient care. Staff turning up late or leaving early making it difficult to discuss patients cases in full.
21. Attencance; late starting; lact of real time data entry. Info not being available electronically
22. A room where the partcpants can't see each other face to face.

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

19 'other' team members responded to this question.

1. When it works it is great but often there are technical clitches., the video conferencing equipment does not work and no one at the meeting knows how to sort it out.
2. We video link to some of our referrers to present specific cases, this aids discussion of complex cases and ensures full histories but always results in the meeting taking longer

3. we do not use telecoferencing as we area POSCU and rarely have to review images , histopathology on screen
4. This has never been used for the breast specialty and would hold no benefit for the MDT
5. Significant reduction in travel therefore has improved MDT attendance
6. Proposals are in place to obtain real-time recording and viewing
7. negative impact when the equipment doesn't work reliably
8. n/a
9. lose 1-1; only see couple of people; distracts from patient focus
10. It tends to focus the meeting more effectively; can lead to some members not being involved when another Trust's patients are being discussed
11. I think it enables the inclusion of Clinicians that would otherwise not be able to, due to distance/time. This is a great patient benefit. I think more resource and more importantly a structured support for the equipment, in times of breakdown/repair needs to be looked at - possibly universally procured across networks that would benefit financially.
12. I don't know. I have no experience of this.
13. I don't know, other tumour sites have tele/video-con. within the trust and it is used.I don't think we need it for colorectal
14. Ensures regular attendance of clinicians who are not on-site at time of MDT. A more multi-disciplinary discussion/decision making process.
15. Ensures pts receive most appropriate treatment
16. encourages people to attend in MDT, but make work in opposite way eg. make people lazy
17. enables off site colleagues to discuss their cases but often means only certain cases are discussed with them and they are not involved in the rest of the meeting
18. Difficult to arrange suitable timing of cross-centre MDTs. Too much going on off camera or private conversations
19. Communication is more stilted however if this is the only way to enable all members to participate it is preferable to no attendance at all

What additional technology do you think could enhance MDT effectiveness?

15 'other' team members responded to this question.

1. We are lucky to have a database with live MDM outcome recording that our referrers can access across both networks. This significantly enhances MDT working.
2. Technology to plug in individuals off site without access to VC facilities via laptop and webcam. Wireless technology to improve real time data entry; Histology via digital to improve access at MDT and prior to meeting pre
3. Not sure - however there should be some form of collective purchasing so systems can talk to each other and the optimum performance is achieved from the technology.
4. Microphone and better links with PACS/breast imaging to ensure quality of projected films.
5. It is not technology that enhances effectiveness but how it is used and implemented
6. It is essential that all trusts use the same technology for compatibility and to keep costs low (expensive bridging technology are required otherwise). N3 should be the accepted communication media.
7. Improved equipment. Trust equipment outdated.
8. I would think that access to imaging results and pathology samples would be an advantage
9. I dont agree with real time recording unless it is agreed because most weeks we will all correct a small mistake in the minutes be it consultant name etc. I think reading minutes would stop if they were agreed at the meeting so losing a sieve for problems
10. I can't say. I think our MDT rooms are very well equipped.
11. Good IT Support across sites - sometimes very difficult with PFI - IT.
12. Ensuring that other non cancer departments do not have access to the cancer MDT room ie doubling up as the emergency preparedness room
13. central computerised patient notes
14. Access to RIS/PACS and breast screening and pathology computer system would be beneficial.
15. A complete record system that allowed display and collection of data from all radiologyand supporting systems

Meeting organisation and logistics

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

26 'other' team members responded to this question. 1 'other' team member referred to the previous multiple choice question (Q13) stating 'as above'.

1. The presenting surgeon should have a patient overview ready - unless they intimately know the case history of the relevant patient. The radiologists and pathologists should have their data and technology loaded and ready. The MDT coordinator should have the dates and appointments of each patient to hand.
2. The name and a brief case history of the patient.
3. Summary of patient clinical history, creation of discussion lists, obtaining notes, histo reports, pacs, ensuring members will be in attendance
4. Short review of pathway and likely treatment options for clinicians, preparation of notes etc by admin staff
5. Review of Case Histories so that all the facts are immediately available. Filling up the MDT form
6. Notes collection, agendas, room preparation and recording of information
7. MDM lists - circulated 24 hrs in advance, ensure relevant histology & imaging is available for meeting, if not chase that up. Full history & referral details e.g. full previous chemotherapy history, not just 'has had chemo'. Review of all imaging to be discussed by radiologist, review of all histology to be discussed by histopathologist. Presenting clinician to have reviewed most recent results including bloods etc prior to meeting.
8. List of patients Patient notes Proforma preparation Room preparation Attendance list
9. Identification of relevant patients + ensuring all relevant imaging/histopath is available. Clinical trial screening based on pre-MDT patient list.
10. Having all patient information available including scan results, x rays histopathology reports etc.
11. From a Manager's position, I go through the MDT with the coordinator, check results and histologies, make notes about the pathways and possible transferring patients to other hospitals for treatment so that everything is ready for the meeting.
12. Ensuring that patients that are listed for the MDT have had the required investigation/Histology and that the report is available.
13. Ensure that minutes are read through before minutes and actions are done and feedback during meeting. AOB may be added as well which may involve other important issues affecting the group
14. Currently the MDT coordinators spend a vast amount of time locating scans, images, Histo reports and directly liaison with outside Trusts - without this knowledge and data collection the MDTs would not run effectively.
15. Complete lists, investigations and results available
16. Collation of results for presentation
17. Collation of documentation. Publication of agenda with sufficient time to prepare as required.
18. Checking patient eligibility for trials
19. Case selection for meeting, Histology and cytology slides need reviewed prior to meeting. Patients screening history obtained Documentation of slide reviews
20. Case notes requested; results available; summary of history; list of pts to be discussed
21. Availability of all required scans, path results, etc. Data on all pts to be discussed to be circulated to all members.
22. Appropriate planning to include all patients that need to be discussed all specialities assess their part of patient care. Coord obtain notes/paper results and printed agenda

24. All participants need to make themselves aware of which patients to be discussed and any points they wish to raise at the meeting. If they have specific requests then they need to ensure they have the necessary evidence/information to back up their request. My own role is as an observer to ensure that the meeting achieves its objectives and to oversee clinical governance so I do not need preparation time as such.
25. All appropriate imaging to be loaded to PACS for viewing at the meeting; histology results to be available; patient casenotes or summary to be available; accurate patient discussion list to be distributed several days before meeting
26. Agreement re patients for discussion (e.g. correct point in pathway); agenda, notes, tests, proforma's; histology & radiology reviewed, reported & added to cancer data base by appropriate clinician.

What makes an MDT meeting run effectively?

27 'other' team members responded to this question.

1. Time management organisation and preparation
2. The list of patients is followed through in a logical manner and not adhoc. The discussion is formal and each member of the team has an opportunity to contribute if required.
3. The Chair is key and should be a clinician. They need to be concise clear and able to move discussions forward to facilitate sound clinical decisions.
4. That the clinician informs the MDT Coordinator very clearly, and in time the details needed at the meeting eg, what should be discussed, any history. Provide clear patient management plans. Room should be ready and equipment problem free and any conference secure and connections fast and images clear. Clinicians to realise that cooperation with the MDT coordinators is absolutely essential. eg not to break the deadline wherever possible. Clinicians to record outcomes live on database. Clinicians to sign attendance without being asked.
5. short clear summary of patients pathway and clinical details.clear decisions approved by the chair
6. Preparation prior to the meeting and making sure all results are available, equipment is working, room ready and if during a lunch time that lunch is provided.
7. Preparation as above
8. planning, good admin, objectives
9. Organisation of the process. Commitment of members. Mutual respect.
10. Necessary documentation prepared, all investigations carried out and to hand and good communication between the clinicians at the meeting
11. Meeting time length is required. This will differ from one MDT to another due to volume. If in staff job plans it is more likely to improve attendance therefore improved clinical outcomes for all patient cases
12. Keep focussed and don't get side-tracked
13. It should, in the main, keep to the agenda with good timekeeping and momentum maintained by the Chair.
14. Having a chairperson who leads the discussion and keeps it on track; having respect for others' views and roles; having list of patients to discuss and having no last minute additions
15. good preparation,organisation and leadership
16. Good preparation by clinicians presenting cases. Availability of all notes, etc for review. PACS imaging integral and cover for all core members provided to ensure all disciplines are represented
17. Good organisation and preparation by all core members
18. Good control of time by the Chair and good preparation by the MDT Co-ordinator is essential.
19. Good Chair, knowledge of the patient, all relevant information available, all relevant members in attendance

20. Each person being quiet whilst another specialist is talking.
21. During the meeting, effective chairing so cases are discussed thoroughly and efficiently to ensure all get time/ energy required
22. concentration, enough time per patient, the right people present to discuss options, not linking outside!
23. Being time aware, prioritising patients and identifying questions in advance. Having a chair of the meeting. Scans being pre-loaded on systems to speed up viewing process.
24. Avoidance of irrelevant discussion
25. All notes and results being available and a chairperson to ensure agenda is kept to.
26. All core members at meeting All information available for meeting. Electronic communications/links working Radiology (electronic) available Microscope linked to screen MDT coordinator available to record minutes
27. Adequate pre-meeting planning + strong leadership during meeting

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?

12 'other' team members responded to this question.

1. usually done at PTC
2. Unable to answer ?.
3. Something pre-decided by the MDT team.
4. Oncologists, radiologists, pathologists and surgeons should discuss recurrence/advanced disease to agree treatment options if not performed at MDT
5. Not applicable
6. n/a
7. inter consultant refferal
8. I don't know. As the clinical audit facilitator I collect the data for all the colorectal treatment and outcomes, without recording patient details who have recurrence or progressive disease at the MDT I wouldn't be able to monitor them
9. Following a protocol agreed with local specialist team for such cases
10. don't know enough to make an informed comment
11. discussion with individual consultant but not recommended
12. All decision making should be protocol driven. If such protocols don't exist they need to be developed.

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

17 'other' team members responded to this question.

1. we implement mdt decisions
2. Usually supportive treatments is considerred i.e gabapentine with Vincristine
3. usually detoration in patients condition
4. pt choice
5. Patient preference/choice
6. Patient choice.
7. Patient choice, or progressive disease.
8. Patient choice or unsuitable for medical or personal reasons. On rare occasions treatment has contraindications which would cause problems with interactions of other conditions.
9. Patient choice or the patient's clinical situation makes an ammendment neccessary
10. patient choice I should think
11. not applicable
12. n/a
13. More information becoming available, patients choice.
14. I would think it is because of patient choice or clinicians change of decision after discussing with patient or more indepth examination if patient was not as well known at first MDT discussion. Some discussions of potential Rx take place before the Consultant has even met the patient
15. Funding availability for oncology drugs
16. Clinical assessment - new patients whose cases have been reviewed in MDM prior to their first appt may not be fit/ may be fitter than thought, for treatment. Discussion with patient - despite risks highlighted at MDM, patient asks to proceed with a treatment. Clinician choice - experienced clinician unable to attend MDM, overrules more cautious, junior colleagues and offers treatment, which then returns to MDM for confirmation.
17. ? Patient choice

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

14 'other' team members responded to this question.

1. This has to be led clinically from the initial referrer - Each referrer must take responsibility for starting the pathway and ensuring that their referral is received. It is then the Trust Consultant who then leads the patient forward through to treatment - including MDT discussion.
2. Raise awareness amongst colleagues and referrers of treatment options available to their patients. Educational meetings for CNSs, consultants, GPs.
3. If MDT's move to 'real time' data entry and validation pre or at MDT then data collection and audit fall out of that process
4. I think measures are in place via radiology/histology and clinicians that already achieve this.
5. Good communication form CNS and consultants
6. Ensure appropriate processes and failsafe mechanisms are in place to record such cases.
7. effective process in place involving MDT members ie, pathology, MDT coordinator, clinicians

8. Education of teams to and good team communication
9. Doen to training of medical students and Junior doctors
10. clear pathways
11. by having a robust referral system in situ that everyone is aware of
12. All other members of the hospital are aware that a confirmed or suspected cancer are called into the MDT coordinators.
13. all 2ww letters via MDT coord, and all new admission with ca referred on upgrade form to coord
14. A pathway needs to be established by each specialty so that new cancer cases are identified and information passed onto the MDT coordinator in a timely fashion to enable the cancer wait times to be achieved.

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

16 'other' team members responded to this question.

1. With the names/ initials of those involved recorded in the outcome and an indication of who has final responsibility for the decision and/ or communication to the patient & family
2. usually treament decions made by POC and MDT discusses supportive treatment
3. This is documented and pt asked which treatment they would prefer
4. recorded in outcomes of meetings and inserted into medical notes
5. On the MDT Datasheet by the MDT coordinator.
6. on MDT outcome proforma
7. majority agreed management
8. In the MDT minutes. Overall decision to be recorded also.
9. In minutes and patients notes
10. If an MDT can not agree then it would be appropriate to involve Clinical Directors to work with the Clinicans and find a solution - possibly seeking external support.
11. I think that is out of my remit
12. Don't know
13. Documented at the meeting on a separate patients data sheet and recorded electronically.
14. Both decisions should be recorded and identified as a split decision
15. As a disagreement/split with the process fully recorded including how a final recommendation was reached.
16. alternatives should be recorded in notes

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

21 'other' team members responded to this question.

1. Their key worker, usually the CNS
2. The person who has seen them most - that's usually a mixture of the CNS and the Surgeon.
3. The patient's clinician or the lead cancer nurse.
4. the key worker
5. The consultant in charge of the case, s/he bears responsibility not the committee/MDT. if however individual responsibility is not relevant the bring on more MDT's
6. Specialist nurse
7. Specialist nurse who has ideally met the patient
8. On the whole this is usually the Advanced Nurse Practitioner
9. Nurse specialist
10. Nurse specialist
11. Key Worker (usually CNS) or responsible clinician.
12. Key worker
13. I think patient should be allowed if clinically stable/appropriate to attend - I imagine in most cases this would not happen however there should be choice. In terms of who the best person is ideally it is the patient or their advocate, be it relation, friend, or a health/social worker.
14. Consultant/Nurse or patient themselves
15. CNS
16. clinician/specialist nurse involved with pt - even pt themselves
17. Clinician or nurse involved in their care
18. Clinical Nurse Specialist
19. Clinical Nurse specialist
20. Breast Care Nurse
21. any professional who has met them and is familiar with their case

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

21 'other' team members responded to this question.

1. This should be the lead Consultant.
2. The Surgeon.
3. The responsible consultant plus key worker
4. the consultant with the key worker
5. The clinician who is leading care at that point in the pathway. There are times when it may be more appropriate for this to be the nurse
6. The clinician
7. Surgeon or Oncologist
8. Specialist Nurse / Clinician
9. Specialist nurse
10. Nurse
11. member of team looking after pt
12. Key Worker (usually CNS) or responsible clinician.
13. Either the clinician who is dealing with the patient or the cancer nurse specialist

14. doctor or cns
15. Consulting Clinician. Unless patient has requested information about what was discussed after the MDT. CNS asks Cons permission to feed back and it has been agreed
16. Consultant clinician
17. consultant and/or cns - who ever has agreed with the patient that they will call them
18. Clinician or nurse involved in their care
19. Clinician or Key worker
20. Clinician or Breast Care Nurse
21. Clinical Nurse specialist

Measuring MDT effectiveness/performance

What other measures could be used to evaluate MDT performance?

6 'other' team members responded to this question.

1. Seeing how well each member of the team understood and appreciated the specialities of the other team members.
2. review to check if call confirmed cases have been through MDT
3. n/a
4. MDT Members questionnaire annually. Anonymous comments may raise questions not previously addressed within perfomance meeting
5. Auditing how many cases are discussed at meetings in full against how many are passed over due to time constraints or a member deciding it should not be discussed
6. Audit of recording of outcomes, impact of MDT in terms of changing referral/treatment patterns across a network from the minor - as a result of MDT all referrers send all sequential imaging as a matter of course with their referral letters, to the large - patients with X disease used to be referred straight for palliative oncology, now they are referred for consideration of resection/interventional radiology

Supporting MDTs to work effectively

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

15 'other' team members responded to this question.

1. Time management, ensure better attendance
2. The room layout is totally wrong and it is too distant making it hard work to set up and get ready for the meetings.
3. technology
4. Some MDT's require more effective presentation of cases to prevent meeting taking too long and MDt discussing issues not relevant to MDT
5. more time (on average 16-20 pts in 1 hour)
6. More of them - we run to capacity on most meetings
7. Illustrated decision of the MDT discussion
8. Ensure better criteria for bringing patient to MDT. ie. 1. B.Enema (then discussion patient not known) 2. CT Staging (then discussion) 3. Bopsy(then discussion) 4 treatment plan if not already discussed. I think this extends the patient pathway time not decreases it.
9. Better organisation of the discussion list so all attendees know which patients are to be discussed; fewer patients at each meeting; better recording and dissemination of outcomes
10. better integration of systems giving clinical results
11. Attendance is crucial - so perhaps some form of formal warning or support from Networks/Trusts when this becomes an issue. What are the penalties for non attendance?
12. Attendance and understanding of the importance of the MDT
13. attendance
14. A move away from discussing patients from a solely clinical perspective.
15. A better referral process between MDTs of different Cancer sites.

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

11 'other' team members responded to this question.

1. We need to widen our scope of understanding to realise that the non-clinical aspects of patient care significantly affect the outcome and course of treatment.
2. the MDT is not for training however EBM enables non-core members to understand why we are doing something. MDT training is not useful in improving the MDT structure (1/2 day on pelican course)
3. not applicable
4. n/a
5. more staff to cover the time that the meeeting takes place
6. Increased knowledge of specific conditions
7. I feel that I contribute appropriately (as a non-clinician) at those MDMs I can attend, I only wish I could attend them all, all of the time.
8. I don't contribute to the MDT I take from the meeting to help with my data collection. MDT co-ordinators do not always put the information on at the time and I feel they could do with better clinical training
9. Having enough time to complete all tasks required
10. Dedicated time
11. Better knowledge of what was going on!

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

6 'other' team members responded to this question

1. Training course for MDT coordinators, regular network meetings for them
2. team building sessions
3. none
4. Network wide groups to discuss particular tumour types- (SSG discussion)
5. Maybe 10 minutes quarterly presentations by particular members of the MDT team on what their role is and how they tie into the team.
6. I think peer review will address some weaker areas of MDTs and perhaps an annual meeting of MDT Best Practice could be set up within each SHA or Network.

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

7 'other' team members responded to this question.

1. Training courses have been provided for MDT co-ordinators through cancer networks and cancer registries
2. Pelican- MDT- TME National MST Co-ordinator course
3. on pelican course 1/2 day given up to MDT training and at ACPGBI (sorry didnt find useful at all)
4. None
5. n/a
6. I'm not.
7. Dont know of any.

Final comments

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

6 ‘other’ team members responded to this question

1. This questionnaire is probably more relevant for PTC than POSCUs
2. the number of patients staged where required the number discussed at MDT compared to Known cases
3. The bigger the MDT the more difficult it is to discuss a patient because everyone wants to be saying something.
4. Clinicians to understand, appreciate and communicate effectively with MDT coordinators. MDT must be process led with strong management support and reliable technical systems.
5. Cancer MDT are an expensive resource and require development and refinement to ensure that they max cost against improved patient outcome.
6. A good MDT functions best when it has a team of A&C staff to support it, as well as the MDT Coordinator and Service Manager, otherwise the objectives can become obscure and taking responsibility outside the MDT can get lost because so many core members are involved.