Multidisciplinary team members views about MDT working:

Results from a survey commissioned by the National Cancer Action Team

Open question responses: Surgeons

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

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

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

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

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

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

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

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

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

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

Method

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

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

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

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

Contents

Domains that are important for effective MDT functioning

What do you think constitutes an effective MDT?

232 surgeons responded to this question.

1. Working to agreed guidelines and protocols. Consensus rather than domination/confrontation
2. Will to care for patients among all parties
3. Where is free discussion on the options available, and a reasoned judgement is arrived at - as opposed to the most vociferous member with the strongest views who may also be chairing it, deciding what needs to be done.
4. Where a team decision leads to the best treatment available for that patient. Cohesive Decisive Functional Directional Regular Well lead but with supportive team members reliable MDT coordinator Easy access to MDT for decisions ability to refer on to other MDTs
5. When it is genuinely MD
6. Obviously one that makes good management decisions about patients with cancer, which is the primary purpose of any mdt!
7. Well cooordinated with good interspeciality relations. All appropriately trained.
8. well attended, time for discussion of complex patients, approriate personnel
9. Weekly, so of practical use. All core members or their substitutes present A good organiser & data collector.
10. True multidisciplinary involvement Integral data collection
11. To have all relevant professional groups is the basis, open and frank discussions is important
12. Timely discussion of patients with all core members present; all pathology and radiology available. Adequate time available for discussion. Prompt recording and dissemination of MDT decisions to patients and clinicians. Good video-conferencing etiquette. Effective chairmanship to ensure all of the above are in place.
13. time to discuss. Leadership from senior clinicians
14. This is a 3 site MDT. Video conferencing equipment particularly sound and imaging is poor quality. The sites are competing with each other which impairs effectiveness of MDT
15. They are a waste of time
16. The right people in an unhurried discussion supported by all the relevant clinical radiological and histological data led well in an inclusive team.
17. The core team Coordinator An individual to collect and input dat
18. the appropriate people determined to work together collaboratively
19. teamwork, accountability, good communication & relationships
20. Team working to the benfit of the patient with enough time to discuss all issues
21. Team working Good communication Good leadership
22. team working participation good leadership
23. Team working
24. Team work, education, common goals
25. Team work, confidence in colleagues, adequate resources & time !!
26. Team work with good communication and ease of access
27. Team which works in co ordinated manner with patient management at the heart of the team working. Not just clinical but all aspects of patient care
28. Team of educated motivated clinicians who respect oneanother and are prepared to debate management of patients in light of knowledge of patient and best evidence.
29. Team memebers who make the materials available for discussion, efficient discussion and members who are open to suggestions and who are willing to listen to others.
30. Surgeon, oncologist, radiologist, cns, secretary, pathologist

31. Supportive team environment with strong educational emphasis, full range of relevant professionals attending and comprehensive consultant lead pick up of all cancer cases
32. Support staff for data entry and consultant time for MDT preparation
33. Sufficient members to allow MDT to function when some members are on leave. IT system for presenting & recording data/decisions.
34. structured, decisive, well organised, accountable, systematic
35. Strong lead Active committed core members Adequate time
36. Strong commitment from all members
37. Smooth and efficient coordination of acticities that results in patient centred clinical decision and clearly defined and documented agreed outcome.
38. skilled appropriate people working together
39. several members from each discipline otherwise completely ineffective and cosy chat with friends without the patient being involved
40. reliable attendance by core members to discuss patients pre and post-op in a multidisciplinary milieu
41. Relevant attendees. Succinct organised approach. Complex cases where multidisciplinary involvement is required only to be discussed
42. regular, well organized meetings regular attendance of core individuals documented outcome
43. Regular wide attendance, with people who can speak freely and will not be denigrated for expressing their opinion.
44. Regular well-attended sessions in adequate , protected time with a formal record kept and good documentation. Good managerial support for all this.
45. Regular meetings with good attendance of members.
46. Regular attendance of all relevant disciplines
47. Regular attendance by core team Weekly meeting Open discussion Good imaging & pathology Good recording of outcome of discussion
48. Regular attendance by core members, educational environment, good record keeping, all members up to date with CPD
49. Regular attendance by all core members and accurate record /data collection. Early action following MDT and good communication.
50. Regular atendance of core members. Effective communication between members and adjacent MDTs. Agreed protocols based on evidence. Audit/research to increase the evidence base
51. Reaching quorate of core professionals on a regular basis, logging of data and its dissemination
52. Presence of team members Availability of records Logging od decisions Implementation of decisions followup of decisions
53. preparation. good co-ordinator and lead clinician. enthisastic attendance by core member
54. Preparation of the information needed for the MDt to make the appropriate decicision. I think a Co-ordinator with responsibility for preparing the list for discussion and ensuring repetition is kept to a minimum.
55. preparation
56. Pre- and postop MDT Discussion with all MDT members Presence of research staff
57. plenty of time; committed participants; good admin support
58. People who want to work togeather and see value in this work
59. Participation by ALL treating the tumour type, ie ALL surgeons, radiotherapists, oncologists. Sufficient admin support (hugely lacking in our organisation)
60. Participation and attendendance of all core and extd core members. Participation of Registrars, SHO'S and Nurse Specialists. Availability of all relevant clinical data and hence the need for a good co-ordinator / data organiser.
61. Ownership of and respect between the members with a clear aim of putting the patient (not externally imposed artificial targets) first.
62. organised focussed well run. strong leadership. answer each question clearly and move on
63. Organisation, suitable supporting personnel and a remit to have some choice in

what to dicuss rather than a blanket "all cases"

64. Organisation & co-operation between it's members
65. organisation quality multi-disciplinary team effective information distribution good data capture to facilitate audit correct clinical grouping
66. Open discussion between menbers. Meetings that enable proper discussion of patients and which periodically address larger issues relavent to the provision of services to our patients.
67. Open and frank discussion of optimum clinical management
68. Onr that hits the peer review standards
69. One with regular attendace of core members who are willing to co-operate with each member.
70. One with an effective coordinator and data collector
71. One with a designated and funded MDT co-ordinated and data collector
72. One where all key members are present
73. One that works well
74. One that allows timely decisions on patient management and allows for accurate data collection.
75. Not too many people. Ours is now so big its ridiculous. You only need about half a dozen core members for decision making, and a few of the ancillary members for the clinic. Sadly, interpretation of the guidance is driven by a fear of non-compliance and so everyone attends and the whole thing becomes too cumbersome.
76. need a team approach - need good admin back up
77. Mutual respect between the specialities involved
78. Mutral respect Adequate resourcing (Time Personnel IT Administrative)
79. Multispeciality input, systemic review, teamwork
80. Multidisciplinary, good team working.
81. minimum of 1 each of oncologist, surgeon, radiologist, pathologist
82. Meeting (face to face and via TV connection) on a regular basis - timely organisation and paperwork.
83. MDt co ordinator, surgeons, pathologists, radiologist, oncologist, nurse specialist as the minimum members. There should be a lead clinician who should chair the meeting, designated place with facilities for review of pathology slides, radiology picutures etc
84. Making evidence based consistent decisions that would not otherwise be made by some maverick clinicians - therefore overy impt to audit effectiveness as MDT is VERY costly
85. Leadership of MDT truely multi-disciplinary (large volume MDT's offering ALL modalities of treatment) Audit / review of practice MDT co-ordinator / admin / data collection support
86. Knowledge of the subject, knowledge of the patient, all medical documents, awareness of research trials, good audiovisual links.
87. It varies from cancer to cancer With colorectal cancer it must meet weekly, discuss all the cases, allow decent discussion, be well attended and come up with executive decisions after each discussion. At sign-off it must stipulate the nature of proposed follow-up
88. It must be well organised and have a strong Chair. Video Conferencing allows Units to interact with the Centres without wasting hours in the car. Decisions must be quickly communicated to clinicians & GPs. Effective data collection for audit & research essential
89. involvement of key clinicians, effective coordination & organisation, technical support, adequate funding
90. Intelligent well informed staff with the flexibilty to listen and be open minded
91. Information Co-ordinater Good presentation Presence of core members Thorough discussion Dedicated appointment slots Effective communication
92. Ideally a meeting where all relevant information (imaging, pathology) gather to a high standard is immediately available. Attendance is such that decisions can be executed almost immediately by the teams attending.

93. I am not sure that I understand the word effective in this context. Different groups have different reasons for beleiving in an MDT. The Trust does so because of target acheivement and certification /accreditation. At the other end of the scale, for myself, it is an easy way to review a case and make appropriate referrals. In between, there are all kinds of views with regard to effectiveness. Take your pick.
94. High level communication with clear outcomes identified for each patient.
95. Having the correct members present to make a decision. Having someone who has seen/knows the patient presenting the case. Having all records/images/histopathology available. Having time for meaningful discussion. having a cohesive team that get on where no-one is divisive and everyone pulls together to treat the aptinet as soon as is clinically safe
96. Having a good coordinator and data gatherer
97. Having a dedicated Specialist nurse with administrative backup
98. Having a good MDT co-ordinator with excellent audio-visual aids and links the the hospital PACS and pathology systems on an intranet. It is also essential that core members are present for decision making including a minimum of 2 surgeons
99. Group of knowledgable individuals from different specialities who respect each other and their opinions
100. Good team working to enable consistent decision making based on the available evidence. MDT support - we have no electronic support at present
101. Good team of dedicated staff. Input from all professionals during the meeting (histo, oncol, radiologist, surgeons, pall care, nurses) and good planning
102. Good team members with live access to all the relavent information about a patient and have time and space to discuss all the issues. Good data collection on IT system is essential for audit and research purposes.
103. Good representation from all disciplines, good communication and views of all members respected
104. Good rapport between clinicians (medical and nursing) Good support from pathology and radiology representatives Effective MDT coordinator with adequate time to fully support MDT and prepare all neccessary notes and reports prior to meeting
105. Good Patient Management and recommendations; interchange of ideas and new trials/therapies...i.e.not ticking boxes
106. Good organisation, good effective leadership, opportunities for adequate discussion of cases. Need to keep track od cases and provide feedback/opportunity for re-evaluation. Good and cocsistent participation of all MDT members. Data collection clerk, dedicated MDT co-ordinators are a valuable resource. Funding for such an MDT to function is implicit for its success.
107. good organisation before the meeting and effective data collection. Clear leadership and clinical structure
108. Good leadership, communication
109. Good leadership and a good team spirit
110. good leader, clear processes, everyone encouraged to contribute, feedback
111. good interpersonal relationships, open minded discussions, ability to listen to all memebrs views and taking into account patients' wishes
112. Good data. Clear presentations, robust discussion and evidence based decisions
113. Good coordinator Good chairman
114. Good communication, data collection, well co-ordinated and plenty of time for discussion
115. Good communication within the team, good communication into and from the team, good record keeping including an electronic dtabase
116. good communication with referring personnel, feedback and access to results,good attnedance
117. Good communication and capture of decisions electronically. Population of data base
118. Good communication and an efficient Co-ordinator, as well as good team working and co-operation among core members
119. Good clinicians and supporting staff
120. good chairmanship, clear decisions, accurately recorded

121. good chairing, discussion of patients staging as each test is reported. Good CNS.
122. Good attendance. Good and accurate record of decisions. Fallow up mechnisms to ensure that such decisions are acted upon faithfully and promptly.
123. Good attendance, team-working, prompt responses
124. GOOD ATTENDANCE, CLEAR LEADERSHIP AND DECISONS, COMPLETE LIST, GOOD COMMUNICATION, ACCURATE DATA
125. Good administrative & Statistical support
126. Good admin/data support Appreciation of individual's roles
127. Good properly funded organisation and logistics, time and good relaitionships between colleagues
128. Good Appropriate Members, Good Data
129. Full core membership, all working hard
130. full complement of members no irrelevant chit-chat clear patient details and plan of action for each case effective dispersal of MDT findings to relevant parties
131. Full cohort of disciplines represented Preparation of patient information including case details prior to meeting. Chairman leading the meeting Accutrate minuting Good audit data collection
132. Full attendance, avoiding lunch times.
133. full attendance of all members, good administrative support to have records ready for discussion and to be able to effect appointments etc afterwards
134. Free and frank discussion about patient care in a multi-disciplinary team where the contribution of each member is valued
135. Forum in which experts from each of the specialities involved in the treatment of the condition can openly discuss the diagnosis, it's investigation, surgical and oncological management, follow-up, research and dissemination of information.
136. focused, well chaired, attended by all core members and with extended members whenever possible or required, Screen projected patients' presentation , decision agreed by all or majority and entered in electronic record real time by designated data collector; regular business meetings to reflect, ample time but should not be too long unless there are enough time to break and stretch; Adjuvant online available real time when applicable; good team working relationship, avoid finger pointing or threatening behaviour and should be seen also as educational opportunity for all, regular quarterly audits
137. Focused team work
138. Few enough core members to be effective Enough core members to be effective Adequate number of tumours per year Not too many new tumours per year (optimum 100 - 200) Team members who speak to each other Team members who ALL have a say Admin support - dedicated MDT coordinator Data inputter using specialist association data base (BASO for breast)
139. enough time, good communication, excellent support ffrom radiology and pathology
140. Enough time and expertise to consider all aspects of patient care and weigh up decisions in the best interest of the patient. All members need to respect each others expertise and opinion and the patients best interest given priority
141. enough admin staff to keep data entry going, and an atmosphere of respect and listening to the views of all collegues
142. Engagement from participants. Adequate time - preferably during a working day. Audit resource (we have none). Clerical backup.
143. Efficient good communications and respect for all members contributions
144. efficient administration, consensus discussions
145. Efficient Administration
146. Effective/efficient use of time Is disciplined: needs an effective chair Has a memory - i.e. so the same question does keep on being asked Has a consensus
147. effective outcomes
148. effective organising
149. Effective discussion and decision making about individual case management to an agreed protocol with real time radiology and histopathology review and effective data collection and recording of decision making
150. Effective decision making

151. Effective collection of date and arranging future appointments for patients. Ensuring patients do not breach to cancer pathway
152. Effective clinical discussion which is undertaken in a professional and friendly manner. Trust betwen member essential
153. discussion, active team, time, orgainised
154. designated time. Clerical supoort
155. Defined roles, defined goals (as per NHS IOG) and weekly meetings with discussion of all patients to reach treatment decisions
156. dedicated group involved in one tumour site
157. core clinincians including nurse specialists with radiology and pathology and admin support
158. consensus appraoch to which dtat to collect and how to dissmeniate MDT outcomes. management guidelines help. open atmosphere with confidence to question decisions/ask for advice
159. Comprehensive team discussing relevant complex cases
160. complete team and ability to record and act on descisions made
161. Communication. Dominant members can ruin MDTs and lead to poor decision making
162. communication and transparency of decision process
163. common aims
164. collaboration of specialist in different speciality
165. Co-ordination
166. Clinically excellence, clinically driven, environment of mutual professional respect, willingness to listen to others, underpinned by excellent administrative support
167. Clear guidelines of which patients to discuss;Clear communications of descisions made,Retain principal clinician involved in patient care to allow proper continued care with principal consultant
168. Clear guidelines agreed Effective dissemination of MDT review Involvement of all MDT members
169. clear discussion of the clinical management of all individual patients
170. clear communication and open free discussions
171. brutal chairmanship to cut the xxxx. preparation of the notes before the MDT culling unnecessary discussions or obvious management decisions losts of time for the important or contravertial discussions
172. Brief, non-repetative discussion of cases and establishement of protocols to speed up the routine cases. Input into national audits from the MDT. Wherever possible, compliance with national guidance.
173. both a designated MDT coordinator and data collector
174. Availability of core members. Communication.
175. Availability of a MDT co-ordinator, Nurse specialist, pathologist, radiologist, oncologist and surgeons
176. Attendence by all relevant members with all relevant data/scans available with adequate time to discuss individual cases
177. at least one surgeon,pathologist, radiologist oncologist and CNS
178. Assessing and discussing areas of clinical uncertainty where they exist, not going through every case. It should also audit the decisions and whether they are carried out
179. Appropriate representation, cohesive patient-focused team, good leadership
180. Appropraite people and time present
181. Apart from core members all attending the resources to discuss all patients with cancer, support real time data entry, liason with patients and GPs, ability to consider patients for trial entry and time to do all of the above!
182. An MDT that makes efficient evidence based decisions for patient management and one that facilitates dialogue, friendship, research and data collection.
183. An enthusiastic team with strong leadership and a sense of purpose. A full understanding of the process and recognition of the importance of high quality care delivered by the team as a whole. It is vital that there is representation from all specialist groups (medical and nursing) within the team. Capture of all patients

is essential therefore the role of the specialist nurse (key worker) coordinator must not be underestimated. Feedback of results and outcome is essential to the process.

184. An enclusive meeting where all viewpoints are received and valued. Evidence based decisions and real time recording of management decisions and efficient feed back to patients and referring doctors.
185. An effective MDT should constitute of all health professionals that play important role in patient management and the team should have effective communication and demonstrable impact on outcomes.
186. All the relevant personnel should attend and should be punctual Adequate clerical support of sufficient quality to record staging information, treatment and eventually relapse and survival information The patients should be known to at least one member of the team ie discussion patients who have not been seen by a member of the team wastes time and often results in management plan which turn out to be impractical. There should be a strong chair who limits discussion which does not contribute to the problem in hand. A list of patients to be discussed is very useful Decisions taken should be recorded and circulated after the meeting. The meeting should not be seen as an alternative to a personal referral letter from consultant to consultant. Increasingly referrals come from junior staff or specialist nurses which is inappropriate. If a decision is made to refer a patient to another specialty this should be made to a specific consultant rather than an MDT. Someone must take ownership of the patient. The meeting should not last more than 1-1.5 hrs maximum It should be recognized that suggested management plans can be made at an MDT but that it is not possible to finalise the plan until the consultant concerned has seen the patient and discussed the treatment with the patient.
187. All relevant information with the right stakeholders to discuss and reach a consensus opinion on care plan
188. all participants committed to making it work
189. All members present on time. Succint potted history. Strong lead who summarises well at end of each case. Harmony within group.
190. All members must buy into the idea of the MDT as an effective means for delivering better care for patients.
191. All information eg x-rays slides available, a good representation of all staff and open free discussion
192. all disciplines represented ie radiology,pathology,surgery,BCNs,oncology both medical and clinical Data recored prospectively and availalble for audit all cancer or suspected cancer pateints discussed all treatment decisions recorded and available to GP and patient patient comorbidity documented All treatment decisions reviewed regularly to ensure that the treatment plan ihas been carried out
193. All data present and correct. Good summary available. Effective teleconferencing (rarely achieved). data recorded accurately and rapidly. Decisions effectively communicated.
194. All core members being present or a delegated representative. Adequate time for discussion. Good data collection.
195. ADMINISTRATION IS THE KEY AS WELL AS ROBUST DATA COLLECTION - HOW ELSE CAN WE COLLECT OUTCOME DATA
196. adequate time , attendance by core members, efficient administrative back-up
197. Adequate support for the clinicians for data collection etc
198. adequate programmed time, enough admin staff, techno support. immediate recording and communication of decisions and subsequent appointment booking, data collection rarely possible but ESSENTIAL - need designated data collectors
199. adequate knowledge and freedom of expression
200. active participation from all parties treating that particular cancer, an effective chair, an effective coordinator, good lines of communication into the MDT and out of the MDT
201. Accurate information, focused discussion, mutual respect among members of the team
202. Accurate data, Communication with patient, clinicians and GPs

203. Accurate and complete information on which to base decisions.Effective teamwork with a common aim to manage the patient's disease to their maximum benefit. Adequate time and facilities for discussion. All membership of team able to be present and allowed to contribute. All concentrating on the same topic/patient.
204. Absence of personality clashes; willingness to be open and honest; genuine discussion of pros and cons of any serious treatment options; one person talking at a time.
205. Ability to listen
206. Ability for all members to contribute, without hesitation. Needs to be well organised (data collection and clinical information), with a good 'leader' to encourage flow. Very important to have constructive feedback about pt decisions i.e what to do next. rather than wolly advice / comment. Also need to regularly review protocols for treatment used in MDT.
207. A proper team with appropriate resources
208. A number of clinicians of different specialities who meet to discuss the total care of patients in a friendly and non-competitive atmosphere
209. A multidisciplinary team (MDT) is composed of members with varied but complimentary experience, qualifications, and skills that work in a coordinated way to maximise the delivery of care to an individual patient. This works particularly well where patient problems are complex and ongoing. It commonly concerns cancer care, but also works in other settings such as the management of cleft lip & thryoid patients.
210. A multidisciplinary team (MDT) is composed of members with varied but complimentary experience, qualifications, and skills that work in a coordinated way to maximise the delivery of care to an individual patient. This works particularly well where patient problems are complex and ongoing.
211. A meeting were all clinical information relevant to a case is available and all team members have an oppurtunity to participate in the discussion. The team should have the necessary experts to make useful contribution
212. A meeting of members who respect each other's views led by an effective chairman.
213. A group of professionals with expertise in a specific anatomical site, covering all aspects of care at that site, working together for the benefit of patients
214. A group of people with expertise in mangement of the tumours who exchange views and agree best management in individual cases
215. A group of people who all have an important role in treating patients with cancer, meeting in an organised fashion on a regular basis to discuss treatment options, and communicating well both between themselves, with the patient and the gp
216. A group of individuals appropriately skilled in that tumour type who share a common philosophy about the delivery of patient care
217. A group of engaged workers (Clinicians, nurses and support staff) debating openly areas of uncertainty and challenging the status quo on behalf of the patient
218. A group of clinicians/ support staff who endeavour to improve the patient pathway.
219. A group of clinicians, specialist nurses and support staff who actually work together as a team on a day to day basis (as opposed to a group of individual clinicians who have been made to get together once a week/month for a radiology/pathology review meeting
220. A group of allied professionals, directly involved in cancer care and treatment
221. A GOOD CO-ORDINATOR AND ATTENDANCE FROM ALL RELEVANT SPECIALTIES IE SURGEON, ONCOLOGIST, RADIOLOGIST, PATHOLOGIST PLUS SUPPORT STAFF, MCMILLAN, RESEARCH CO-ORDINATOR FOR ONCOLOGY TRIALS.
222. a good chairman
223. A functioning team comprising surgeons, oncologists, pathologist and radiologist, nurse specialists/key workers, MDT-co-ordinator and data manager. It must be adequately resourced and supported with IT, PACS and projection facilities plus video link capabilities. Most importantly, trusts need to recognise the fundamental importance of the MDt in the management of cancer patients and all sufficient PA's and time in job plans.
224. A fully supported(funded) MDT. It is vital that all stakeholders are involved. A

designated chair/leader should bbe appointed on a basis that vthey will sign off on any interventions or decisions as the MDT can be used as a rubber stamp for a clinicians teatment preference. The MDT should have the power to stop clinicians outside the MDT from treating patients .

225. A forum to discuss and document patient management with all appropriate information available. The MDT should document disease stage and treatment accurately in a format that allows reliable and meaningful data interpretation. This will then allow effective service development.
226. A forum for informed debate with each member's views, knowledge and experience valued. Representation from each field.
227. A defined Chair and core/extended members, held regularly with 90% attendence. Suffiecent time to discuss cases with every body's view taken into consideration.
228. A core group of individuals with varying input into the patients care, that can discuss all aspects of patient diagnosis, investigation, treatment (incl palliation) wellbeing and make a formal recorded decision which is disseminated in a timely fashion to relevant personnel. This must include immediate patient feedback. There should be a fascility to assess results, numbers etc.
229. A cohesive group of people that respect each other. There a potential for MDTs especially those that have been created in response to the recent initiatives to suffer from individual's or groups attempting to empire build rather than concentrating on improving patient care which is their primary aim. A key element is good data collection but in my experience this is difficult to achieve. The IT departments I have experience of are driven by the requirement to collect the data required for government statistics and not data that is particularly required by individual departments. We have our own data collection but the trust is not prepared to support by allowing the database to be placed on the network. Further if this was developed appropriatley the trust would aquire have access to this data which would provide all the information it requires but it would have the benefit of being considerably more accurate. There is unnecessary duplication of effort by all parties at present.
230. 1.Required information to make decision is available{ imaging, histology] 2.Evidence based decision taking process based on best practice agreed at network level 3.Action on the decision and communication to all concerened. 4. Data collection and audit of practice All above componants are required for effective MDT
231. 1. Effective information gathering 2. Process to display the information to the team 3. Effective recrodng of decisions and prompt publication 4. Ensuring every member of the team has a voice
232. 1)A moderator who is not directly responsible for clinical decision making to lead the meeting and keep everyone up to speed, this avoids the MDT chairman having to run the meeting as well as deal with clinical problems[this could be a renal MDT member moderating the prostate MDT] 2) Enough time to deal with the cases 3) good preparation by the MDT coordinator with a summary of the clinical case prepared in advance, the scans reviewed in advance by the radiology team and ditto the pathology slides. Although it is interesting to have the pathology slides presented it rarely affects what the pathologist has reported. The CT/MR scans however are important to review and so good images [we have PACS which is excellent]. 4) effective arrangements for communications after a decision has been reached. The patient needs to be either sent/contacted for an O/P appointment or details of what is to happen. The GP needs to be informed. The referring clinicians need to be informed. 5) Data should be collected live. Each month the MDT team should review what data has been collected to correct any gaps. This should also have a quarterly and 6 month major review so the team can see what work they are doing and will not have to rush at the end of the year to collect the data. 6) Every month outcome data should be reviewed perhaps as well as looking at the patients being entered into clinical trials. A record should be kept of each case to see if they had been considered for a trial and if entered what happened to the patient. 7) Good liaison with the palliative care team so their worries about patients on end of life/palliative care pathways are reviewed.

The team

What qualities make a good MDT chair/leader?

132 surgeons responded to this question. In addition, 4 surgeons referred to the previous multiple choice question (Q35) stating that the qualities that make a good MDT chair/leader were 'as above'.

1. Willingness to give the time to do the job. Throughness in preparation & paperwork Command prefessional respect (and , hopefull, affection!) Integrity,e.g. not to "pinch" the easy cases! Ability to chaoir a big meeting and move the agenda on Fairmess to other people in the room A sense of humour. ....I could go on...!
2. Whoever is prepared to do it
3. Understanding of other professionals sensitivities and a clear view of the diseases and their natural history and how it can be influenced
4. Typically some one with a good broad knowledge of the disease in question who can call on the relevant members to commnet in each situation.
5. Time keeping and strong but not waffley leadership
6. Those that make a good doctor
7. There should be a strong chair who limits discussion which does not contribute to the problem in hand.
8. The moderator should not be part of the clinical decision making team. This frees those who are having to decide on management of a case from the problem of running the meeting, but the moderator clearly must be a competant chairman who is well prepared before the meeting. Good time keeping, clear objectives, a bit of humour, patient centred, interested in clinical trials, able to deal with opposing points of view in the meeting[conflict].
9. The above does not adequately reflect the importance of each statement all of which are important in different ways. It is important to listen to all points of view and bring the team to a unified agreement and then to summarise the agreement. Should not be oppressive, should be inclusive. Requires common sense.
10. Tact, diplomacy, time keeping skills, intelligence
11. Strong but fair. Ensures equal input from all members of team. Can fight for resources and promote good audit and research.
12. Sound knowledge, respect, good communications, general leadership qualities
13. someone who understands and can apply the evidence to each case. He/she must have respect for and be willing to listen to the views of all members.
14. Should be acceptable to most members, allows participation from all members
15. Should be able to guide discussion and allow all members an oppurtunity to participate.
16. Sensible
17. sane
18. Respected, impartial, allows time for discussion but moves meeting on
19. Respected member who respect and value contributions of all member, focused on discussion and keep side talks to minimum, decisive and able to refocus the group on the real issues, good listener and effective communicator, person with common sense who sees the bigger picture and able to identify & suggest new developmental opportunities for the group, keeps to time and draw discussion to conclusion at appropriate suitable time and able to suggest alternative ways to take on the discussions elsewhere. Some one who leads by example and stays for the whole meeting and avoids walking out and in during the discussions, avoid arriving late leaving early before the end and thanking all the attendees. He/ she should have known two or three deputies to ensure continuity and smooth running of the meetings during annual/ study leaves or absence for other reasons
20. Respected individual by all members/experience

21. respected and able to get on with other MDT members
22. Quick mind able to grasp situations and analalyse quickly, good sense of humour to keep everyone happy considerate to everybody. The antithesis of autocratic
23. Prescence in order to have enough credibility to manage the group, chairing skills (ensure equal input, encourage or stop contributions as appropriate, ability to summarise, understanding of need to make progress and ability to ensure that is done.
24. preparation cull the xxxx
25. people willing to follow them
26. Organised, team player, able to plan, leads by example
27. Organised facilitator keen to encourage participation but capable to preventing repertition
28. Organised and prepared Good communication skills Respected Other core members feel valued Allows more time for complex cases, and less for routine cases
29. organisation and
30. one who does not impose his opinion on other members but allows free discussion.
31. not a bully
32. Not a 'bully'. A listener and facilitator. Someone who can resist listening to their own voice all the time!
33. Non dictatorial, inclusive,
34. Must be a practising clinician. Must listen to other members views
35. Motivate and support teamwork. Good prepararion of cases
36. Members contributions are made to feel valued
37. mange time effectively, allow all to have equal contribution, make sure decissions are patient centred and evidance based.
38. listener who can clearly co-ordinate inputs from several sources and collate that info to give a clear plan of action
39. leadership skills
40. leadership up to date knowledge
41. KNOWLEGEABLE WELL PREPARED, CAN LEAD A DISCUSSION NOT IMPOSE THEIR WILL. WE ROTATE THE CHAIR AT MEETINGS BETWEEN THE CLINICIANS. WE ALSO ALLOW DIFFERENT CLINICIANS TO LEAD ON DIFFERENT CASES, IE ONCOLOGIST LEADS ON ONCOLOGY CASES THIS PRODUCES GOOD TEAM WORKING.
42. Knowledgeable, confident and good interpersonal skills
43. Knowledge,experience,open mindedness,no personal agenda
44. knowledge, making the group work as a team
45. Knowledge, keeping to agenda, making members feel important without deviation from agenda. Only allow one person to speak at a time.
46. Knowledge of the subject able to keep time and order open affable
47. knowledge of subject matter treatments etc good leadership qualities, good team player
48. Knowledge of other disciplines and time management
49. knowl;edge, even handedness, clarity, diplomacy
50. keep order keep to time involve all attendees
51. keep meetings on time
52. Inspires other members and has their confidence and trust. Good time management.
53. insight
54. Informed, up to date, willing to accept other opinions
55. Inclusiveness impartiallity good clinical knowledge
56. Inclusive. Incisive. Decisive
57. inclusion and consideration of members
58. I do not support this role
59. Humour, tolerance, clarity and intelligence as well as humility. They should avoid

trying to give their own decision as of right (difficult when you know best!). Good interpersonal skills

60. humanity
61. good time managment ability to summarise
62. good time-keeping ensuring all can have their say then decisiveness
63. Good team member, respected by all
64. Good management skills. Empathy with patients needs. Lead by example.
65. Good listening and competence
66. Good listener & communicator
67. good leadership, impartial, keep to time, has sufficient knowledge
68. Good leadership with clear objectives
69. Good leadership skills
70. Good leadership ,knowledge and communicatipon skills
71. Good knowledge obviously of the subject being discussed excellent communicator
72. Good communicator and time manager.
73. Good communication skills; organisational ability
74. Good communication skills
75. good commiunications skills, freindy, ensure contribution of all MDT members
76. Good clinician
77. Good administration and communication skills. Fairness. Expert understanding of the diseases being discussed/presented.
78. Focussed, efficient, fair
79. flexibility
80. Fairmindedness
81. Fair and firm. Knows the members of the team and can encourage comment from those who are relevant but reticent.
82. experience, team worker, listener
83. Experience and knowledge of the field. Ability to value the roles and contributions of all disciiplines
84. Experience Open to change Willing to listen
85. Experience communication skills
86. enthusiasm, knowledge, dedication to the concept
87. ensuring all views heard
88. ensure good teamworking and open discussions
89. Ensure efficient running and participation by members as necessary and appropriate
90. Ensure all views are heard before making final decision.
91. Ensure all cases are discussed and all MDT members are given the opportunity to express an opinion or reservations. Does not necessarily have to "lead" the MDT meeting, which may naturally follow the list of patients for discussion
92. Ensure all are able to contribute and no one "takes over"
93. Enjoying the respect of other MDT members by including all groups in discussion, ensuring patient centred discussion to inform evidence based decision. Reconciling conflicting views by informed and relevant comment so patient outcomes are improved. Ensuring that the MDT is a valuable use of clinical time.
94. Encourage engagement by all
95. Egalitarianism and democracy
96. Efficiency. Clarity. Ability to control
97. Effective listener and assertive
98. don't know
99. Direction, pragmatism and inclusiveness
100. decisive
101. Controls momentum during meeting by encouraging relevant discussion/presentation of information and summarises decisions insuccinct manner before moving on to next case. moves
102. control of the meeting

103. control and good humour
104. CONFIDENCE
105. Communication skills, integraty, clarity of thought. they must command the respect of the group
106. Communication
107. common sense
108. Commands respect and good communicator.
109. COMMAND COONFIDENCE
110. clear vision, good communication,
111. Clear thinking and decisiveness with an ability to change his/her mind
112. Clear and informed thinking and communication skills
113. capable of asking for a consensus before final decision
114. Being prepared to listen but keep an eye on the clock to prevent innappropraite diversions
115. Authoritative knowlegeable person who works well with other people.
116. attitude
117. As for any meeting, a good MDM chair will ensure all discussions are inclusive and fair.
118. Approachable, flexible, humble, decisive, willing to compromise, knowledgable.
119. Approachable , organised clear and concise
120. An individual from any background who is able to represent the views of all core members and facilitate effective delivery of patient care
121. Allows engagement of all professionals, can promote patient discussion, good team working
122. Affable but firm
123. Affability, leadership communication skills, ability to listen. Good time management, punctuality and discipline
124. Able to facilitate smooth running of the MDT meeting
125. Able lead, organised, brave, thick skinned.
126. Ability to listen be well organized able to motivate
127. Ability to facilitate productive discussion and timely decision.
128. Ability to engage all members of the team Good time keeping
129. Ability to cordinate the actions of the individual members.
130. Ability to allow all opinions to be heard and valued, and assist in decision making weighing opinion and evidence and guidelines
131. A person without strong predjudice
132. A clinician who deals with the patient face to face, who comunicates well, and who is prepared to work hard.

What types of training do MDT leaders require?

111 surgeons responded to this question. In addition 3 surgeons referred to the previous multiple choice question (Q35) stating that leaders require training in “the above”.

1. Working knowledge of jobs of all the members. Why not have a day in each different department?
2. Whatever delivers the product you want
3. Visiting a well run MDT at another centre would be a very obvious way forward. Likewise vistis to one's own centre by an "expert" I have made several such visits.
4. Visiting other MDTS (not necessarily in the same speciality) would be interesting
5. Very individual depending on their experience of chairing. Clear understanding of processes particularly if teleconferencing.
6. usual clinical leadership training
7. Up to date science, trials update, cancer management updates, network functions, group dynamics and meetings managment
8. unsure
9. training to deal with different personalities, keeping focused. Leading in a nonprogressive situation (ie lack of information etc)
10. Training requirement is dependant on their experience and leadership capablities and can be dependant on the group they have to lead
11. time keeping skills, skills in chairing effective meetings, conflicts resolving & effective communication skills, interperonal skills
12. time keeping keeping uo to date with treatment developments and evidence based medicine
13. They should have a global understanding of the medical and paramedical aspects of diseases (ie doctor) and shouldknow how to organise and chair a meeting.
14. There is probably a course out there!
15. The chair should be elected by the members on a regular basis. This would ensure that the best person does the job.
16. That depends upon the lead and will depend upon their experience.
17. Technology; ? leadership
18. Technology
19. Team working and leadership skills.
20. Team working
21. Team leadership training
22. team building
23. Team and conferencing skills
24. STANDARD LEADERSHIP TRG
25. specific to their needs which will vary
26. Some just can, others will need formal training.
27. Simple leadership skills.
28. sharing good practic e
29. remedial if they are not doing the job. Most of it comes from long experience
30. Primarily in communnication
31. Practice. See others doing it well.
32. People management!
33. OURS WORKS SO I DON'T THINK AANY SPECIFIC TRAINING IN OUR ENVIRONMENT IS REQUIRED
34. organisational and getting resources
35. none. Common sense is innate
36. None. Just choose the right person.
37. None.
38. None there is too much training!
39. None specific but has to have good Team management skills and communication

40. None really. If you aren't any good at it then no amount of training will fix it. If anything - managing/chairing meeting skills and some knowledge of resource management.
41. None if you need teaching to do that sort of job you should't be doing it
42. none if you have the necessary leadership skills already
43. none if they have requisite skills
44. None
45. None
46. none
47. none
48. none
49. none
50. none
51. non specific/common sense
52. Nil unless they or their MDT think they need it.
53. national meetings to discuss experience of running effective MDT and SMDT
54. medical school
55. Medical degree
56. Management, time management, etc
57. Management skills, communication and conflict skills
58. Management and leadership
59. management and communication skills
60. Management
61. little
62. Leadership, communication
63. Leadership training
64. Leadership skills,team building/working and rationalisation
65. Leadership (MDT specific) and communication skills.
66. Leadership
67. Leaders may be borne not made
68. Leadership skills
69. Knowledge of MDT electronic support.
70. It should be a post that rotates around the (willing) members and doesn't require specific training.
71. In general very little
72. I dunno
73. I do not think such a course exists, but valuable to speak to others involved in effective mdt's
74. I do not know
75. How to chair a meeting and how to motivate others
76. General overview of how all MDTs work effectively. Good secretarial and coordinator support
77. formal training
78. experienced
79. Experience of other MDTs in same speciality
80. Don't really know never received any perhaps miliary background helps
81. Don't know
82. Don't know
83. don't know
84. Depends on individual
85. cross fertilisation of ideas from other MDT's
86. Communication skills/experience. IT and data management/interpretation skills?
87. Communication skills, negotiating skills.Chairing skills
88. communication skills generally
89. Communication skills and leadership skills.

90. Communication skills
91. Communication and leadership
92. Common sense
93. clinical leadership
94. Chairmanship skills and video conferencing.
95. Chairmanship skills
96. Chairing skills, Process management, generic team building skills
97. Chairing skills
98. Chairing meetings training and team building
99. chairing meetings and leadership
100. CHAIRING MEETINGS
101. case based discussions
102. Assertiveness
103. Appropriate clinical training in their specialty, leadership and communication skills
104. Apprenticeship is all that is required i.e practical training such as sitting in on MDTS and being allowed to chair an MDT under supervision of a veteran MDT Chair
105. apprenticeship in leading the mdt while a trainee, under supervision
106. Any generic leadership training course
107. Any basic leadership, committee chairing or even discussion facillitating training would be a good start
108. advance commiunication skill course
109. ?
110. ?
111. How to chair a meeting

What makes an MDT work well together?

121 surgeons responded to this question. In addition 3 surgeons referred to their earlier remarks ("as before/above").

1. work too well when no one disagrees.
2. Wide variety of expertise / experience This prevents one personality dominating
3. We discuss over 60 cases per week. This needs order in the classroom!
4. We are fortunate - we do not have any interpersonal clashes and work well together. I have seen the opposite elsewhere which is destructive
5. understanding each other, evidenced based treatments, knowledge
6. Trust
7. The team
8. The meeting should not be seen as an alternative to a personal referral letter from consultant to consultant. Increasingly referrals come from junior staff or specialist nurses which is inappropriate. If a decision is made to refer a patient to another specialty this should be made to a specific consultant rather than an MDT. Someone must take ownership of the patient.
9. the chairman
10. Teamwork and leadership
11. team spirit . small egos!
12. Similar vision, trust and the belief that treatments delivered to patients are in their best interests
13. Similar goals
14. sharing the a commen objective
15. Shared values and goals for patient care and management, friendship and comraderie, professionalism, the odd joke or lighter moment.
16. Shared objectives. A willingness to compromise.
17. shared objectives

18. shared objectives
19. Shared goals, good communication and iclusiveness
20. shared decision making a working knowledge of up to date treatments even outside your particular field no monster egos
21. Shared common goals.
22. Shared and agreed goals, dedicated time in job plan and support,
23. sensible bunch of people who listen to each other and don't 'push' their owm agendas
24. Respect.
25. Respect of eachothers' views.
26. Respect of all members involved.
27. Respect for other members of the team and removal of the need to compete
28. Respect for each other
29. Respect for colleagues
30. Respect between members
31. Respect
32. respect
33. Recognising talents and personalities of members to co-ordinate and minimise conflict.
34. Put the patient first. Shared objective to do your best for the pt.
35. Proper discussion with evidence base and guidlines.
36. PERSONALITIES AND PROFESSIONALISM
37. Personalities and commitment
38. Patient centred objective
39. openess and a willingness of all parties to participate
40. Open discussion
41. Obvious
42. Mutual respect. Ability to discuss cases freely and to add urgent cases at short notice
43. Mutual respect. Sense of humour Adequate facilties and time Good preparation by the chairman and others so that people feel that the time at MDT is used effectively (and not wasted, e.g. searching for reaports, etc.)
44. Mutual respect, honesty, good interpersonal skills, tolerance, a no-blame culture.
45. mutual respect, common aim,
46. Mutual respect for members in the team
47. Mutual respect for each other's expertise and for what each can contribute.
48. mutual respect and understanding of others' roles and responsibilities compared with your own
49. Mutual respect
50. mutual respect
51. mutual respect
52. more respect from core and chair for extended members
53. Members work effectively together throughout the week, not just at the MDT.
54. Luck with one's colleagues and good chairmanship
55. luck
56. Listen to each other. Able to reach a consensus.
57. Like minded pleasant colleagues!! We are very lucky in this respect.
58. like minded ness
59. leadership, shared vision
60. leadership and space
61. Knowledge of each other strenghts and weaknesses, respect between members, good out of meeeting communication links
62. Inter personal relationships & good communication
63. Highly motivated individuals are extremely unlikely to make a poor or substandard decision for patients because of interpersonal problems. However, a hostile or confrontational meeting may lead to delayed effects in team working which reduce

the effectiveness of the service and can also have deleterious effects on the individuals in the longer term.

64. have to get on wiht each other accomodate different opinions chairman to make decisions after listening to members
65. good team working
66. good team work
67. good relationships, open discussion - being self critical and challenging
68. good relationships
69. Good relationship between members
70. Good leadership
71. Good interpersonnal relationships and, good communication
72. Good interpersonal relationships. Seeing results of good work. Having enough time to do the job. Good facilities. Good leadership.
73. Good interpersonal relationships between all involved
74. good ineterpersonal relationships and trust and respect and skills
75. Good humour!
76. Good communication and respect for members
77. Good communication
78. Good chairmanship, broad based membership (not just doctors)
79. good administration
80. Generally because of close relationships outside of the MDT eg on wards or in clinics but also openess to listen to all points of view equally
81. general aim of working together with a committment to professional evidence based efficient care and its development
82. Friendly atmosphere
83. Experience and motivation to improve. The collective qualities of the MDT members
84. Everybody gettingon and having a common goal
85. equal attention to every opinion
86. enthusiasm, skill dedication common goala
87. enough time
88. empathy and honesty
89. effective communication
90. Effective communciation & team working
91. Discusion is inclusive
92. Constructive discussion Same specialist radiologist each week
93. Complex, takes time, but key leadership and communication
94. Communication and personalities
95. Communication and easy access to MDT
96. COMMUNICATION
97. common purpose with shared objectives, regular updates on the successes of their treatments eg operative, DXT results, trial recruitment, avoid too much work in too short time. Make them feel valued
98. common purpose and vision
99. Common Purpose Patient centred Respect for colleagus
100. common purpose
101. Common goal, mutual respect, good communications.
102. Common goal
103. common aims superceding personal agendas
104. common aims and goals
105. committed core members
106. commitment
107. cohesive unit in regards to coordinated care
108. Cohesion and respect
109. Co-operation
110. Clear leadership Agreed goals and policies

111. Clear goals, resources, shared objectives. Feedback and equal participation. Fairness in criticism and compliments
112. Clear goals
113. Being valued as an equally important member of the team should usually ensure that everyone pulls their weight
114. appreciation of each others role and professional training
115. Appreciating individuals abilities and the importance of the doctor/patient meeting where a more complete picture is available and the MDT choice suggestions can be discussed with the patient.
116. All team members pulling together to work in unity under a strong leadership
117. All members buy in, and use the process appropriately
118. Agreement fo process
119. A willingness to accept others views
120. a sense that the work is valued by the patients and the hospital
121. a general acceptance that all views should be considered

Infrastructure for meetings

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

176 surgeons responded to this question.

1. You need a projector for all to see Xryas, slides etc, as well as in line data. Size of room to get everyone in. Air conditioning in summer!
2. Working across multiple video lnks. It is relatively easy to present cases from a satalite site but difficult to contribute to the discussion
3. when core members do not turn up
4. we run a telemed MDT and poor electronics = no meeting.
5. Videoconferencing equipment with poor sound and image quality and poor setup in different venues
6. Video link technology. Trouble with viewing imaging and histology, to good resolution, across several distant sites simultaneously
7. Video conferencing, overly large meenings inability to tollerate different opinions effectively (minority reports)
8. video conferencing not suported by IT staff
9. video conferenceing has its draw backs and the arrangement of the room is one of these
10. Very highly opiniionated individuals.
11. Unable to hear others views
12. travel /videoconferencing. very difficult to have meaningful discussion thro video link
13. Too small, poorly ventilated and inadequate AV facilities.
14. too small a room/facilities/usuall xxxx hospital notes
15. too many cases to discuss followed by an even busier clinic
16. too many associated health care professionals are overly interested in just their area rather than the overall patient
17. Time. Targets. Government interference. They are a waste of time
18. time, ours is too pushed and often workloads means that some members can't attend
19. time available to all members, admin support
20. Time
21. time - mdt members arriving on time from other (clinical) committments and not rushing through the MDT
22. There aren't any if you gets rthe basics right. Friendly good realtionships between the participants is a great help, but is by no means essential.
23. The data presented and decisions made are not obvious to every attendee

24. Technology failure
25. Technology failure
26. Technology
27. Suitable facilities
28. space
29. sound quality and distractions
30. Small, noisy ill-lit room with no facilities to see radiology or histology or ones colleagues.
31. Small stuffy rooms. No table tops or worktops for notes and writing materials.
32. Slow transfer of data between hospitals. All core members not being present/represented
33. size of room / number of chairs and shape of table
34. Shyness, intimidation, size of room. Not able to see the information needed. Not able to hear. Notes/records/info missing. lack of preparation me ket members. patients presented who nobody knows
35. SHAPE OF ROOM
36. See my earlier answer. Too many people and too many empires and self-interests.
37. rubbish rooms
38. Room too small. Dodgy teleconferencing
39. room to small, can't see IX
40. room not available/ double booked
41. Radiology preparation and succinct histology
42. Projection facilities breaking down Temperature of the room,too cold in winter,too hot in summer
43. problems with technology
44. poorly functioning technology
45. poor video conferencing technical stuff
46. Poor turnout/haphazard attendance and those who know the patients being unable to attend
47. Poor technology and lack of technical support in running the meeting
48. poor technology
49. poor technologgy
50. Poor technical facility and unsuitable enviroment.
51. poor team working, ego issues
52. Poor team work, poor organisation and administration
53. Poor Spatial arrangment of members
54. poor room layout
55. poor prparation, lack of information, lack of experts,
56. Poor organisation. Lack of support personnel. Professional rivalries. threatening/aggressive attitudes. Diagnostic delays, failure to recognise targets dates. Flexible working. Good communication between MDT members. Agreemene on cover arrangementsfor core MDT members, chair and MDT co-ordinators
57. Poor IT support
58. Poor IT links esp video
59. Poor equipment and communication
60. Poor environment and technology and frequent breakdowns
61. poor data entry of proforma
62. Poor communication. Inadequate information. Very strong personality.
63. poor communication, imaging not available
64. Poor communication
65. Poor acoustics or poor presentation aids
66. Poor accoustics
67. Poor accommodation
68. place to keep notes on the table

69. personnel not turning up, decisions not being recorded, chaotic
70. Personality
71. personality
72. personal agenda ego
73. Performing to the audience
74. People lost at the back of a big room will not engage in the discussion particulary where there is a large audience.
75. People doted about all over a big room so you can't hear them. Results not being ready. Not being aware of why a patient is being discussed. Not knowing when the patient is coming back to clinic next
76. PAX not loading cases, imaging from other hospitals needs to be loaded onto hard drives before meeting
77. Participants feeling they cannot get their points across
78. overheated room, equlity of opinion
79. Not sufficient time poor attendence
80. not having a dedicated venue
81. not enough room
82. not being open minded
83. not being able to view diagnostics
84. not being able to hear each other
85. Non quorate meetings due to leave etc
86. non core members sitting at the back of a room laid out lectutre theatre style and chatting- very off-putting!
87. non attendance and lack of resourcing time for the members
88. noise, failure of technology, failure of admin investigations, notes , results ot available
89. noise,
90. No lunch for a lunchtime meeting!!!
91. No dedicated room
92. no coffee provision
93. No access to diagnostics
94. Members unable to communicate with each other ie poor acoustics, visibility
95. MDT Co-ordinator not present
96. Malfunctioning IT
97. Leadership; admin; technology
98. lack or failure of audiovisual equipments
99. Lack of working technology.
100. Lack of time
101. Lack of technology
102. Lack of space and projection facilities
103. Lack of space , overcrowding
104. Lack of room and poor IT facilities
105. Lack of resources and apathy from members
106. lack of required information
107. lack of protected time lack of resources lack of CNS lack of cover for holidays of Co-ordinator
108. lack of projection equipment
109. lack of preparation or availability of results
110. Lack of preparation by coordinator/referring centres, people dipping in and out and having their own conversations, too many cases, poor chairing.
111. Lack of notes/available information. Absence of key colleagues if cross cover arrangements do not work.
112. Lack of IT support
113. lack of IT
114. lack of information
115. lack of good IT support

116. Lack of facilities
117. lack of data access
118. Lack of communication if everyone cannot see/interact, demonstrated with videoconference technology breakdown
119. Lack of co-operation between team members
120. IT problems
121. IT has to work No long delays getting items on screen Room being used by another team, so have to go elsewhere
122. IT failure with videoconferencing/display of radiology/histology
123. IT !
124. IT
125. Interuption
126. insufficient information
127. inadequate technology
128. Inadequate facilities and room
129. Inadequate A V facilities
130. inaccessibility or inconvenient location of the room
131. inability to write in notes due to insufficient desk space
132. Inability to see diagnostics
133. Inability to present radiology / pathology.
134. inability to hear or see properly
135. Images should be seen by all the attendees
136. if all members are not able to see and hear the data and results
137. human behaviour
138. Having a "dominant" character in the MDT who stifles discussion
139. hasty meetings, non-attendances
140. good vision of board
141. Faulty AV equipment, poor slow images, no slides etc
142. Failure of visual display (especially videoconferencing links)
143. Failure of technology especially imaging
144. Failure of IT equipment
145. Erratic technology (for diagnostics and video).
146. Equipment or information breakdown.
147. enough room for everyone to sit down properly
148. Efficient IT
149. Don't understand the question
150. Distraction from other clinical commitments (list, bleeps, telephone etc)
151. disorganisation
152. Discussing routine early cancer cases for sake of completeness
153. Cramped sitting arrangements and poor views of x-ray and histology images
154. cramped room without space to read the notes or record the decisions
155. cramped environment, poor temp conrol, lack of coffee, non functioning video link
156. core staff and chair do not value extended member skills
157. Communication/IT/transport or courier difficulties preventing case notes, histology slides or radiology being available in good time for review
158. colleagues unable to work together and obstructive management that don't recognise the importance of such meetings and allied staff.
159. Clash of personalities
160. caseload, disorganisation
161. Break down of technology re pathology and radiology
162. Being able to get to the MDT in time.
163. BECAUSE OF OUR USE FO THE TELE MEDICINE ROOM OUR LAYOUT IS FIXED, OUR TIME IS FIXED THERE ARE NO INTERRUPTIONS LUNCH IS SUPPLIED WHICH ALWAYS PROCUDCES A GOOD TURNOUT!. WE HAVE A FIRST CLASS CO-ORDINATOR WHO PRODUCES THE CASE REPORTS, MARKS THE NOTES AND IT IS EXTREMELY PROFESSIONAL. THIS MAKES

HER THE MOST IMPORTANT PERSON WHOSE ABSENCE WOULD BE A DISASTER.

164. Bank Holidays! Conflict between MDTs for different cancers (for personnel and facilities)
165. availabilty of patient information
166. audibility
167. appropriate ;venue with viewing facilities
168. Adequate space
169. Access to radiology and pathology results.
170. Access
171. absence of dedicated venue large enough to accommodate all participants
172. Absence of core members
173. Abscence of tehcnology for viewing pathology and radiology
174. Ability to view details of the case and personal interaction
175. A room with imaging and pathology projection facilities that is always avilable for the MDT meeting
176. A couple of big egos, usually surgical, who won't listen to the views of others.

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

171 surgeons responded to this question.

1. would improve our communication with the specilaist MDT at XXX Hospital
2. would be able to share joint MDT with outlying units too small to run own MDT
3. when it works it is fantastic
4. We have not done this yet, but it is due to come in with the supra-network MDT with 3 main sites and several satellit sites. Geography means that one MDT in one site would in reality not be attended at all. Video-conferencing is the only chance that it might occur, but is yet more time on top of the local MDT which already takes up a considerable amount of time.
5. We can use it if wanted but have always avoided it and I am glad of that. It is better for communication to be located together
6. W e are using video-conferencing, on positive side you can involve clinician working in different hospital at the time of the meeting, and the negative side is the techincal faults and needing an expert to look after the vedio system.
7. Vital in our network across a large county involving many centres
8. Videoconferencing allows clinicians from distant hospitals to be included which has a favourable outcome allround.
9. Videoconferencing allows appropriate communication when geography would otherwise restrict meeting attendance. However, it does not always promote a cohesive MDT environment.
10. Video conferencing is more effective than teleconferencing. Videoconferencing enables members to effectively participate without being physicaly present
11. Video conferencing facilities inadequate
12. Video conferencing allows all members to attend without having to drive to the one centre, but often it is not possible to satisfactorily view images or histology via this link, and even viewing the members and hearing them clearly over the link can be troublesome. Now there are two satellite centres joinging via the link, it is even harder.
13. very useful - we tried publishing our initial data when we started in 2003 - but none of the journals were interested - this is an important part of our practice and allows us to service 6 other sites without a lot of disruption to their work pattern
14. Very poor way of contributing to an mdt, limited person to person communication and hugely delays process with almost no benefit.
15. Very difficult to do effectively. Needs training but essential for complex involving

more than one hospital

16. usually negative becasue it frequently fails
17. Useful for connecting centre with units
18. Used to allow joint MDT with cancer unit
19. Unreal environment. Not always possilbe for all sites to connect and poor quality sound/images and video
20. undue delay
21. to be able to involve those clinicians that can not attend the meeting for some reason e.g having committment in other hospital, and to involve more clincian perhaps from other hospital. the negative side is technical problems and needing staff to run it
22. Time keeping problems, background noise can't be minimised
23. The person on video conference is not really part of the meeting. Only useful for discussing an occasional case when no other means of member attending
24. The above answers are only generally applicable, technological failure as previously alluded to is a regular problem and would only be magnified by videoconferencing. There is no substitute for face to face contact.
25. Teleconferencing is unacceptable as you cant see and images Videoconferencing allows individuals to present cases for discussion and observe the discussion. However we often have 4 sites video-conferencing into the centre at the same time and this means it is nearly impossible to chair the meeting except in the centre and it is more difficult to effect the decision making process which tends to occur between the core members attending the centre
26. Teleconferencing is not yet highly effective in large group settings and does not seem to lead to joint decisions but one by each locality
27. Teleconferencing has arisen as a fudge. It is a poor substitute for attendence and a significant barrier to effective discussion. It should not be permitted as it encourages smaller units to continue as they were and avoid change
28. teleconferencing can be useful to bring in a member with a specific query but cannot interact effectively with whole team so value of multidisciplinary group lost
29. Technology is limiting factor
30. Technical problems
31. Technical failures and inconvenience.
32. Technical difficulties tend to detract from the patient management
33. Sub-optimal engagement
34. speeds up journey time with patients from cancer units
35. Slows it down massively, reduces interaction.
36. slows it down
37. slow it down and disjointed
38. Sites which are geographically far apart can have joint meetings with effective improvement
39. Saves lots of travelling tiome and allows members to participate who otherwise would not be able to.
40. Removes travel pressures, impairs quality of images seen. Likely to feel fragmented by sites and not a true team
41. reduces travel time by over 1 hour for the meeting
42. Reduces travel requirements; decreases quality of discussions
43. Reduce travel time for core members
44. Real-time discussion facilitated but equipment may fail; enables staff on different hospital sites to communicate but should not supplant their physical presence if feasible
45. Quick decisions on management are reached this way
46. Positive: it could improve time utilisation as our MDM discuss patients from more than two units and avoid unnecessary travel time between sites, encourage most members to attend Negative: takes longer time to set and has risk of equipments failure that may result in delay patients' treatments, less contact time with other MDTmembers
47. Positive: Contribution from all remote specialities and services. Distances, traffic,

parking, other committments etc do not pose barriers to core member participation.

48. positive. new equipment is very good
49. Positive impact for communication with outlying hospitals.
50. Positive if technology is working and appropriate etiquette is observed
51. Positive always
52. Positive - allows people to attend without travelling. Negative - poor equipment is a hindrance
53. Poor
54. outcome for the patient.
55. Only If patients can participate through the web cam from home. No good for clinicians.
56. not utilised for our MDT
57. not much
58. not experienced it
59. Not experienced
60. not available
61. Not as good as actual attendance
62. not applicable to us as we are all on one site
63. None
64. none
65. none
66. none - what the point?
67. No experience
68. Never tried it.
69. never tried it
70. Never done I have no idea
71. Negative. Poor sound and poor raport with other team.
72. negative. inhibits interaction, team working, discussion greater riskof miscommunication
73. Negative. Always problems with connectivity. Huge bureacratic delays in funding it.
74. Negative - intereferes with good dialogue
75. Needs to be carefully chaired. It lacks a degree of atmoshere and inclusiveness
76. NA
77. N/A
78. n/a
79. n/a
80. Multi-site working possible Increases fequency of meetings Reduces travelling time
81. Much more inclusive to teams on distant sites eg 80 miles away
82. Much better if participants are physically present in same room
83. more people attend communications are not as effective as direct attending
84. More likely for some people to dominate the meeting - may not obtain full spectrum of opinion or relevant input to base decisions.
85. Means that you don't have to keep running just to attend the MDT.
86. means that decisions are made there and then rather than e-mailing and awaiting response
87. Makes the meeting more disjointed, but is better than no MDT participation
88. Makes it possible. It also should take special disease management (pituitary disease) outside local cancer networks which are completely inappropriate
89. little experience
90. Lack of personal, person to person interaction
91. Lack of interest from some members when their cases aren't being discussed
92. Its rubbish. It creates the illusion of having people attending but the reality is that it doesn't help and just allows another "box" to be ticked

93. it reduces interaction and quality of decisions
94. It makes a vast (positive) difference. It is very easy to run. It secures regular timely attendence of off-site core members
95. It is vital
96. It is important a member would be available thro tele or video confernce preferably the later.
97. It is better to interact in person, but this is not practicable given the pressures everyone faces, not least in parking
98. It generally works well and saves travelling time
99. it can run the risk of undermining team cohesion but it does facilitate discussion that would otherwise not occur
100. it allows us to fulfil a target by attending a very poor meeting
101. It allows members at other Trust sites participate in the MDT especially when they can not attend phyisically. It alos facilities enriching the MDT with expert opinion from external non core members who are located
102. it allows communication - good
103. it allow attendance without travelling
104. It's always felt a bit distant. When your on the other end, you don't quite feel part of the meeting. Although can be useful for 'drop in' presentation of single cases from afar.
105. Irrelevant
106. invaluble due to local geography
107. Interrupts flow of discussions Maintains contact with peripheral specialists
108. Interactive discussions are slower
109. Interaction/discussion with other MDT members is hampered by geographical separation despite video link.
110. informative only positive
111. Inefficient. No substitute for live discussion
112. increase difference opinions
113. In this institution, since all the breast oncology work is generated at one site, we do not use teleconferencing although other disciplines do.It is inclusive when several centres are involved and reduces wasteful travel time during core hours.
114. In my region it is generally regarded as a waste of time due to inter-hospital rivalries/ill feeling
115. Improves the attendance of members esp clinical and medical oncologists who may be in different hospitals
116. improved attendance, remote members ?less involved
117. impersonal, information loss, hinders discussion
118. impersonal meeting
119. if someone can't get to a meeting they are unlikely to attend teleconferening. It is only usefulif the MDT is across aregion rather than within a sinle institution
120. If it is working then it does allow people to attend more easily, if it is not working properly it is a nightmare.
121. Ideally the majprity of members hould be in the room and only the occasional member linked by VC if too much traffic over the ether the team spirit is lost
122. I have no experience of teleconferencing
123. I have never experienced it
124. I expected to be able to log on for the whole MDT but can only do so for my patients which reduces the learning opportunity
125. I do not think video conferencing is appropriate
126. I do not believe it is good enough to be an adequate substitute for personal attendance.
127. I am unsure of benefits of video conferencing in every situation. There might be some situations where it is required such as physical location of team members is not within single hospital.
128. I am not a fan of teleconfrencing
129. hopefully positive but we are told number of dial ins will be limited
130. good when works. irritating as hell when fails (often)

131. good if it works
132. Good if it works - potentially disastrous when it breaks down
133. good
134. generally premits access to all members of MDT
135. excellent
136. essential for regioal MDTs
137. Essential (5 sites)
138. ensures increased input from outlying unit
139. ensures attendance reduces quality of communication
140. enables more to "attend" slows/disrupts interactions between members
141. enables more members from different locations to join in the decision making process.
142. Enables meaningful discussion between colleagues on different sites
143. Enables all clinicians in widely dispersed geographical areas to be involved.
144. Dont us it. My experience is that is largely negative and distracting
145. DONT DO THEM
146. Don't use it
147. Discourages attendance by oncologists who are a core part of the team. Technology is poor at the best of times and uses up valuable time trying to link up. Not as good as face to face working and discussion.
148. dictatorial management from chair or core no discussion of case
149. detracts significantly
150. Depends of individuals between centres know each other, if they do, saves travel time
151. decreases the involvement of participants
152. Contact with radiotherapist
153. can disrupt timing of meeting and case grouping
154. Can cause delay when technology fails, which is often.
155. can be helpful but not as good as physically there
156. can be distracting; unable to comment on clinical images or slides projected elsewhere
157. being interactive, we see the person speaking and air your views as well
158. Attendance
159. At least we can see each other and interact
160. AS WE HAVE ALWAYS DONE THIS TELEPHONE CONFERENCING WITH TWO TV SCREENS WE ARE USED TO IT, IT WORKS EXTREMELY WELL, PRODUCES A BIGGER GROUP FOR GYNAE CANCER AS DIFFERENT HOSPITALS DO DIFFERENT AREAS OF GYNAE CANCER AND WE ARE GREAT SUPPORTERS OF THE SYSTEM. WE HARE HAPPY WITH THE TECHNOLOGY WE HAVE GOT. THE POTENTIAL WEAK LINK AT ONE END OF OURS IS STAFFING AND ORGANISATION THOUGH FORTUNATELY NOT MY HOSPITAL.
161. As we are a common tumour group all our essential memebrs are present in the hospital. Teleconferancing would not help us, time for people to attend would. Just declaring time proteched does not make it so.
162. Allows units to participate Stops units from participating in the whole of the meeting - just their patients
163. Allows people who should be at the meeting to join - only effective for very limited sub-specialist MDTs with separate contributors
164. allows outside teams to join but also means they feel they dont have to attend
165. Allows only one screen to be available, pixelated transmitted images, noy suitable for detailed review.
166. Allows networking for an MDt covering a large geographical area
167. Allows geographically separate specialists to discuss cases. Not as effective as being in the same room.
168. Allows attendance over wide geographical area Poor chairing/setup defeats object

169. All decisions recorded in patient electronic notes for the hospital and not limited to a specialised database
170. Absolutely essential between different hospitals and unit/centres particularly with large geographic area.
171. +ve - able to have core members present - ve - no 'face to face' contact with some members of MDT

What additional technology do you think could enhance MDT effectiveness?

116 surgeons responded to this question.

1. wireless access for laptops
2. Whatever allows easy access to investigation results is good. Whatever encourages people not to attend in person is bad
3. We need to be able to record decisions and project in real-time
4. Videoconferencing needs to be state of the art. I need to be able to hear clearly, see and identify who is presenting in the rooms and above all receive high quality images of CT scans etc.
5. Video/tele link to Trials Co-ordinators who are not always available. Reliable connections so diagnostics etc can be viewed from Centre and Unit sites.
6. Use of apprpriate link up
7. unsure.
8. unified database across all hospitals in anetwork
9. Two way sharing of all information
10. Trans-portation !
11. The use of newer technologies such as decision support systems could be very helpful in achieving many of the objectives mentioned before.
12. The technology we use is poor and images especially pathology are usually poor quality. I would support videoconferencing and when this is so readily available even on standard pcs I find it difficult to believe that we are unable to get this to work effectively
13. The pathologist could make digital pictures of the relevant images and project them at the meeting rather than trawl through lots of inkblotted slides
14. the above but faster and better images
15. the ability to load and view imaging sent from referring units. Encrypted discs are anonymised as is the encryption code making matching difficult or impossible.Therefore imaging not present or delayed!
16. Tape recording of discussions.
17. Secure web based connectivity.
18. Reliable technology, that doesn't keep crashing, and different hospital PACS systems being compatible.
19. Reliability
20. Regularly updated computers
21. really effective bomb-proof video-conferenceing
22. Real time projection of decisions. and effective data collection by TRAINED personnel.
23. Real time database
24. real time database
25. Real time data recording and projection
26. Real time data collection.
27. Real-time recording of discussion and decisions to an accessible data base
28. Quality information systems / databases for recording all relevant information and allowing analysis of outcomes.
29. Projection of stored pathology slide images
30. Projection of operative imaging, either video or stills, from theatre. This allows all

clinicians to gain insight into the anatomical boundaries of the tumours and other vital structures. We use this on an adhoc basis but it is becoming more popular. This concept could extend to the pathologits initial cutting up procedure.

31. Projection of case summary
32. prjection of case details on screen
33. Previous screening mammograms should be available.
34. Please see my first written entry & comments in this questionnaire
35. Perhaps one screen for the imaging/radiology, and one for the members. But what seems to be a big problem is getting the hardware to work
36. on line facilities for data collection
37. on line databace which we hope to aquire with the somerset system in the very near future. digital mammography so we can project images. a business case is in progress
38. not sure
39. None yet that I can think of!
40. None just get what is already there to work!
41. NONE AT THE MOMENT
42. None
43. None
44. none
45. none
46. no comment
47. Nil
48. nil
49. Network wide access to PACS, pathology and online cancer registers.
50. Needs support as technical breakdowns occur
51. N/A
52. Multiscreen viewing
53. Multiple screns to visualise Xrays, path etc simultaneously
54. most of your aspirational stuff mentioned above
55. more bandwidth
56. Microphones to allow all to be heard.
57. MDT data base
58. live entry of info onto database
59. Just make what we have got work, lets nor descend into fantasy that IT is some form of miracle cure all
60. Joining up of all NHS databasesand making them MS Windows compatible
61. IT support,treatment decisions to cancer regsitry data abse in real time. Deaths and recurrences to be snet ot cancer registries in real time treatment decisions to primary and tertiary care in real time to generate approraite clinic and treatment slots
62. IT support
63. In corporation of patient ASA status and relevant medical history at time of MDT and SMDT meeting
64. improved sound and picture quality
65. If you dont have a working clinical info system with all patient records including all letters you will be in the dark ages and are seriously behind the times.
66. If all core staff could access a computer connected to the intranet in the MDT it would help. This would mean multiple workstations but it would be very useful
67. higher level video conf facilities PACS in different hospitals that talk to each other - we have to send images on CD at present
68. Hi Def
69. Good real time IT and access to good quality refreshments as opposed to standard NHS quality
70. Good data recording, softward and compatability between involved hospitals.
71. Get the IT to link promptly - too many delays and holdups at present
72. Fully functionong radioligy projection accross sites / mutli function imaging

73. Full video link as interactive webcast
74. for me teleconferencing would be good. but we the timing of the MDT in another place almost always interferes with clinical work. therefore it is possible to attend even by video conferenc eing
75. faster access to all datasets
76. Facilities to project case summary, xray and pathology simultaneously. Recording decisions live which all members can see
77. excellent
78. enough time
79. electronic tranfer of high quality images prior to MDT
80. Electronic recording of each patient into a clinical database
81. Electronic recording of decisions after discussion.
82. Electronic projection of database details
83. Electronic patients records
84. Electronic MDT software.
85. Electronic collection of data in real time
86. effective assessment and consideration at the meeting of co-morbidity and patient choice
87. Easy phone access to the lab for results
88. Digital imaging of lesions
89. Dedicated MDTM management and data recording software system
90. Data sharing between hospitals i.e ability to access radiology & pathology images without the need to physically transfer between hospitals
91. Comprehensive EPRs
92. coffee making facilities!!
93. coffee machine!
94. Clinical photographic database and access
95. cakes and coffee
96. Better/ faster links
97. Better visual images at remote teleconferencing sites. Internet ISDN based secure access to radiology and pathology images even at remote sites
98. Better visual display
99. Better microphone. Better projection and getting to know the other team a little better.
100. Better job planning
101. better connection for teleconferencing
102. Automatic filling of data fields from reporting systems
103. anyone should be able to join from their phones or office PC is cant physically get there
104. an IT man to run it
105. An electronic patient record for there cnacer site would be very helpful.
106. All scans,pathology etc available to view via one computer with one technician
107. aim to have PACS imaging reports/path images, present and retrospectibve and data field inputting with decisions real time and I would be happy!
108. Adjustable lights and sound equipment in the room
109. Access to PACS
110. access to hospital letter archive, and pathology archive, so latest correspondence and results can be accessed if not yet filed in records.
111. Access based collection of data to avoid duplicating work & to populate fields for reports
112. ABILITY TO SHOW DIGITAL PHOTOS; PACS CONNECTED TO PROJECTION EQUIPMENT
113. ability to project decision
114. Ability to access MDT decisions electronically for hospital doctors and GPs.
115. a person controlling a central monitor with tabs for Clinic letters, Blood results, Microbiology, Radiology. pathology, previous MDT consensus and present discussion

116. a coordinator who recorded decisions / made sure that they happened

Meeting organisation and logistics

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

211 surgeons responded to this question. In addition 4 surgeons referred to the previous multiple choice question (Q13) stating “as above” or “as Q13”.

1. we have real time fully computerised records and PACS therfore happens in the meeting
2. usually review of clinical information, uploading of images and retrieval of histology
3. underxtanding case, being able to answer questions etc
4. Understaqnding what are the questions to be asked of the MDT, who need to answewr them and to achieve an answer
5. There is no recognition in job plan of the time spent in MDT
6. the preparation required depends on the individuals role. Pathologists, radiologists will spend significantly more time than most of the clinicians who have met and know the patients whose role is often setting the system up and then acting on the group decisions
7. The person presenting each case needs to know (have seen) the patient and their records. The pathologist and radiologist has to have reviewed the slides / films
8. the MDT coordinator makes all the arrangementrs
9. The imaging and Histopath needs to be prepared and all medical notes available
10. The chairperson at least should have access to the notes prior to the meeting and have protected job planned time to summarise the case prior to the meeting. there should be similar time after the meeting to complete paperwork and to complete outcomes and communicate these to the appropriate teams/clinicians
11. surgeons need to be familiar with case histories, pathologists & radiologists benefit from seeing specimens/images before
12. Summary of clinical case, collection of results of investigations, relevant specialists aware of results needing to be discussed
13. Summarising and collecting all patient details and results, for an effective MDT meeting
14. Some patients attributed to my name are unknown to me. I need to know about the patient to be able to discuss them.
15. See above: clinicians need to be familiar with their cases to be discussed. All appropriate clinical information (summary and case notes), pathology and radiology should be organised and available in order of case discussion. Technology especially video links need to be functional. The tea and coffee should come on time!
16. Scan list and take docs of my own patients
17. Reviwe and update oneself on every pts details and stage and current plan of treatment. Ensure your contributions will be upto date and relevant. REview radiology, histopathology results.
18. review the submitted cases and check information to be discussed is available
19. Review that all data is there, and assess availability of clinic appointments and operating sessions in proportion to staff availability. Junior staff availability fluctuates a lot week by week and this affects capacity in clinic. Patients with cancer need to spend more time with the consultant
20. Review of the reason for discussion, rather than individuals using the mdt for reviewing imaging/pathology with the radiologist/pathologist which could easily have been done on a one to one.
21. Review of notes to allow preparation of summary to present to other members

22. Review of notes of cases to be discussed and especially the results of investigations not yet seen.
23. Review of imaging and histology. Knowledge of individual pateins case
24. review of clinical presentation, patients co-morbidity, medication, clinical exam findings, test results. formulating a picture on the whole patient not only the cancer. establishing which area we need more information to inform treatemnt dicission
25. Review of clinical detials and review of histology and radiology to be presented.
26. Review of cases
27. Review of case notes, imaging and histology
28. Review of case notes by treating clinician as he is patient's reprenstative. The downside of MDT process in patient is not involved and therefore, it is responsibilty of treating clinician to convey his patient's views to MDT members{ It does not happen all the time}
29. review of case notes and informal discussion with other members informally in some cases
30. Review of case and investigations. Confirmation of clinicians involved and those needed to be informed
31. Review of available results and recent letters
32. review of all relevant notes and results of investigations understanding of patient's views and concerns
33. Review notes personally and summarise findings
34. Review notes
35. Review last week's minutes. Review minutes of PTC tumour panels x 2. Review all contacts in the week. Update on chemotherapy
36. Review history to present in concise fashion, perparation of radiology and pathology findings
37. Review case notes and clinical information.
38. review and summarise all clinical info relavant and treatment already give, co morbid conditions
39. Reveiew of case notes. Recent investigations. Important points to covered in the discussion
40. relevant path and radiology available
41. reading notes and revirewing results and investigations
42. read notes. Think about the cases
43. Radiololists and pathologist must have adequate time in their job plan to prepare for MDT
44. Radiology assessment of cases Collation of results.
45. Radiology and pathology. The MDT should not degenerate into a radiology reporting session.
46. radiology and histpatholgy review to facilitate sensible discussion. avoid "hot" reporting in meeting
47. radiology & histo path review
48. Radiological review of images, production of discussion list and collation of results/notes
49. radilogy & pathology review
50. Proforma acurately filled in by consultant so information is concise and complete
51. Prior knowledge of the issues to be discussed at the meeting with access to pathology and radiology results.
52. Prior knowledge of histology, past history if any and all relevent investigations before the meeting
53. preparing the patient list and making sure the notes, reports, scans are available for decision making.
54. Prepare case presentation. Read up if difficult case. Literature search if needed.
55. Preparation of summaries Collation of results Tracing results, investigations and notes data input
56. Perusal personally of case notes. Choice of cases and a way of identifying those cases that are ready for discussion (dependent on pathology and radiology

services)

57. patient notes present, details of ongoing treatment, and review of histology
58. Patient list, Notes, Pathology slides, Xrays
59. Patient histories, scan assessments
60. Pathology review.case notes and investigations to be made available
61. Pathology and Imaging preparation most important
62. Pathologists and radiologists need to have reviewed material before the meeting
63. Overview of patients clinical situation and reason for inclusion on MDT list. Accuracy of MDT list / clinical isssues
64. notes, with upto date clinic letters typed up, all imaging and pathology available for review
65. Notes, pathology, radiology and other relevant details to be available.
66. Notes review, results, summary preparation
67. Notes collection, summary of case. availability of radiology and pathology reports, films and slides. Any relevant correspondance
68. Notes and investigations got together. propwer list generated, missing results chased up. All necessary path and radiology reported.
69. Notes and imaging collation. Clinician should review these and have problems ready to hand
70. note gathering
71. None
72. No preparation required if co-ordinator has prepared patient data
73. Need to know the case so as to summarise and also raise specific problems if any. The relevant test results and necessary pathology slides and radiology images should be available
74. Most of the preparation is done by the MDT co-ordinator in the form of organising the lists, collecting notes, scnas etc. The radiologist might look at the scans a day or so before and report on them which might take up some significant time. Most of the work for the surgical MDT lead comes after the MDT - in sorting out the patients appropriately, fitting them into theatre lists etc. especially as theatre lists do not follow the extra workload that the MDT generates.
75. Most of the preparation comes from the CNS and Coordinator in bringing together notes and results. The radiologists are very good at spending significant time reviewing the films prior to the meeting and the same is true of pathologists. As a clinician I know the case history of my patients and know the important decisions which need to be made regarding patient care - little specific pre meeting preparation is required on my part as most is done when I see the patient.
76. More relevant for pathology and radiology
77. MDM coordinator to clate info notes results films etc and distribute list. No prep for attendees attendance and contribution to discussion at meeting
78. mainly MDT co-ordinatorwork to get together names, relevant staging- making sure info is availablke for meeting essential.. radiologist does largest preparation in reviewing cases prior to meeting.
79. mainly admonaistative, identifing patients and obtaining records. much by patholgy in obtaining images for display. we have done quite a lot of work in organising a system that is then reliable and cuts down on time needed to prepare each individual mdt.
80. mainly administrative, making sure records and results are available
81. Mainly admin in terms of ensuring that patients are not repeatedly discussed for no good reason.
82. Main preparation is for radiologists and pathologists. When we have an electronic systtem at that point we will change practice to summarise cases. At present our coordinators have enough problems getting the notes without further calls on the notes.
83. Looking through the notes, preparing case summary for the meeting
84. List of patients, their relevant data such as histology and x-ray reports
85. List of patients to be discussed needs to be circulated. Notes need to be available.
86. List of cases prepared and circulated Up to date imaging and pathology

87. Lead for sub-specialty needs to have details (min dataset) for each case to be discussed
88. largely work by the co-ordinator to have everything ready. Radiologists and histopathologists need to have images/specimens to review prior to meeting
89. Knowledge of the patients, availability of all relevant info and making sure that all patients who need it are reviewed.
90. knowledge of the cases including clinical status of the patient results and interpretations. A good team spirit to allow debate
91. Knowledge of the case history and "other" factors that can influence the treatment decision such as co-morbidity etc. The problem with the MDT's that I have attended (4 MDT's in 2 regions as a Consultant) is that there is no pre or post MDT time scheduled in our job plans. In my view this weakens the functioning of the MDT's
92. Knowledge of patients to be discussed and relevant results of investigations and pathology
93. Know your patients and the questions you need answering. Ensure pathology and radiology have lists to review cases and films and that all necessary information is ready. Ensure all necessary patients discussed and that you will be there
94. It varies for different members depending on their role at the meeting. The MDT coordinator and facilitator/chairman do most of the preparation so the cases can be presented adequately and quickly
95. It is important for the pathologist and radiologist to review the slides and x-rays. The nurse specialist and surgeons are affected by those rather than an extensive discussion of the history of the patient. We have found that unless the patient is present or only jist seem some decisions must remain open until it has been discussed with the patient. Review of the x-rays and pathology does lead to changes in reports and so is very important and cannot be done within the confines of the time of the meeting itself.
96. Inclusion into the weekly MDT lists is from several sources : the imaging department (screening and symptomatic image guided biopsies), the wards (post operative results discussion) the surgeons (clinical needle cores and complex clinical problems) the breast care nurses (metastatic screening investigations, etc) oncologists (patients receiving neoadjuvant therapies as well as those who develop problems while on therapy)and occasionally other disciplines who make incidental diagnoses of breast cancer. Once the patient details and reasons for discussion are passed on to the MDT co ordinator, he/she makes the necessary preparations.
97. In complex cases perhaps some preparation may be needed, simply to summarize the case notes
98. imaging reviewed, notes pathology and relevant images available, information uploaded onto system to ensure all in mDT can see clicnial summery and images
99. Identification of cases (me, clinical secretaries + MDT Co-ordinator) Typing/circulating list of cases + Collecting and delivering case notes for meeting (MDT co-ordinator) Collecting and delivering X-rays/copy reports and Histology slides/copy reports for meeting (Path lab and X-ray clerical and technical Staff) Booking meeting room, basic IT support (including visual display systems and videoconferencing set-up), catering arrangements (MDT co-ordinator) Provision for data recording using MDT report forms etc. during and after meeting (MDT co-ordinator and dataclerk)
100. ideally the incharge clinician should review case notes, histology and imaging before presenting the case 10 min per patient
101. I have said none [*no time spent preparing for MDMs*] but in fact my whole job, and interaction with the patient, prior to the meeting is in fact a form of preparation for it?!
102. I go through my pt notes.
103. I am the MDT chair. I look through all notes beforehand (on average,38 to 48 patients are presented weekly). This facilitates the smooth running of the MDT.
104. I am the Chairman! So I go through everythiong in detail with the clerk-coordinator the day before. We chase after any "missing" results. (There is also a debrief meeting with her next day to clear up "loose oncologicts, pathologists and

radiologists have adequate notice of the cases to be discussed. We do NOT have the case notes: they are not necessary. We have an elaborate data retrieval system to get round this.

105. How to present cass Review of radiology
106. Histology and Imaging review and ensuring all data that can be entered proir to the MDT has been added
107. good knowledge of the case histories and patient's choice, in order to provide a good summary upon which to base sound clinical decisions
108. good and informative relavant clinical data specfic question/s on each patient that need answers and as per my answers to Q13 above
109. get all patient information available for mdt
110. Full review of all relevant clinical information, imaging and pathology
111. Full review and access to all relevant information
112. Full information on symptom history, results of investigations/previous treatments, comorbidities and circumstances
113. full history ,clinical notes , all available tests images etc need to accessed
114. Full case summary. Results of tests. Knowledge about patients health and comorbidity
115. For effeceive presentatin the presenter ofr each case 9Particularly a new c ase) should present a history and findings as if on a ward round. He/She should eb familiar with imaging and pathology results. He/She should have specific questions that he/she wants answered.
116. Fimiliarise with the patients to be discussed, review their results and management plans
117. ensuring that notes, images and histologies are available
118. Ensuring patients that need to be discussed are put on list
119. ensuring cases notes are seen and person to present them present at meeting
120. Ensuring availability of all investigations and patients records.
121. ensuring all the appropriate patients will be discussed and that the details of their case are avaialable
122. ensuring all available information is available
123. Ensure that notes, imaging and histology are all available and relevant.
124. Ensure that appropraite patient information is given to the co-ordinator for the pateinets to be discussed
125. ensure all records / Xrays available
126. effective note/imaging pulling, histology result collection and clear history for each patient is required
127. Effective list production for meeting with full note retrieval. X rays and histology to be reviewed before meeting.
128. Effective collation of all information, summaries prepared prior to meeting to allow discussion of clinical situation rather than basic data gathering
129. dissemination of information, perusal of same
130. Different for different team members. Radiologists should have a look at all images before hand and pathology should look at their slides. Each clinician may only "own 6 or so patients per meeting and should be familiar with that case and be prepared to present it, or to ensure that someone who knows the issues is present to do so. The MDT coordinators and data managers may well need a full day to prepare. The work of an MDT for the clinician is after the meeting, setting up appointments, wroting to patients Gp's etc to communicate decisions and arrange decision to trrat conversations in a timely but senstitive manner
131. Depends of membership, but collation of records is important
132. depends whom: eg radiologists need time, as doCNS and coordinator.
133. Coordinator to ensure that complete information is available
134. Coordination of patient records, test results and ensuring the core members will be represented
135. confirmation that the right question is being asked by the right person in the right way
136. Completion of staging forms, finding the relevant results in notes that often in a

mess and preparation of the patient (expectations etc.)

137. Compile list, ensure imaging, path from distant sites available, ensure summaries in place. Circulate list and ensure attendance
138. collection of allclinical details and test results
139. collect all pt info and scans, radiology review of images, path review of histology, data collection
140. collation of information
141. collation of all relevant info - imaging, path reports etc in timely fashion
142. Collation of all individual patient information (clinical; histology) with details circulated
143. collation and proper filling of the data required for presentation of cases, go through the list of cases for discussion so that you are prepared to offer advice
144. collating of results obtaining notes ensuring pt listed fro MDT discussion after surgery minful of availability of pathologist
145. collate all pathology and radiology correctly
146. Colection of notes, images, slides Review of notes by clinician presenting case
147. CO-ORDINATOR PREPARES CASE HISTORY, LISTS OF INVETIGATIONS AND TREATMEN. INFORMS RADIOLOGISTS TO BRING SCANS. MARKS NOTES WITH COLOUR MARKERS SO APPROPRIATE INFORMATION IS EASILY AVAILABLE. CO-ORDINATOR HARASSES CONSULTANT MEMBERS TO MAKES SURE THEY TURN UP. SHE MAKES OUR MDT'S WORK LIKE CLOCKWORK. WE HAVE GOOD RECORDS ESPECIALLY AS OUR MDT IS PERFORMED VIA TELE LINK WITH ANOTHER HOSPITAL WITHOUT HER IT WOULD BE CHAOS. HER PREPARATION TIMES RUNS INTO HOURS
148. Co-ordinator needs to make sure all information in our system (JCIS) and notes available. Then needs to highlight why we are discussing the patient so the relevant people can check scans etc.
149. Co-ordination
150. Clinicians to know the patient histories, images and path reviewed
151. clinician preparing short summary of case Radiologist reviewing all images Pathologist reviewing all pathology
152. Clinician needs to know patient or have as much information about patient as possible about patient in writing and absolutely essential to have imaging
153. Clinical summary with salient facts,check imaging,histology and responsible clinicians available
154. clinical review of pathology and radiology investigations. plus casenotes
155. Clinical history, cancer staging and comorbidities need to be reviewed and the problem for discussion formulated
156. clinical details, uptodate results and problem/issue raised.
157. clinical data, images, story of patient
158. Clinical and investigations review some times litterature review
159. Clerical Radiology Pathology
160. Clearly defined roles and dedicated team with planned time for organisational roles
161. clear info on what steps taken already and results of tests done, info on co-morbidity, info on where on 62 day pathway patient is currently
162. checking the list and apprising self of details
163. checking notes and results are available
164. Check the list and make sure know about new and old patients in details.
165. Chairing a meeting requires a review of the cases prior to meeting allowing some thought to be given rather than coming cold to the case
166. chair to run through all details of patients with coordinator. presenter ensure all info is available
167. Case summary, central review of biopsies/histopathology and radiology. Referring clinicain must decide what question he/she wants MDT to answer
168. Case summary to be written. Investigations to be sorted. Issues to be discussed clarified. Ensuring that the relevant specialist dealing the particular case are present and if not who ever is deputising or coverin be detailed and briefed before

about the case and issues before the meeting so that appopriate preparation can be made. Relevant information about patient personal circumstances be collected and made available

169. Case summary needs to be produced including identfying appropriate radiology and histopathology which should be reviewed in advanced and then presented.
170. Case summary indication for discussion Needs co-ordinator
171. case summary and the presence of a member who has counselled the patient
172. Case summary clear questionnairs regarding management availablity of records availability of pathology and radiology
173. case summaries, path and radiology prepn
174. Case summaries, all images must be available in a convieniant format
175. case summaries and images complete. The meeting should be able to allow time for any discussion/futher consideration
176. Case summaries Find relevant old films, slides etc
177. Case presentation requires good preparation and is ideal for SHO'S, Registrars training and education.
178. Case notes, latest blood tests and details of patient's next appointments should all be available
179. case note review exclude benign cases
180. case note review
181. Brief assessment of the salient points of the case
182. Be familiar with clinical history, comorbidities and investigations to date. As well as any previous discussion about patients choices.
183. Aware of the case and the availability of results. Points to clarify at the MDT
184. availability all scans & histology
185. Assuring the relevant imaging and histopathology available
186. Assessment of Xrays and histology Summary of patients detail but not full info if available to meeting on electronic record
187. Assessment and summary of clinical history. Pre assessment of histology and imaging. Prioritisation of cases
188. As Unit lead I need to familiarise myself with details of relevant paients and ensure that necessary information available for MDT
189. As a surgeon I think it is the job of the MDT co-orduinator to get all the informaion, summaries etc, this is not part of my job. I go and discuss the clinical aspects and then follow them through. MDTs slow down decision processes and limit 'patient choice', whaever that means in cancer services
190. As a minimum, the notes need to be gathered and a list of patients to be discussed needs to be circulated.
191. areview of cases to be discussed
192. All relevant patients need to be identified. All notes, xrays and slides retrieved. Lists should be generated in an orderly fashion for e.g new patients and post op patients should be grouped togther to facilitate a streamlined meeting.
193. All notes, imaging and reports to be available. Prior radiology and histology review.
194. All notes and images and results to be present. Clinical preparation is in seeing the patient!!!
195. all investigations and patient details to be available with the clinician involved
196. All data available
197. All case notes/reports/images, past and present, should be available at the meeting.Information about patients to be discussed should be collated and summarised prior to the MDT meeting
198. all case notes must be reviewed by the presenting clinician pathologist must know the case radiologist should have seen the images
199. Admin prepartion of notes etc Radiology need to reviw scans etc Pathology need to review slides A clinician should prepare case histories
200. adequate patient information (notes/summaries) ensure relevant information available and given to relevant person (histology/radiology). Room available, technology working, list circulated. Questions to be answered made available for each patient

201. Accurate staging, imaging / histology to be discussed. Also generalised data such as performance status, renal function and significant co morbidities.
202. Accurate clinical, radiological and pathological information.
203. aCCURATE CASE HISTORY, RADIOLOGY REVIEW, IDEALLY A COVERING QUESTION ADDRESSED TO MDT. AN IDEA OF NUMBERS BEFORE HAND WOULD BE USEFUL
204. Access to patient details and notes
205. a) the presenter (usually diagnostitian or current clinician) needs to have obtained all relevant test results and prepared a coherent summary of the issues to allow a sensible and appropriate treatment planning decision b) the organiser and chair should ensure all necessary facilities are available and working and progress is made through each case in a timely effecient and equitable manner
206. a lot of preparation from nurse specialists and clerical staff. Case summaries, lists of patients to radiologists and pathologists. Most people need a lot of time to prepare but surgeons need to do v little
207. A list of patients to be discussed is very useful
208. A full ist of people to be discussed must be circulated with ample time for other preparations. The clinicians need to know their own patients but the histopatholgists and radiologists need to have seen all the patients' investigations.
209. A clear patient history and appropriate investigations. Appropriate review of literature for unusual/rare cases.
210. 30 to 60 min per mdt
211. 1) The radiologist needs to have time to review CT/MR/other scans 2) The pathologist needs to have time to review any slides for second opinion 3) The MDT coordinator needs to circulate the list together with the summaries allowing the clinicians time to look at Xrays and look at patient details 4)The moderator should have time to look through the cases 5) The notes need to be avialable. If referral from another hospital the standard form should have been audited and shown to provide all the info needed.

What makes an MDT meeting run effectively?

187 surgeons responded to this question. In addition 6 surgeons referred to their previous answers or stated 'as above', referring to Q16.

1. You need someone to lead and take charge - so that it flows. No waffling. Concise summarys. Be certain decisions are recorded before moving onto next pt.
2. What mentioned above already
3. Well led. Summarised after each case. No bullies
4. We often have to discuss more than 35 cases and this can be very hard going. Delays to the following week merely exacerbates the problem to the following week. The ideal is probably 16-25, but the reality is that we have to discuss more than double that number. There is no time elsewhere in the week and our meeting already lasts more than 2 hours and has lasted 3. Under present rules there is no way of reducing the numbers.
5. We do not have the ability to control numbers in the meeting - it varies between 30 and 55 cases - all need to be discussed as we do not have access to a second meeting in the week
6. venue, acoustics, organisation of notes and results, technology, relevant specialists
7. unihibited expression of openion
8. time, resources, preparation ,enthusiasm, a reliablealarm clock (8 AM start!!)
9. Time keeping, prior review of the patient's notes, imaging and histology
10. this group of questions are not helpful. Different specialists have different relevancies to sections of the MDT meetings and therefore attendance is not necessary for sections of the meeting to which their function is not relevant. Concentration span is such that meeting much over 90 minutes are less valuable but an absolute figure would be inappropriate to apply. the optimum number of cases also will vary widely on tumour type and the complexity of cases an MDT sees.
11. They are a waste of time
12. There should be a strong chair who limits discussion which does not contribute to the problem in hand.
13. Team working
14. Team work, availability of information
15. Team work and mutual respect
16. Succint presentations of history, investigation results and plans of treatment
17. Strong leadership from the Chair. Functioning technology sytems and an efficient co=ordinator
18. Strong leadership ans willing of partcipation by all core and none core member.
19. strong focused chairing
20. strong chair
21. Staying focussed and avoiding distracting discussions
22. Relevant cases given appropriate timing
23. ready accessibility of information, clear agenda, co-operative team, chairman, ownership of process by clinicians
24. Prompt start, good attendance and adequate preparation
25. prompt start, effectiveness of chair
26. Prioritisation is desirable but should not result in a subset of patients being deemed as being'not important' either covertly or by implication. If they need to be discussed at the MDt , then they deserve the full and undivided attention of the group. Making exceptions based on presumptions will lead to mistakes , delays and inefficiencies which defeats the purpose of the MDT
27. Presentation of data, good timekeeping and avoidance of airing individual political agendas
28. presence of all key members. Cases has been reviewd before hand. All relavant information available

29. prepration, commitment of members to engage and strong chairman with organised co-ordinator
30. Preplanning, all data and summary ready and presented by relevant clinician, effective chairmanship of discussion, decision making that is clear and definite, making progress withinn an agreed timeframe
31. preperation, team working, adequate break if very long meeting
32. Preperation before the meeting by all those who will contribute and firm chairing to ensure the discussion remains focused. Plus speedy communication of the MDTs decisions
33. preparedness of members, completeness of relevant information and results and focused discussion avoiding unnecessary digressions.
34. Preparation.
35. preparation,planning and team work
36. Preparation, team commitment, planning
37. Preparation, punctuality and brevity. Good leadership - supress the bullshit and encourage constuctive dialogue.
38. Preparation, presence of key members
39. Preparation, available documentation and radiology.
40. Preparation, all necessary players present, chaired efficiently, all necessary data available. Good clerking
41. Preparation before the meeting and availability of clinical, pathological and radiological results to enable appropriate management decisions.
42. preparation and time
43. Preparation and leadership(chair)
44. Preparation and avoiding repetitive discussions
45. preparation chairmanship cull case dsicussions on obvious management decisions
46. preparation and time
47. Preparation
48. pre meeting preparation
49. Please let us know when you find out
50. organistaion
51. Organisation, results all available and imaging visible/retrievable. No interruptions.
52. organisation, leadership
53. Organisation, cooperation, team working
54. Organisation, clear identification of who is responsible for each of the defined tasks,regular reassessement to improve the meeting.
55. organisation and preparation
56. organisation and participation of all members
57. organisation and control
58. organisation & preparation
59. On-line live data entry
60. no views
61. no disruptions (eg people popping in and out to phone)
62. meticulous preparation and the presence of results, notes and treating professional
63. Manageable number of cases per list for optimal discussions. MDT co-ordinators should worh in harmony with chait, medical secretaries, CNSand supportive staff. Positive feedback to reward effeciency.
64. maintaining focus on the purpose of the meeting
65. List prepared and circulated Results available Members on time. Strong leadership
66. limiting unecessary discussons and ancedote telling!
67. leadership and commitment to making it work
68. leadership planning (admin support) preparation (radiology, pathology etc)
69. Keeping to the point in question. Consistency of decision-making
70. Information being available and no defined end point.

71. Information and participation
72. Having the records, imaging and pathology and clinicians to present these. Better videoconferencing equipment.
73. Having the data available and the time to give each case the appropriate amount of time
74. Having notes , pathology specimens and imaging to review
75. Having enough time to discuss cases
76. Having electronic records and an effective MDT co-ordinator
77. Having all the right information and people in the right place at the right time
78. Having all the notes, properly functioning IT
79. Having all the information to hand. In my view this includes having a presentation of the clinical case which contains all the relevant information. So often, we have histology results and imaging, but without the case history this is difficult to put into context.
80. Having all the information available on each patient. Presence of the normal MDT co-ordinator rather than a stand-in.
81. Having all the data neccessary for decision making
82. have all relevant information and documents to hand, and all necessary specialties represented (imaging, onco etc)
83. Good time keeping Good pre meeting preparation Multi disciplinary discussion
84. good technology and motivaed co-ordinator who has power to make the meeting happens and ensures discipline between participants.
85. good team spirit, clear quick decision making
86. Good summarisation of cases and where 3 words can be used don't use 300
87. good preperation and leadership
88. Good preparation; availability of case records; proepr functioning of equipment (PACS and microscope)
89. Good preparation. Make sure all the notes and results of pathology and radiology are present so discussion can be maeningful
90. Good preparation, all info available
91. Good preparation and organisation Good timekeeping to limit discussion to (all)relevant issues
92. Good preparation and effective chairmanship.
93. Good preparation and clear leadership
94. good preparation
95. good organisation by the coordinator
96. Good organisation and scheduling to facilitate teleconference links
97. good organisation and availability of all data
98. Good organisation ,well presented notes and documentation
99. good managemnt - team participation, open mind
100. Good leadership, team working and organisation
101. good leadership, focus, people there for the whole meeting, espec start time
102. Good leadership
103. good data; good chair
104. Good coordination. Willingness to discuss. Careful preparation and willingness to act on recommendations
105. Good coordination and effective use of technologies for displaying images and data
106. Good communication, data, presence of all core members & time keeping
107. Good communication and pre-agreed pathways
108. good communication
109. good communication
110. good co-ordination
111. Good chairperson. Efficient preparation. Adequate and functioning technology. All members concentrating on the patient under discussion.
112. GOOD CHAIRMANSHIP; ALL INFO NEEDED FOR DECISION PRESENT; IT WORKING

113. good chairmanship, dictation of outcome 'in public' for all to agree, time keeping but allow teaching
114. Good chairmanship and preparation by the co-ordinator
115. Good chairmanship Efficient access to technology (Scans, path, database etc)
116. good chairmanship
117. Good chairman. Succinct presentation. Clinical information to hand
118. good chairman and availability of accurate data
119. Good chairing. Exclusion of inappropriate cases. effective technology. Prompt attendance
120. good chairing. cutting the xxxx ,not allowing several converstaions at one time!
121. Good chair. Politeness, but informed debate. All info available
122. good chair, affability of members, everything being available, especially the technology working!
123. Good Chair or coordinator.
124. Good chair and time keeping
125. good chair and co ordinator.
126. Good chair Discussion length related to complexity Good Co-ordinator
127. Good chair
128. Good administration, all notes and investigations available at meeting
129. good admin. team working, regular attendance and mutual respect
130. forward planning, we start with the post op cases and move on to the pre op cases and leave complex cases to the end of the meeting, this works well in our unit, but all units need to communicate with all members to formulate the best plan.
131. Excellent organisation and availability of relevant specialist. Effective communication among members. Mutual respect for each other and views expressed even when they are different. Good working and personal relationship between core members.
132. everyone must feel able to contribute
133. everyone arriving on time - previous MDT meeting finishing on time - good PACS systems
134. Efficient time keeping Not allowing members to waffle Keep to the point and not use MDT meeting to decide drug and treament policy decisions
135. Efficient planning, good co-ordination, team members understanding their roles, conflict avoidance and keeping the patient's best interests without getting into personality differences
136. Efficient organisation and good chairmanship
137. Efficient coordinator and pre-meeting review of cases
138. Efficient clerical help Good radiology and IT
139. efficiency and preaparation
140. effective time management, clear minutes documented
141. Effective technology (videoconference and imaging), effective chairing and no background chatter. If a meeting is any more than 90 minutes there should be a break.
142. Effective preparation of agenda by coordinator, efficient Chair, efficient preparation of results
143. effective leadership, efficient presentation and availability of clinical information.
144. Effective leadership
145. Effective chairmanship
146. effective chairman and MDT co ordinator
147. effective chairing, good preparation, a committed team, humour(mine only)
148. effective chair, working technology
149. Discuss complex cases or where there is a discrepancy between the views of the pathologists or clinicians ie they need to look at each case before the meeting.
150. designated role for each mdt member full co-operation between members
151. Core members knowing about their patients and having relative info. Technology not breaking down. Remaining focused on the case and question to answer etc. Relevant breaks, not too many patients (less than 45)

152. Core members arrive on time details available IT systems working chairman keeps members to time
153. core member Cancer specialist Nurses active participation
154. Contribution is sometimes limited by all those present. The format is good as a learning and educational exercise. Some would say (and I don't) that there are better ways to spend two hours.
155. Consensus.
156. Concise summation with review of all relevamt radiology and pathology followed by a focussed discussion and a recommendation for treatment or follow-up.
157. Competence of all team members and resilient sense of humour.
158. communication and respect of other members
159. Co-ordination between chair and MDT facilitator
160. chairman as good coordinator of time for each case
161. chair. preparation. focus
162. Chair
163. chair
164. Availibililty ofo doetails for each case and strong leadership to get thru cases effectively
165. Available data, knowledge of patients.
166. Availabillity of core data and images
167. Availability of notes, good coordinator, as many members present as possible
168. Availability of notes and results. The presence of members.
169. Attendence of the relevant members in time and availability of the case notes and relevant test results, pathology slides and radiology images.
170. A good chair, available data, specific questions (and to whom addressed eg radiology/path) as well as timely feedback if satellite hospitals involved
171. Allowing sufficient time to discuss complex cases and moving on / curtailing discussion on straightforward cases.
172. Allow unit leads in gynae cancer to work to protocol, simply to audit outcome
173. All the information available, snappy presentation, good open inter-professional relationships.
174. All relevant information readily available. An organised MDT chair who facilitates more time on complex cases
175. All patient and treatment information being readily available
176. all of the ticked ones above
177. All members present. Good chairmanship.
178. all invests and clinical data including knowledge of general patinet fitness available
179. All emmbers there for the whole meeting. Focus. Needs effective chairing to stop breakout conversations
180. Adequte resource to make it efficient. This includes the pathologist having the results ready above all. It also needs resources for radiology. Otherwise cases are on and discussed without all the results and have to be put on again for the following week
181. Adequate secretarial / coordiantor, and IT support. Painstaking preparation by the chairman. Good attendance Chairmn allows all prersent, especially the non-doctors, the space to conrinbute. An orally dicated AGREED summary o each case. good post-meeting communication to patients, GP's, oncologists & others.
182. adequate pre-planning and good attendance
183. Accurate information about patients current condition and staging and ability to discuss patients with core members
184. a good coordinator and effective chairing to stop irrelevant digressions
185. A good chairman and efficient radiologist
186. A full complement of members
187. Chairman to prevent deviation from/repetition of discussion

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?

116 surgeons responded to this question.

1. within agreed protocols
2. Why do we need a "model"!!
3. we discuss ours at MDT
4. We are looking at how much extra work this would bring to the MDT
5. usually presentation of cases if represent with recurrence for info to team, also sometimes other palliative treatment or help with diagnostics is required
6. Use of protocols and discussion at joint clinics
7. Use of clinically effectice practice pathways eg Map of Medicine
8. Use of agreed protocols if possible
9. up to lead clinician to bring selceted cases
10. Treatment along previous agreed or National guidlines.
11. they shouls all be discussed.
12. They should be discussed. Oncologists need to integrate better with MDTs
13. They should be discussed or separate section of MDT
14. They should be discussed but in emergency relevant clinician can make management decisions
15. they should be discussed
16. they should be discussed
17. They should be brought to MDT as a separate agenda group- period, no other option should be allowed. These are often more difficult decisions than the new cases which demand 100% discussion
18. They should all be discussed at the MDT and the MDT suggestion of treatment then explained to the patient. However as in all cases the patient plays a very improtant role in the decision making process. In respecting the patient views treatment options other than proposed by the MDT may be followed.
19. They should (and are in our) be discussed in the mdt
20. THey should
21. the real Q is what difference does an MDT make to Rx decisions - if little - is it cost-effective (however educational it may be)
22. the oncologist I am lucky enough to work with will contact me directly if there is surgical input required or needing considered in such patients
23. Surgeon and oncologist should see the patient together or at least discuss between them
24. Standard protocol
25. Standard care of treatment
26. some time the decision is obvious and waiting untill an MDT delays care, boggs down the MDT in trivia abd limits time and entheusiasm for important discussions.
27. should not happen
28. should be discussed
29. should be and are brought to MDT for discussion
30. Should always be considered for discussion. We have certainly seen oncologists make decisions that were not discussed and did not have the support of the MDT if found out about!
31. Separate Oncology/Palliative care meeting
32. Protocol or sub-group decision
33. Protocol driven providing MDT aware a patient on a particular protocol.
34. Protocol based management of recurrence if protocol agreed by MDT
35. Protocol based according to current cancer management guidelines

36. protocl driven
37. preferaly all cases are discussed in MDT
38. Only if there is an existing care Plan or protocol
39. Ongoing decisions should be discussed via the MDT
40. oncology unit discussion with palliative care team
41. Oncology opinion
42. oncology discussion between consultants
43. Oncologist/palliative care team should be given an opportunity to report back to MDT
44. Oncologist/paliative care liaison. To come to MDT onl if problems with imaging or if surgery might be contemplated
45. oncologist reports back to MDT what he/she has done OR weekly meeting between onc and pall care to discuss such patients
46. Oncologist discuss with patient, GP, specialist nurse, palliative care.
47. Offer best treatment available and inform MDT retrospectively of decision
48. Nothing else appropriate.
49. Not all recurrent or progressive disease needs formal MDT discussion. However, management of progressive disease should have a guideline agreed by the MDT and that this is audited.
50. none unless previously agreed ther are no more treatment options for pt
51. None
52. None
53. Network agreed protocols/pathways for recurrent disease NICE recommendations Network agreed national guidelines
54. N/A
55. n/a
56. Must be discussed at MDT.
57. must be discussed
58. Most patients should be discussed but not all
59. mdt causes delay in treatments, be it palliative or therapeutic.
60. Letter or a standard template to inform theMDT of the treatment given
61. Knowledge about survival and QoL related to current palliative techniques derived from our own MDT pts.
62. Jointly oncologist & surgeons
63. Joint/parallel clinics withaccess to clinician oncologist and nurse specialist(s)
64. Joint out patients clinics or ad hoc clinical meetings.
65. Joint oncology / surgical clinics
66. Joint Clinics
67. It varies from cancer to cancer. For colorectal cancer the numbers are smallish. There must be dioscretion allowed all groups regarding which patients they bring back to MDT.
68. It shouldn't. Only viable alternative is discussion amongst relevant core members outside the MDT
69. Ist event recurrence all discussed progressive disease requiring multidisciplinary involvement
70. independant openion and counselling from surgeon , Nurse specialist and oncologist
71. If a set pathway or protocole exists there is no need to involve the MDT otherwise all change of treatment modality should come before the MDT
72. I think they should be discussed in the MDT (but if not protocols should be drawn up)
73. I think they should be discussed
74. I think it would help if they are all discussed to ensure the data is recorded appropriately at the very least
75. I don't know as we always discuss them.
76. Having Joint clinics with oncologist.
77. guidelines and protocols based on available evidence or consideration of

involvement in clinical trials

78. Formal care-pathways
79. For some eg prostate, progression may be simply treated 1st line with relatively non toxic means. If there is a protocol requiring interventional treatments eg cryotherapy to be discussed then this will help
80. For some combined clinic discussion between Surgeon and oncologist discussion in combined clinic may be all that is required particularly if the treatment is palliative chemo or radiotherapy
81. Experienced clinician based
82. Existing care pathways for the disease which have been ratified and agreed by NSSG
83. evidence based pathways
84. Each team for each tumour type should agree rules where individual clinicians can act on their own, but such decisions should be recorded and if needed reviewed at a later date
85. Don't know
86. Discussion/referral in combined clinics
87. Discussion between patient and the specialist looking after them.
88. Discussion between oncologist, patient, CNS as long as all images and pathology reviwed and verified in centre
89. Discuss at clinic
90. Direct discussion between responsible clinician and oncologist
91. Depends on complexity of the case - ease of confirmation of diagnosis and assessment of extent, site(s) affected, whether or not there is a clearly defined maagement plan for the specific problem or if there are several available options etc. This aspect does need to be individualised to the specific patient but there needs to be close team working with low threshold for all members for bringing those cases needing discussion to the MDT
92. Dedicated clinic for patients with recurrence. Oncolcogist and radiologist and could follow agreed MDT protocols for many situations
93. communication with mdt
94. communication between oncologist and appropriate other sepcilist
95. common sense and good inter professional relationships
96. Clinicians can institute reasonable and appropriate treatment or referrals (that is why there are consultants) but ratification should be sought at the MDT and other possible alternatives MAY be suggested for consideration
97. Clinical knowledge
98. clinical judgement by relevant professional
99. clear protocols
100. Bring decisions to MDT retrospectively
101. Best practice
102. Back to MDT
103. Attendance at MDT leads to education of oncologist who can discuss some cases but does not need to the discuss all
104. as above
105. Are discussed at MDT
106. all to be discussed
107. ALL should be discussed at MDT
108. all patients with significant change in their status - at diagnosis, post treatment or after failed treatment should by definition be discussed at theMDT
109. All patients should be discussed. Protocols & Guidelines should be in place
110. ALL CASES DISCUSSED MDT
111. Agreed protocols. This is particularly the case in prostate cancer patients. Bladder cancer is monitored differently and protocols are helpful here. Relapsed penile or testis cancer tend to be less surgical problems and mor radiology or histopathology but presenting the data in a formal setting has much to recomend it if a new intervention is possible.

112. Agreed guidelines
113. adherence to protocols
114. according to agreed protocol
115. A poor model that provides suboptimal care
116. ?

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

167 surgeons responded to this question.

1. Wrong decision taken due to incomplete information about a patient
2. When the MDT has not been appraised of the patients performance status and extent of co-morbidities
3. VERY VERY SELDOM HAPPENED. LACK OF DOCUMENTATION OF MDT DECISION
4. unrealised comorbidity and pt choice
5. Too many patient discussed when lead clinician is not present
6. This would require an audit
7. This should not happen. If so, the case should be brought back to MDT and clinician involved should give reasons why they cannot adhere to the MDT decision.
8. They're wrong as they have not met the patient
9. The responsible clinician none attendance at meeting
10. The patient is unfit / not suitable for the treatment recommended
11. The patient appears quite different to the naked eye than the mere data suggested at MDT. e.g. significant co-morbidity often colours treatment options when the patient is eyeballed.
12. The clinician not attended the MDT meeting, not aware of MDT decision and lack of MDT proforma in patient's note
13. The clinical situation may warrant change. |These parients records are brought back to the MDT(usually the next) to document the change and the reasons for the same.
14. Tertiary referrals are often discussed before seeing patient so they may be deemed suitable for resection but medically unfit for complex major surgery when seen.
15. Some data missing at the time of the meeting (usually comorbidity)
16. Revised histology and imaging reports.
17. recommendation may be wrong or not appropriate for the patient in question
18. rarely happens
19. Rapid change in clinical situation
20. pts choice
21. Pt's choice.
22. poor communication an uncertainty about a clear ladder of responsibility
23. poor communication
24. personnel openion of a clinician based on his life experience
25. patinet unfit for proposed idea treatmnent
26. Patients refusal to comply with advice
27. patients fitness, patients choice, clinical findings does not fit with test results
28. Patients don't accept them or new information comes to light
29. Patients choose not too follow recommendations. Further information becomes available after MDT which changes views.
30. patients choice, opting for another opinion or no treatment.
31. patients choice to take different treatment influenced by internet information and spouce

32. Patients choice and co=morbidities
33. Patients change, some members don't follow descisions
34. patients are often discussed who have come via pathways and no member of the MDT may have met them. Sometimes they are not suitable for surgery or do not want treatment when it is discussed with them
35. patients' choice
36. Patient wishes.
37. Patient wishes, fitness for treatment.
38. Patient wishes
39. patient view of treatment or additional info coming to light
40. Patient too ill or frail to permit surgical intervention. Deterioration in general condition.
41. Patient related factors that arise after the MDT - we then re-present them to update the MDT
42. Patient refuses to contemplate the preferred option.
43. Patient refusal of treatment Patient comorbidity so treatment can not be carried out
44. PATIENT REFUSAL
45. patient preferences
46. Patient preference.
47. patient or family may have a differing view
48. Patient not wanting MDT recommended treatment.
49. Patient not being present
50. Patient may not accept, circumstances may change, clinician may review decision after discussion with patient
51. Patient events making recommendations inappropriate
52. patient disagreement
53. Patient decision, performance status
54. Patient decision
55. patient compliance
56. Patient clinical condition precludes recommended treatment WHO performance status, or full clinical fitness is not available for all patients at the time of clinical discussion at MDT
57. Patient choice; change in patient's condition; change in staging
58. Patient choice. When reviewed patient not fit enough for the proposed procedure
59. Patient choice. Subsequent information about patient's clinical status alters treatment options.
60. patient choice. change in patient condition. new information becoming available.
61. Patient choice.
62. Patient choice.
63. patient choice,medical co morbidity,social circumsatndces
64. Patient choice, patient comorbity no appreciated at MDT
65. Patient choice, MDT failure to appreciate co-morbidities
66. Patient choice, clinician decides after further patient discussion
67. Patient choice or reassessment of comorbidity
68. patient choice or performance staus
69. patient choice or patient morbidity
70. Patient choice mainly
71. Patient choice and MDT does not have full awarenes of all patient related variables.
72. Patient choice and decisions being taken by MDT in the absence of the primary clinician
73. Patient choice and comorbidity
74. Patient choice and co-morbidty, see publications Wood et al, Blazeby et al and more recently repeat work shows 20% in UGI change (and delay treatment starting)

75. Patient choice Patient fitness
76. Patient choice
77. Patient choice
78. Patient choice
79. Patient choice
80. Patient choice
81. Patient choice
82. Patient choice
83. Patient choice
84. Patient choice
85. Patient choice
86. Patient choice
87. Patient choice
88. Patient choice
89. Patient choice
90. Patient choice
91. Patient choice
92. Patient choice
93. patient choice
94. patient choice
95. patient choice
96. patient choice
97. patient choice
98. patient choice
99. patient choice
100. patient choice
101. patient choice
102. patient choice
103. patient choice
104. patient changes mind
105. Patient and clinician decision depending upon co-morbidity.
106. Patient & family express alternative view
107. Patient's comorbidity not being known, or the tumour size in relation to breast size being different to as described
108. Patient's choice/ objection
109. Patient's choice or factors
110. Patient's choice
111. Other pathway already initiated
112. oncologist or surgeon changes treatment "on the day"
113. Once the patient was seen either the patient did not agree or was not suitable for the decision made.
114. Not sure
115. Not our remit in shared care unit
116. not being clear what patient's comorbidity is at the time of the meeting patient choice
117. Not all the relevant facts may have been available during mdt. Patient choices have not always been included.
118. new relevant information or patient prefernce
119. NB above guestimates
120. more details of the case discovered or the patient influencing the decision
121. MDT not aware of the patients condition and wishes.
122. MDT discussions have taken place in the absence of notes. When the patient attends outpatients with significant comorbidities, the recommendation could clearly be inappropriate
123. Many cases are given various options eg in curable prostate cancer the patients tumour may be suitable for surgery external beam radiotherapy brachytherapy or

active surveillance. This has to be discussed with the patient and the MDT meeting is not able to offer very narrow guidance.

124. managing clinician involvement. Patient decision
125. Main reason is patient's refusal for treatment
126. Lack of respect for MDT process???
127. Lack of involvement of core clinicians and inability to distribute the mdt recommendations effectively
128. Lack of full information about the patient at the time of MDT discussion
129. Lack of fitness or patients views
130. Lack of elevant facilities; patient choice or dispersal
131. It transpires either that the patient is too unfit, or they refuse what seems to us to be reasonable treatment
132. Inertia
133. Incorrect decisions being made in the abscence of the senior surgeon
134. incomplete information presented to MDT
135. Incomplete information available at first discussion.
136. Inadequate information-clinical or radiological
137. Important information on co-morbidity, etc not available at the meeting
138. I endeavour ensure that this does not happen <5% should read 0% clear decision pathway agreed before pt seen if not feasible telephone /on table discussion with fellow core member(s) which is the communicated back at the next MDT
139. hardly ever happens - if it does happen it is due to patient choice
140. furyther information became available at the time of counselling eg H/O dvt means pt should not go on tamoxife even if recommended at MDT
141. full medical history and contraindications not known to MDT RE qU 29.1 NO TREATMENT RECOMMENDATIONDS MADE PRIOR TO MDM
142. Failure to communicate effectively
143. Dont know
144. Dont know
145. Don't know
146. Don't know
147. Disagreement with a protocol or that it is not appropriate in the individual case
148. disagreement of another surgical collegue who will then change the mdt decision when she next sees the patient, and patient choice
149. different staging at pathology review
150. death of pt
151. Co morbidities Incomplete information presented to MDT Pt choice Non documentation of MDM recommendation
152. Co-morbidity of patients not recognised by MDT and patient choice
153. Co-morbidity and patient choice
154. Clinicians following personal protocols
155. Clinician involved not present - patient circumstances not known to other MDT members
156. Clinician disagrees with decision.
157. Change in patient circumstance/?patient choice
158. Change in clinical situation mainly patients co morbities.
159. change in clinical picture
160. Change in clinical condition of patient or patient choice.
161. change in circumstances for both doctors and patients
162. Change in circumstance, patient choice
163. All the facts not being available at the time of the meeting
164. Age and co-morbidity.
165. Additional patient co-morbidity becoming apparent when the clinician who is to treat the patient meets the patient often for the first time Patients being unwilling to consent to the treatment suggested
166. Acute change in condition of patient or unwillingness of patient to accept decision.

167. absence of the key clinician involved in that particular patient care

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

114 surgeons responded to this question.

1. You need a complex widely spread net. We get all secretaries to send a copy of any clinic letter that mentions colorectal cancer to our MDT coordinator. Likewise any path report, or X-ray report. CNS, oncologists, pahyscians and others all have access to this route. So also do GP's Our coordinaotr keeps a ring file with the patients lisetd alphabetically. All these documents are filed in it. We miss out vanishingly few patients.
2. Withold payment by PCT if this has not happened unless under extraordinary circumstances
3. via the coordinator
4. Via histology Via all team members
5. very limited resources available
6. Tricky. If the diagnosis is by pathology, the MDT coordinator can develop links with the path department and have a record of all cancer diagnoses. This works well for many prostate and bladder cancers. Where a prostate cancer patient present with high PSA and mets they may well be treated with hormone therapy without pathological confirmation. This happens less often in bladder cancer or penile cancer. Occasionally testis cancer will be treated without histological confirmation. Renal cancer however is often not diagnosed histologically until after the radical nephrectomy and thses cases need to be discussed in a radiology meeting to plan the surgery.This relies on the surgeon looking after the patient.
7. Through Cancer office
8. This is seldom a problem for breast units as virtually all the cases are referred via the breast clinic and are therefore automatically discussed in MDT
9. This is not necessary
10. The diagnosis of cancer is made largely by pathologists and they should elert the MDT co-ordinator. In addition for some tumour types i.e.renal the diagnosis is radiological in the first instance and so they should also elert the MDT co-ordinator
11. strict policies
12. Stop discussing cases that are not yet cancers
13. SPREAD THE WORD TO ALL SPECIALITIES
14. Some of the questions above clash with previous sections.They should not be refered it should be automatic.
15. safety netting...multiple redundant back up plans
16. robust systems especially pathology and radiology
17. Repeated reminders to all staff likely to diagnose patients so that they are aware of the pivotal role of the MDT
18. REGULAR ASSESSMENT OF ALL PATIENT ENTRY
19. Radiology protocols
20. Quality componant of commissioning
21. Publicity. Good feedback on cases referred to MDT
22. Provide the administrative infrastructure to identify the patients and give the MDT proper time to meet and consider them.
23. policies so path and imaging notify MDT coordinator of new cases as well as clinicians
24. patient key workers and clinicians should refer their cases to the MDT co-ordinator. The appointments teams in cancer care should also alert the Cancer teams to referrals
25. Pathology should bring all new histological tumours to the MDT. Clinicians should have to register any new cancer at once on a national register.
26. Pathology screens all new specimens (coded separately for cases not discussed

at MDM yet) we code path differently after discussion. Theatre lists feed into MDM.2ww database feeds into MDM. All radiology discussed at MDM.

27. pathology checklist good communication to chair
28. pathologist can bring along all histologiscal/cytological diagnosis as can radiologist of suspected radiological malignancy. othwerwise the clinicians will referr any suspected or confirmed malignancies
29. Only members of MDT can treat and advise on cancer cases on there particular site. Pathology could refer all positive biopsies irerespective of source.
30. ongoing best practice
31. Not paying for cases unless discussed
32. networking
33. multiple referral sources ie clinicains and pathologists reporting all cases as they are diagnosed
34. More administrstive support especially in the cancer units
35. MDT form needs to be forwarded by Trust for all new cancer diagnoses or treatment not remunerated
36. MDT coordinator to chech with pathology. CNS to monitor ward patients
37. make it mandatory feedback education
38. Make it mandatory
39. make it automatic on diagnosis - ie code all reports and have automatic referral of all cancers found on path, imaging, or clinical to appropriate MDT
40. Local protocol and audit
41. Links between Pathology and Cancer Support teams
42. Link pathology database to MDT
43. keep on checking
44. it happens for us good admin and team working
45. It happens any way
46. Information to GPs
47. Increase awarenes among colleagues
48. Include it in the funding of cases by the purchasers
49. Histopath/cytopath/radiology etc
50. Histology & cytology results, monitoring of fast track patients & review of clinic letters.
51. Have a single point of entry for care pathway. Ensure cancer cases can only be management by core members signed up to cooperate
52. Have a central point of referal
53. GP and doctor awareness
54. Good data, checking all pathology results. Copies of all correspondence about cancer patients sent to CNS and co-ordinator
55. generally this is not necessary in our hospital as all new cases are reviewed in MDT - early on there were a few cases managed outside - that we all knew about. This doesnt happen anymore so no need for policing !
56. Ensuring that all key members take the responsibilty to identify and refer not just one individual doing it
57. ensuring compliance with established pathway with involvement of MDT co-ordinators.
58. ensure MDT Co ordinator is well know and contact details are published. Make sure all those likely to come across cases relevant to the MDT are informed hoe to refer.
59. Ensure guidelines are circulated Ensure commissioners consult guidelines
60. Empower all MDT members to flag up any cancer that their diagnostic dept picks up for MDT discussion. Liaise with MDT co-ordinator
61. Electronic data systems
62. effective notification system within each trust using, pathology, radiology and all other department.
63. Effective data management by the hospitakl trust from time of initial referral/presentation.
64. Effective communication and increased access

65. Effective care pathways. Education
66. education of referrers particularily for rare cancers and doh recognition of those cases not sent to mdt to encourage future referral
67. Education and having triggers both in primary and secondary care to direct patients to the appropriate treatments
68. Education af all clinical staff . Key areas of referral ie path lab and radiology.
69. education
70. Ease of communication with MDT co-ordinator.
71. Ease of access to the MDM co-ordinator
72. Don't know. All pancreatic cancers need to be discussed at the pancreatic mdt but many hospitals are selective in who they refer for discussion
73. directly log them from histology/ endoscopy / radiology
74. Diligent networks of communication when a cancer appears in the system. We have secretaries, radiologists, pathologists and all able to contact MDT coordinator to ask for a case to be comsidered
75. Difficult one as advanced cases coming in under geriatricians for example may not be referred. All clinicians need to be aware of the MDT process even if in non cancer specialties. Pathology and radiology data bases should ensure we capture the majority of patients both within the specialty and from other areas.
76. Develop a single MDT support software
77. demonstrate that MDT works.As last resort make failure to refer a disciplinary matter.
78. demonstrate objecetively that referral makes a real difference to Rx AND outcomes
79. Dedicated data collection clerk.
80. Data collection may need additional resource.
81. computer inter link and alert systems .
82. compare with histology database
83. Communication. Depends on cancer type andindiviaul MDT systems.
84. Communication, failsafe checks such as snowmed and National registries supplemented by audit
85. Clear pathways agreed at the clinical level in all departments.
86. clear pathways
87. Clear guidelines of referral, restriceted 2ww referral pathway to core members only close working relationship with radiology and pathology to ensure cancer cases are referred directly to the MDT
88. Clear guidelines
89. central register
90. Cancer leads in hospitals
91. By the culture of the institution within which the MDT operates
92. by regularly circulating guidelines for referral to GP's and Hospital Consultants.
93. By providing the best service. ("If you build it, they will come"). Don't try and bully people into referring - it won't work.
94. By pathology referring cases to the MDT co-ordinator as they come through the department
95. by linking with imaging,cytology and pathology data bases as well as clinics
96. By having as many ways as possible to enter a patient. This provides backup and should hopefully stop them slipping through the net.
97. by comparing
98. By collective agreement e-mail contact
99. By alerting all potential sources of a malignant diagnosis (imaging and histology especially) that cases should be reported to the MDT. Ensure hospital intranet and switchboard have contact details of MDT coordinators and specialist nurses
100. Automatic tranfer of all relevant patients from Path comupter system and MDT and vigilence by all MDT members
101. Appropriate referral mechanisms and tracking
102. any clinician seeing a new cancer should feed into the MDT process

103. already happens - clear instructions
104. Allow referal from any source ie other clinicians, pathology,imaging etc
105. Allow Mdt listing at the first point of diagnosis and the person who gives the diagnosis.
106. All ours are
107. All new cancer cases will be referred to an MDT if there is equity of distribution
108. All MDT members have the ability to nominate patients for MDT consideration.
109. All malignant histologies reviewed
110. all core biopsies/fna are recorded and data collected by the mdt co-ordinator, for screening and symptomatic cases
111. All clinicians should have a personal responsibility to present every new patient seen. MDT co-ordinator should monitor
112. All cases flagged up at the various points of diagnosis. Clinic, Endoscopy, Imaging and pathology. Using these 4 points of contact there will be overlap but misses will be rare.
113. All cancer cases come through a dedicated cancer clinic in all trusts
114. alerted by pathologist

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

133 surgeons responded to this question. In addition two surgeons responded by simply stating 'yes', appearing to affirm that this should be done rather than describing how it should be done.

1. Written in case notes
2. With minutes
3. wherever it is felt that the implications are significant
4. We use a narative verdict
5. WE HAVE ALWAYS COME TO AN AGREEMENT
6. verbatim or narritive
7. Verbatim
8. Verbatim
9. Truthfully!
10. truthfully
11. treatment options should be documented
12. transparently and communicated to the patient (in a sensitive and appropriate way)
13. This should not occur.
14. This is rarely a problem in the breast MDT - I cannot recall any case where our MDT has had difficulty in reaching an agreed compromise
15. they should not unless no majority decision possible or treating physician is the disagreer
16. They should be recorded at the MDT and discussed in the cool light of day
17. They dont need to be
18. the senior clinican
19. The reasons for the split decision should be recorded in the patients records and should enable the clinician to communicate this to the patient if the changes result in significant changes to therapeutic intervention.
20. The options should be recorded and discussed with the patient along with their differing outcomes
21. Text form on the proforma.
22. summarry of the different options

23. shouldnt be any split decision if cahired properly
24. Should be acknowledged and reasons for chosen strategy recorded
25. Recorded in patient notes and discussed with patient
26. recorded clearly in decision
27. Recorded at the MDT and signed by the chair
28. recorded as majority
29. Record main decision, name dissenters, if split decision, return to it next week, with practical ways to gain information in the mean time
30. Record both options then record decision to treat consultation with patient where both options discussed, then record eventual patient decision, then feed back to MDT which was chosen and why.
31. Reasons for and against should be recorded with core members vote counts entered. Such decision and split decision must be shared with the patients
32. Pros and cons of the various decisions should be recorded.
33. Patients notes and database
34. Options should be recorded on the MDM outcome sheet and discussed with the patient who should be helped to make an informed decision.
35. Opinion and evidence both noted and if necessary 2nd opinion sought
36. On the Proforma forms
37. on proforma and discussed with pt
38. On proforma
39. on proforma
40. offer options and opinions to patient so she knows there is more than one way of treating her
41. Not sure it has in ours
42. Narratively
43. Minuted; the ultimate decision should be made by the treating clinician and conjunction with the patient.
44. MDT decisions should be presented as options for the clinician and patient to consider. It is not the |MDT which is treating the patient.
45. MDT coordinator records options and numerical split and chairman's final decision
46. Majority view recorded but disagreements /splits should be very rare in a good MDT. If protocols are robust and agreed by all members.
47. majority view clerly stated with statement of minority view acknowledged
48. majority decision recorded
49. It should only be recorded if the individuals feel strongly that they want to be disassociated from the group decision
50. Individual cases will need to be assessed by the moderator. This happens rarely.
51. In writing??!!
52. in writing, in the MDT minutes
53. in writing
54. in thenotes
55. In the records of the patient under consideration
56. In the Proforma of course and in communication with the GP and patient
57. In the patient notes.
58. In the pateints notes.
59. in the notes
60. in the MDT summary of the patient, any disagreement should be clearly documented
61. IN THE CONSOLIDATION FORM
62. in patient notes
63. In notes and on MDT pro forma
64. in MDT records
65. In MDT record
66. In MDT minutes
67. in full with reasons

68. in detail
69. In descriptive detail without ambiguity. The reasons for the differences in recommendations should be documented. Evidence in support of decisions to be documented or requested to be made available for addition to the documentation
70. In database record
71. In clinical record.
72. In minutes.
73. If an individual/individual feels that it is necessary to record a split decision this should be done by name.
74. Honestly
75. Honestly
76. honestly
77. haven't really come across this. From our point we have a very harmonoius MDT! Seems unusual from your tone!
78. fully
79. Factually, including the reasons for them, on an MDT proforma or other definitive record
80. factually with accountability clear
81. factually
82. External assessor
83. exactly as they happen
84. exactly as they are discussed.
85. Exactly as that.
86. Exactly as that! We have never been in that situation in 10 years of the MDT - agreement has always been reached.
87. each view should be recorded with a reason for each view and name of the person(s)
88. Don't know but possibly doesn't matter as long as patient's final choice of treatment is recorded.
89. documented on the proforma
90. Documented in notes
91. documented as it is
92. Documented and discussed with the patient. Treatment is not black and white and more than one treatment option may be appropriate.
93. Document the differences and document the consensus opinion
94. Document the comments without naming the person
95. Discussion and majority decision recorded on MDT proforma
96. Discussion and alternative opinions should be recorded. Rationale for different opinions should be recorded. Choice should be given to the patient.
97. Discuss with patient
98. Disagreement should be recorded and the patient and GP should know there where more tan one opinion and the reason why the final recommendations where made
99. Decision made by chair
100. Dead easy: record them in the city-wide database as a disagreement. Usually there are sevral options. Then these should be put to the patient
101. Core member with clinical responsibility documents discussion on options
102. Consensus opinion no individual names unless requested by dissenters
103. Completely. Record each opinion.
104. Clearly, with evidence for each decision and conclusion stated
105. by name of the clinician and what they would best think done and the evidence behind it. all decisions should be resolved.
106. By MDT coordinator in notes and MDT database
107. Based on evidence and patient choice with options including benefits.
108. As treatment options with equal weight.
109. As treatment options for discussion with the patient. A tertiary opinion can be sought.

110. As treatment options
111. as they wouod be in minutes, X for ... Y for ... final decision ...
112. as they are
113. As such
114. as such
115. As split decisions
116. as options for the patient if all are equal. Treatmnet can then be carried out according to patient choice.
117. as narrative in the notes with a box on the proforma ro indicate this has happened
118. As factually as possible
119. As exactly that could do either and leave patient and clinician to decide together
120. As alternatives discussed and for discussion with the patient, who is the final arbiter.
121. As already happens- majority verdict but with clear reasoning if no consensus
122. as a choice of treatment
123. Amicably
124. All recommendations can be offered to the patient. The patient should be aware which one the majority favoured
125. All aspects of discussion should be recorded and 2nd opinion sought
126. All opinions recorded
127. Accurately by name and opinion in summary document.
128. Accurately and honestly.
129. Accurately and honestly.'there was wide discussion about the options but ultimately the patient in informed discussion with the clinician will decide which approach to pursue'
130. Accurately
131. accurately
132. According to individuals comments
133. A consensus does not have to be unanimous. In some instances the differing views should be presented to patients and on occasion members should be gvien tthe opportunity of presenting supporting evidence

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

194 surgeons responded to this question.

1. we take the views (options) from mdtm to the patient after meeting.
2. via key worker, consultant is responsible in meetings both before and after to represent patient views
3. Usually the Nurse specialist
4. Usually the breast care nurse
5. treating professional or keyworker
6. Treating doctor
7. treating doctor
8. This is often the Specialist nurse but might be the clinician
9. their doctor or oncology nurse
10. Their Consultant and CNS.
11. Their Consultant
12. Their consultant
13. Their clinician or macmillan nurse
14. Their clinician or CNS, whoever knows the patient better
15. Their clinician

16. the team
17. The surgeon or breast care nurse who have seen the patient
18. The specialist nurse who has previously met with the patient and thier family
19. The specialist nurse or the clinician who saw the patient
20. The specialist nurse but I would expect the doctorto be doing this anyway.
21. The specialist nurse
22. The principle surgeon/physician involved in the care of the patient.
23. The person, or persons, who have got to know them best.
24. The person or persons who have met the patient, usually both Surgeon and CNS
25. The patient's Doctor
26. the patient's clinician
27. the one who has met the patient
28. the nurse specialist
29. the nurse specialist
30. The named clinician overseeing care.
31. the member who knows the pt best
32. The medical and nursing team
33. The keyworker or the principal clinician/ nurse specialist
34. The key worker, usually CNS, may be clinician, may be palliative support
35. The health care professional who has met the patient (or is familiar with the details.)
36. THE GYNAE CANCER CO-ORDINATOR IS THE BEST PERSON IN OUR DEPARTMENT TO LINK WITH THE PATIENT. ALL GYNAE CANCER PATIENTS HAVE HER TELEPHONE NUMBER. SHE IS PRESENT IN THE CLINIC WHEN PATIENTS ARE SEEN BY EITHER THE ONCOLOGIST OR THE GYNAE SURGEON OR BOTH TOGETHER.
37. The doctor/nurse who knows them. Sadly "straight to test," in combination with pooled endoscopy lists, often means patients will be discussed before even meeting a member of the MDT.
38. The doctor who saw the patient, if he/she can remember them all.
39. The consultant or senior nurse who has SEEN the patient.
40. The consultant looking after the patient's care of a breast care nurse who has met the patient
41. The consultant in charge of the patient
42. The consultant
43. The consultant - providing he has a detailed knowlege of the patient, and is not a complte prat
44. The clinician(s) in charge of the patients care
45. the clinician who met the patient or the specialist nurse
46. the clinician who has responsibility for the patient at the time
47. The clinician who has met and investigated that patient and who, by that point, has also given them their diagnosis
48. the clinician who has had most contact with the pt
49. The clinician resposible for that patients care
50. the clinician responsible for their care
51. The clinician responsible for delivering care providing they know the patient. Otherwise the person who knows the patient and their background.
52. The clinician looking after the patient
53. The clinician involved with their direct clinical care i.e. doctor or specialist nurse
54. the clinician involve
55. the clinicial who last saw the patient
56. The clincian and/or specialist nurse
57. Surgeon, Breast care nurse
58. Surgeon in charge of patient or SPR
59. Surgean and BCN
60. Specialist nurse/key worker

61. Specialist nurse or someone who knows the patient
62. specialist nurse or consultant
63. Specialist nurse (BCN)
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 breast care nurse
75. Specialist / clinician met with patient &/or breast care nurse
76. Someone who knows the patient. If the patient has been referred by proforma then advise on the management of the tumour can be given but whoever sees the patient to discuss this with them will need to take into account their physical and mental comorbidity
77. someone who has met them or will meet them to discuss options
78. someone who has met the patient - often the CNS
79. responsible clinician / specialist nurse
80. Responsible clinician
81. referrring clinician
82. Probably the CNS although an effective data collection system might allow any MDT member to record the patients point of view
83. principle clinician taking care of primary diagnosis or recurrence usually
84. person who has met the patient
85. Patients should be seen in clinic after the MDT meeting
86. patient/relative
87. patient with clinician
88. Paints Consultant/clinical Nurse Specialist
89. Oncology nurse
90. nurse specialist, consultant
91. Nurse specialist or whoever has had that discussion with the patient
92. nurse specialist or consultant who's seen the pateient
93. Nurse Specialist
94. Nurse specialist
95. Nurse specialist
96. Nurse specialist
97. nurse practitioner who has met the patient
98. Nurse practitioner or referring consultant
99. Not always easy when the patient has had all their tests WITHOUT seeing a healthcare professional!! Very common now with STT policy. Just sometimes feels a little impersonal
100. No one the patients views are taken into consideration when the recommended treatment options are discussed with the patient after MDT discussion
101. No one individual but the responsible clinician and the CNS and other allied individuals who have met the patient can give input
102. No evidence to show who does this best - but some one needs to do it who is aware that patients views can change
103. Named nurse (Breast, Sarcoma, Dermatology)
104. lung cancer specialist nurse or investigating physician
105. Liason/specialist nurse
106. Key worker or responsible clinician
107. Key worker or Clinical Nurse Specialist

108. Key worker and consultant incharge /team.
109. Key worker
110. Key worker
111. Key worker
112. key worker
113. key worker
114. Key worker - usually CNS
115. It varies quite a lot from patient to patient, but somebody must do this.
116. It depends on the tumour site
117. individual who is treating the patient
118. Ideally the patient! Notes are not always clear and if there are a variety of possibilities, patient's own choice can greatly influence things. We have so many patients that preparing patient's views in all cases would be extremely difficult if not impossible. We do not have enough nurse practitioners to offer choice in key-worker. If we did this would probably work better, but we have only one nurse and as noted before usually more than 30 and occassional more than 40 patients to discuss in a week. The key worker is always the nurse but there is a limit to what she can do,
119. Health care professionals such as breast care burses or nurse specialists
120. Either the consultant responsible for care, their deputy or the cancer nurse specialist
121. Either clinician or CNS who has met the pt.
122. DOCTOR/CNS
123. doctor/ nurseb specialist
124. depends on pt / clinician / situation - ie varies
125. consultant surgeon and the clinical nurse specialist
126. Consultant or key worker
127. Consultant or CNS
128. consultant or cns
129. Consultant in charge of that individual
130. consultant in charge of case
131. Consultant in charge
132. Consultant & specialist nurse
133. consulant/spec nurse
134. CNSp
135. CNS and clinician who met patient
136. CNS
137. CNS
138. CNS
139. CNS
140. CNS
141. CNS
142. CNS
143. CNS
144. CNS
145. CNS
146. cns
147. Clinicians
148. Clinician/colorectal nurse
149. Clinician with most input at the time and who is bringing the case
150. Clinician who has seen the patient and has indepth knowledge about the patient
151. clinician who has had interface
152. Clinician responsible for their management and their specialist nurse
153. Clinician responsible for the patient's care
154. clinician or specialist nurse involved in their care

155. Clinician or specialist nurse
156. clinician or nurse specialist
157. clinician or CNS
158. clinician or cns
159. Clinician or clinical nurse specialist
160. Clinician involved in their care
161. Clinician incharge of the patient or Cancer Nurse Specialist
162. Clinician in charge
163. clinician caring for them
164. Clinician and clinical nurse specilaist/
165. Clinician / CNS
166. clinician
167. Clinical Nurse Specialist but will add delay to treatment if wait to see Tertiary referral before discussion at MDT
168. Clinical Nurse Specialist and Diagnosisng Clinician
169. Clinical Nurse Specialist
170. Clinical nurse specialist
171. Clinical nurse specialist
172. Clinical nurse specialist
173. clinical nurse specialist
174. clinical nurse specialist
175. clinical nurse specialist -ptient views not really important at the MDT stage as the conclusion of the MDT is of what treatment is possible then this can be discussed with the patient and the way forward agreed
176. Cancer specialist nurse
177. cancer nurse specialist
178. breast care nurses
179. Breast care nurse.
180. breast care nurse if she attended that patient
181. Breast Care nurse
182. Breast care nurse
183. Breast care nurse
184. Breast care nurse
185. BCN/Palliative nurse
186. BCN
187. any one who has consulted with pat
188. Any member
189. All involved with the care of the pateint ie clinicians,specialty nurses etc.
190. A patient but this would be inpractable. Second best is a clinician/nurse specialist who has assessed and discussed with the patient
191. A health professional who has met the patient
192. A health care professional who has met th epatient and has the relevant info to hand . This could be ANY health care prifessional-nurse, oncologist, doctor or a combination as sometimes, a nurse wil get info doctor doesn't have
193. a clinician who has seen and knows the patient
194. A clinical nurse specialist

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

191 surgeons responded to this question, 15 of whom referred to the answer they had given to the previous question (Q32).

1. Whichever clinician knows patient best
2. treating professional or keyworker
3. treating doctor
4. This should be the doctor who is treating the patient or the nurse practitioner who then communicates to that doctor (who still takes responsibility for the discussion)
5. This may be the clinician or maybe the nurse practitioner
6. Their nurse specialist or consultant
7. Their consultant or key worker.
8. Their Consultant and CNS.
9. Their clinician or macmillan nurse
10. the treating surgeon or physician.
11. the team
12. The specialist nurse or the consultant clinician
13. The Specialist Nurse contacts the patient to say what the arrangements are and an outpatient appointment is arranged with Surgeon/Oncologist/both to discuss in detail what is being proposed
14. the Specialist dealing with the patient
15. The same person.
16. The responsible consultant
17. The responsible clinician - in the majority of cases the surgeon as that is the person who is best qualified to be able to answer all questions, in particular those related to risks and benefits of proposed treatment.
18. The referring consultant
19. the patient's consultant
20. the patient's clinician
21. the one who is due to meet the patient
22. The named clinician with specialist nurse support.
23. The named clinician
24. the key / link worker
25. the Doctor seeing the patient in clinic or a breast care nurse who has met the patient or who is going to meet the patient
26. The doctor and the key worker
27. The consultant or senoir nurse
28. The consultant or his/her nominee.
29. the consultant in presence of breast care nurse
30. The consultant
31. the consultant
32. The CNS or clinician involved with the patient.
33. The clinician(s) in charge of the patients care
34. the clinician who will be delivering the care
35. The clinician resposible for that patients care
36. The clinician or nurse specialist
37. the clinician leading the treatment
38. the clinician in charge of the case or the specialist nurse
39. the clinician in charge and /or specialist nurse
40. The clinical nurse specialists
41. the clinicain reponsible for the care plus the speciaty nurse
42. that same clinician
43. Surgeon/oncologist

44. Surgeon or Oncologist
45. Surgeon in charge of patient
46. Surgeon in charge
47. specialist nurse/ own consultant
48. specialist nurse of clinician
49. specialist
50. Sp Nurse
51. Someone who knows what the treatment options are and preferably who will be doing the treatment. This should be doctor, but in practice a good CS can do the job
52. Senior Nurse Specialist or the concerned clinician.
53. senior clinician and nurse specialist
54. SEEN BY THE APPROPRIATE DOCTOR IE SURGEON OR ONCOLOGIST
55. see above
56. See 32.
57. same or SpR
58. Same clinician as above or most appropriate clinician from the MDT if not above person.
59. same
60. same
61. responsible clinician/surgeon
62. Responsible clinician or nurse specialist
63. Responsible clinician or key worker
64. Responsible Clinician & specialist nurse
65. Principle clinician
66. Principally the consultant responsible for their care at that time.
67. primary treating clinician
68. Physician or surgeon
69. physician in charge
70. physician carrying out the treatment
71. person who has met the patient
72. person to deliver treatment should then talk to pt
73. Person agreed with patient beforehand. Usually nurse specialist or consultant at follow up. sometimes phone call is better if previously arranged.
74. One of the clinicians who has seen the patient before or a member of that team
75. oncologist if going on to have chem or radiotherapy or surgeon if further surgery is needed
76. nurse/ doctor
77. nurse specialist or consultant
78. Nurse Specialist / Consultant
79. nurse specialist
80. Named consultant
81. Named consultant
82. Most appropriate person! May be Dr, Oncologist or Specialist nurse
83. Medical/surgical team
84. MDT coordinator
85. Key Worker
86. Key worker
87. Key consultant or team member who is fully aware of patients case with key worker present.
88. Joint clinic run by Surgeon, oncologist and CNS
89. It varies from patient to patient, but somebody should be specifically named to do this (Often the CNS, but sometimes the GP)
90. In general the clinician providing the resulting recommendation but with others as indicated or request by the patient
91. ideally the same individual clinician

92. Familiar clinician
93. Doctors and nurses
94. Doctor/CNS
95. Doctor or Sp nurse
96. doctor or nurse specialist
97. Doctor or breast care nurse
98. DOCTOR
99. Doctor
100. Daignosisng Clinician
101. core members
102. Core member of MDT in a clinic setting
103. conusltnat, nurse specialist
104. Consultant, esp oncologist who can discuss trials
105. consultant surgeon
106. Consultant responsible for care
107. Consultant or specialist nurse practitioner
108. consultant or nurse
109. consultant or key worker
110. Consultant or his deputy
111. Consultant or designate
112. CONSULTANT OR CNS WHERE APPROPRIATE
113. Consultant or CNS
114. consultant or cns
115. Consultant or BCN
116. Consultant in overall charge
117. Consultant in charge of the case
118. Consultant in charge of case
119. Consultant in charge of care or their deputy
120. Consultant in charge
121. Consultant delivering care/responsible for patient.
122. consultant and key worker together
123. Consultant
124. Consultant
125. consultant
126. consultant
127. cons in charge of pat but can delegate
128. CNS/Keyworker
129. CNS or consultant
130. cns nurse
131. CNS first then consultant
132. CNS and consultant who know the patient already
133. CNS
134. CNS
135. CNS
136. CNS
137. cns
138. clinicians (medical or non medical) who have met the patient
139. Clinicians
140. Clinicians
141. Clinician/colorectal nurse. It is impractical to bring patients to the MDT as the time delays will impede the discussion of as many cases in detail.
142. clinician/ nurse specialist
143. Clinician who has already seen and known the patient
144. Clinician responsible for their management and their specialist nurse

145. clinician providing care
146. clinician or specialist nurse involved in their care
147. Clinician or specialist nurse
148. Clinician or specialist nurse
149. clinician or nurse specialist
150. Clinician or CNS who has already met the pt.
151. Clinician or CNS depending on the circumstances
152. clinician or CNS as appropriate
153. Clinician or CNS
154. Clinician or CNS
155. clinician or CNS
156. clinician or cllinical nurse specialist
157. Clinician managing patient. Sometimes appropriate for CNS to communicate decision when patient has already been seen and patient aware of different options being discussed.
158. Clinician looking after the patient and/or Cancer Nurse Specialist
159. Clinician in charge
160. Clinician / CNS
161. Clinician
162. Clinician
163. Clinician
164. Clinician
165. clinician
166. clinician
167. clinician
168. Clinical Oncologist or Head and Neck Surgeon
169. clinical nurse specialist or consultant
170. Clinicain or Breast care nurse who has been dealing with the patient.
171. Breast care nurse
172. breast care nurse
173. BCN
174. As above
175. As above
176. As above
177. as above
178. as above
179. as above
180. as above
181. As above - the individual who the patients knows and has been intimately involved in their care
182. as 32
183. Appropriate specialist
184. appropriate clinician or specialist nurse
185. anyone who understands the situation - could be clinician who is going to be involved with treatment, someone who was involved in diagnosis or CNS
186. An appropriately trained person - Doctor or nurse
187. A physician or specialist nurse that they already know.
188. A member of the medical and nursing team
189. a core member of the MDT
190. A clinician
191. A clinician

Measuring MDT effectiveness/performance

What other measures could be used to evaluate MDT performance?

67 surgeons responded to this question.

1. We are about to test some standard conditions across different MDT's as part of the tumour panel audits
2. Very difficult to use cancer outcome data as a measure of MDT function as the data is very patchy at present and can take a very long time to present. Need short/medium term measures.
3. validating and comparing decisions between MDT
4. Useful/quorate attendance, feedback from network sites re timeliness of response (and usefulness of interpretation)
5. timeliness of informing GP of decisions production of audit data recording of recurrence rates
6. time when all core members present divided by number of cases discussed
7. Throughput. Discussion time per case.
8. Survival is guided by skills possessed not decicion making process. Too difficult to weed out confounding issues of case selection etc.
9. Survey of members feelings and assessments of outocmes
10. Survey of GP awareness and satisfaction
11. SURROGATE MARKERS E.G RECTAL CNACER TREATMENT CRM POSITIVITY
12. Stop with all the targets. What do you want? better survival, better care, happy team members or just targets hit? They are not all the same thing....
13. STOP MEASURING ME!!!
14. standard of data collection
15. Simple audit of data would be helpful!
16. Regular review of MDT treatment decisions.
17. records of meetings, data on targets such as getting info to primary care, audit of practice, contribution to national audit, quality assessed in terms of performance/outcomes against a benchmark
18. Reasons for and against should be recorded with core members vote counts entered. Such decision and split decision must be shared with the patients
19. Questionniares of this type to the MDT members
20. Quality of audit data
21. presence of all data for the patinet recorded or recording of missing infoor when patinet couldnt be discussed becasue of lack of info
22. percent of cancer patients discussed at MDT percent of patients getting added value treatment - e.g. liver resections for secondaries
23. Peer review and 360 degree appraisal
24. Patients managed appropriately according to agreed cancer guidelines
25. Participants/members surverys of effectiveness of decision making/improvement in quality of care
26. Outcomes are the only really important parameter, that recommendations are followed and patients and staff feel they are doing a good job is a useful surrogate. The previous and current tick box excercise called peer review was a disasterous mishmash which has demoralised a large number of dedicated cancer clinicians and set back cancer care by years in this country. Please stop micromanaging people who actually know what they are doing.
27. outcomes and satisfaction surveys.
28. Nothing
29. None that readily comes to mind!
30. none of the above seems appropriate- try degree of communication between clinicians
31. none

32. No other necessary.
33. nil
34. national data collection and comparison
35. N/A
36. Measuremtn of the individual input of each clinician into the team i.e. who owns and sorts out problems these are the people who should be recogised and listened to
37. We now spend 1 afternoon a week talking about decisions that we used to make in clinic. Very few decisions are effected but it makes sure there is not some maverick. Now you want us to spend some more time talking about the way that we talk about the decisions we used to make in clinic. It is possible to make an industry out of this with awaydays, seminars and 360 appraisal of the MDT. The question is do we have the extra resources to allow this or should we be allowed to see some patients and try and help them to the best of our ability accepting that as we are human we will make mistakes!
38. Local and regional relapse rates
39. It should be recognized that suggested management plans can be made at an MDT but that it is not possible to finalise the plan until the consultant concerned has seen the patient and discussed the treatment with the patient. Measure effectiveness The best way to measure effectiveness will be to publish treatment results ie relapse and survival data stage for stage.
40. IOG measures and standards achieved e.g. reporting and minimum datasets in path
41. Internal audit compared to published protocols
42. In the long term survival rates are important, but really the MDT is there to avoid mavarick managements groups and to deliver evidence based treatments.
43. how much time is wasted
44. GP/Patient/carer satisfaction with efficiency/personalisation of care
45. Effectiveness appropriateness of investigations
46. dont know
47. Don't know
48. Don't know
49. depends upon the MDT in H & N No. pts in trials survival rate of pts flap failure rate pharyngeal leakage rate recurrent laryngeal nerve trauma rate parotid weakness
50. Core members attendance records
51. Completeness' of (nationally agreed) baseline datasets Local recurrence rates
52. Compare it with guidlines and outcomes.
53. comment - improvement in survival is not a good measure if good outcomes were already being achieved.
54. Clinical outcome data Patient satisfaction / experience audits
55. cancer free survival
56. Can we not utilise our time to do somthing more useful.
57. bench mark against guidelines for treatment eg nice guidelines for management of early breast ca
58. attendence and completion of minimum data sets
59. Attendance: if the MDT is no good, people won't come.
60. attendance records
61. Attendance by oncologists
62. Attendance and contributions
63. accuracy of staging, quality of pathology, accuracy of diagnostic,
64. Accuracy of staging (post op), survival figures. More info on non-opertive treatment outcomes.
65. 360 apparaisal of the team, by the team.
66. ?
67. % of decisions which are evidence based on auditing data.

Supporting MDTs to work effectively

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

135 surgeons responded to this question.

1. Wouldn't!
2. Trust to provide brakfast (we run from 08-00 - 0915) but the misguided skin flints won't.
3. Train leaders
4. Timing of the meeting in relation to timing of assessment and results clinics - problem is to find a time which fits with the timetables of all the other team members.
5. Timing
6. Time of meeting
7. Time availability.
8. Time availability, people commitemnt to the process and objective, skill level
9. The time recognised in job plan and half the number of patients/core member
10. the networked groups
11. The Chair
12. technical support
13. Suitable qualified MDM coordinator
14. Stronger chairman.
15. Streamline attendance
16. Stop discussing unnecessary cases and concentrate on more complex cases with more detail than currently availabvle.
17. Stop discussing G1pTa bladder cancers.
18. Stop competition between two of the sites - there is alot of testosterone flying around!
19. split it to cover sites individually (2 DGH's in the trust)
20. Some team building time and more time for deciding where further clincical benefit can come from by altering the sytem to help patients
21. Solve A V problems
22. Rotate MDT chair.
23. remove cult personalities
24. remore the core staff in making decisions
25. Referring clinician or member of his team who knows the patient/case must be present to discuss
26. Reduce the numbers of patients discussed at each meeting. Unfortunately this would mean increasing the numbers of MDTs to 2 a week and nobody seems to have the space in their job plans to do this.
27. Reduce the amount of irrelevant discussion about some patients to move on to the next patient once the treatment plan has been formulated
28. Radiologists should not be allowed to add on irrelevant cases at the last minute when notes are not available. Better oncology attendance
29. projection of info and decision
30. Prevent people moving on before discussion of a case is finished. Particularly as the afternoon goes on this becomes a tendancy we need to avoid.
31. PACS systems that are inter-compatible between Trusts.
32. PACS CONNECTION TO PROJECTION
33. ownership
34. Our Sarcoma MDT is already extremely effective; come and see!
35. Our MDT runs from 4.40 to 6.30PM. An earlier start would enable the MDT to be more effective aand ensure core members stay throughout the MDT and not just for their own patients.
36. organise order of discussion better

37. Only discuss cancer cases and reserve discussions on benign disease for outside the MDT meeting
38. on line data collection and IT support
39. Omit cases that have really obvious answers esp cases that are clearly benigh
40. number of personnel involved in cancer management
41. nil
42. network structure
43. need two pathologists, two radiologists, two surgeons and two oncologist not one of each coming alternate weeks
44. Need more time to present breach reports and outcome data. Would like to make it educational for juniors as well as just a decision making process
45. need more clerical and data input support
46. Move timing to 0900 -1000
47. More time.
48. More time, small physical change to bring PACS work station on to main table, so radiology at centre of meeting when XR reviewed
49. More time, less cases!
50. More time!
51. more time to consider cases and record data
52. More time for preparation before meeting.
53. more time for preparation
54. More time for preparastion (radiology) and meeting itself. Electronic audit tool.
55. more time for data entry
56. More time and skill from coordinator
57. More time
58. More time
59. More time
60. More time
61. More time
62. more time
63. more support with resources
64. more support for MDT coodinator
65. More resources to enable access to investigation
66. More clinicians available, particularly radiologists & oncologists.
67. More allocated time
68. More administrative support from the Trust
69. making sure someone who knows the patient attends the meeting
70. making it more friendly
71. live data recording
72. Less patients!
73. less overstretch on support services, particulary Radiology
74. leadership
75. Layout & space
76. its OK as it is
77. IT
78. Increased support for Histopathological review
79. Include palliative care - it would provide a treatment option that we currently do not seem to have. It would improve overall patient care, save money, improve quality of life, make realistic decisons about patients and reduce hospital complaints
80. Improved data
81. improve oncology input
82. Improve interactions with external groups (sarcoma, melanoma MDTs or other non core individuals)
83. improve administrative support for effecting actions after the meeting e.g. tests appointments etc

84. imaging! Encrypted discs
85. I would ban them
86. Having a data manager
87. Have time to make it cancer specific.
88. Have PACS systems which are the same in all hospitals and which can be accessed from any hospital within a network
89. have it during working hours
90. Have full pathology for everyone discussed,report by"breast Pathologist"
91. Have a moderator who does not need to deliver clinical management decisions but facilitates the core members get the best information, encourage the best debate and summarise with clear distribution of work to deal with decisions agreed.
92. Get rid of those members who really do not want to be there
93. Get regular radiology and pathology attendance
94. get all to turn up on time!
95. get a coordinator who makes sure that DECISIONS are recorded and implemented
96. flatten hierarchy
97. Fewer cases to discuss
98. Ensuring all core members are present more than 75% of the time
99. Ensure all core members are able to attend. This is a problem for some, who have double commitments in their job plans.
100. Enable our oncologist to attend the whole meeting (she is detained by clinical work on site, as she works at several hospitals)
101. electronic records
102. Electronic recoding of proceedings of meeting.
103. electronic MDT software. In Essex we have been trying to get this in place for 5 years.
104. Don't know
105. Digital image availability
106. Dedicated time in core hours to ensure all could attend. ideal I would split it into 2 parts, diagnostic and theraputic or screening and symptomatic as it's often very long and discussions may not be as detailed
107. Dedicated time
108. dedicated one tumour site professionals
109. decrease work load!
110. Data entry coordinator
111. data collection at MDT meeting
112. Cut out the repetative routine
113. Cut out histopathology and work on the reports
114. cull more xxxx
115. Complete data sets
116. Collect data in BASO database
117. change team leader every month
118. change oncologist job plan so mdm time protected and cover for his absences
119. Better videoconferencing between sites to facilitae better communication
120. Better IT and database support
121. better facilities
122. Better attendance of some key members
123. Better air-conditioning
124. Better administrative support
125. An MDT feedback joint clinic regularly with an oncologist
126. Allow more time
127. Allow members nmore time for preparation
128. Allow adequate time for discussions and should not be rushed. needs to be at a working time and not the lunch hour. The MDT should be participative.

129. All core members present from start to finish
130. Administrative support.
131. Admin / technical support
132. adequate secretarial support
133. additional working time for the MDT Co-ordinator
134. absolure adherence to having all necessary data available
135. A dedicated data coordinator.

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

100 surgeons responded to this question.

1. video conferencing
2. training
3. To have more time per case
4. To have fewer patients!
5. to finish my screening clinic early enough to attend the full MDT meeting.
6. Time.
7. time management
8. Time availablity
9. Time and backup for more audit/research
10. time allinfo available from a single screen electronically from any PC in the world
11. Time
12. Time
13. Time
14. time
15. time
16. time
17. time
18. support with prparation and typing
19. SOMEONE ELSE CHAIR
20. Some respect
21. Should attend more national meetings
22. Retirement
23. Regular updates on treatment strategies
24. Recognition of MDT in job plan
25. Recognisation time given to MDT.
26. Permit presentations on clinical topics and feedback from meetings
27. Patient information prior to the meeting
28. Nothing, it is pointless
29. Not possible
30. not being pressured into making it some kind of management game. If I want those I'll watch Ricky Gervaise.
31. More time!
32. More time!
33. More time!
34. More time!
35. More time to proepare for it.
36. More time to prepare for MDT
37. More time to prepare
38. more time to dedicate to the mdt, instead of rushing though them
39. More time spent in education and proffessional development with the team
40. More time in working week. Better information and preparation before meeting.
41. More time in local unit to discuss pathology / radiology before going to Centre

MDT

42. more time in job plan and more people in team
43. More time for preparation
44. More time both to prepare and for discussion.
45. More time available for the meeting i.e not shoehorned into any time space available
46. More time
47. More time
48. More time
49. more time
50. more time
51. more time
52. more time
53. more time
54. more time
55. more time
56. more secretarial and admin help
57. more recognitionof work in job plan
58. More hours in the working week (or permission from colleagues outwith the MDT to give up other clinical/on call committments which do not relate to the working of this MDT)
59. More allocated time
60. meetings whilst not on call in another town 30 miles away
61. MDT is too large and goes on for too long. Trying to discuss all patients (curative and palliative)in a unit with a large catchment area is not realistic.
62. Make it run to time, better
63. Longer access at video confernece
64. Less targets, guidelines and protocols!!!!!!!
65. less pressure before and after the meeting!
66. Learning to keep quiet!
67. knowledge (eveidence) that MDT makes a real difference
68. it is already perfect.....so this needs to be assessed to see if it is true
69. Interaction with other mdt members at professional and specialty meetings and conferences.
70. Information
71. I do not think there is anything at present that will. The line of questioning above suggests that a lot more is being made of the MDT than is really necessary - specific training is not required in most instances and if introduced risks adding to the burden of the 'tick box' culture that has been generated by the NHS. The MDM is a straightforward clinical forum to establish best practice and treatment for an individual - most members will have received the necessary training for this during career development. It doesn't answer the above question but is an important statement.
72. Having the significance of my role recognised
73. Have the appropriate facilities to assess the pathology and radiology. Regular quorate meetings and all members feeling that this is an important opart of the units work rather than feeling it is a major undertaking when other clinical jobs are waiting to be done
74. Have more time to discuss individual patients.
75. happy with my contribution
76. Give me another colleague who will take some of my clinical workload 13PA at present!!
77. Full attendence of all MDT members reguarly
78. Free up time in my job plan to be core member.
79. Don't know
80. Dedicated time

81. CPD
82. Continuing professional development by constantly increasing knowledge base, courses, external meetings
83. coffee
84. Can't think of anything! I already give it a decent slice of my time. The participants say that they like coming.
85. by the time you have reached a position where you can become a MDT member, you should have learned team working, as almost nothin in Medicine is free of teamworking nowadays. If you haven't learned by then, there's little scope to improve
86. Better IT support
87. Better IT , more a and c support
88. better administrative support better quality mdt facilities some coffee for a 4 hour meeting
89. Being able to attend every meeting
90. Away days to discuss particular aspects of patient care. This should be nonclinically and clinically based
91. Avoiding boredom. With specialisation you end up discussing the same type of case time and time again so that it is very easy to go into rubber stamp mode.
92. Attend conferences and overall knowledge
93. Another 20 years of experience!
94. alotted time in job plan fro the actual meeing together with planning time
95. advice and training on chairing it effectively
96. Adnin support
97. additional help from an MDT Co-ordinator
98. Access to intranet for all results during MDT
99. A sensible database and not this awful Info-flex
100. ?

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

48 surgeons responded to this question

1. Workshops with own team. To have meetings observed/recoded and critiqued
2. Work shops
3. Visits to other (well functioning) MDT's On site vistis from other MDT's
4. visiting other site specific MDT's
5. visiting other MDTs see how they do it
6. Visiting other effective MDTs and seeing how they actually work as oppossed to externally suggested (often by those who know little about the subject they are advising on).
7. visit from expert to assess and comment
8. video conferences with other network
9. Unsure
10. To be effective all participants need a good knowledge base so attendance at appropriate meetings should be recorded.
11. Time.
12. time in timetable without squeezing in at start / end of day or over lunch
13. there is a already too many nonsense training courses, anotherone will not help!
14. team building not necessarily work
15. Site visits to other MDT's or sessions on 'process mapping' within teams and jointly with other teams can help iron out local difficulties and help teams learn from the best practice of others
16. Sit it on another MDT meeting. Be part of - or even chair - an MDT Peer Review
17. regular audit

18. Peer review
19. outside assessment
20. Other members of outside MDT attending each others meetings to provide outside view and feedback.
21. observation of functioning of an examplary mdt
22. Not sure
23. Not a Basingstoke type of training
24. None
25. None
26. None
27. none
28. No idea
29. nil
30. N/A
31. more practical help than training
32. more data collection input
33. Meetings with other mdts carrying out similar work and feedback from patoents and noncore members
34. Keep management consultants out.MDT's should not be part of the gravy train that is the NHS
35. It would be useful if all members of an MDT could observe how other local MDTs and colorectal teams operate.
36. Good database
37. Facilitator to attend and advise on team functionality
38. Each team will have different needs. Make things available, give time to use those applicable.
39. dont know
40. don't know
41. conferences and updates
42. Communication skills course
43. Combined training with other groups in videoconference
44. Clinical decision support tools
45. Cancer Network needs to have some involvement
46. Better data collection, management and timely interrogation/reporting tools
47. Attendance at MDTs that are recognised as functioning effectively.
48. ?

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

53 surgeons responded to this question.

1. With the pressures to achieve targets it is impossible to attend away-days or courses since clinical activity will go down
2. Via network clinical advisory group.
3. Used serendipitous courses - e.g communication skills to team build - no other specific courses, keen to try them
4. unaware of anything
5. TME training was excellent
6. Teams Talking Trials
7. Sorry, not had any.
8. Professional body meeting (ABS)
9. Pellican centre
10. Pelican Centre
11. Pelican
12. Pelicabn Basingstoke Courses. Plenary sessions at national meetings (e.g. ACPGBI)
13. NOTAWARE
14. Not aware of any
15. not aware of any
16. Not aware
17. None that I am aware of other than IT staff if the video conferencing goes wrong!!
18. none known
19. None current. I wa spart of the initial collaborative and saw how MDTs evolved. I have also taken part in and chaired Peer Reviews
20. None
21. None
22. None
23. None
24. None
25. None
26. None
27. None
28. None
29. None
30. None
31. None
32. none
33. none
34. none
35. none
36. NK
37. Network away day on MDM functioning
38. MDT development Basingstoke
39. MDT developement programme Pelican foundation Basingstoke Training DVD, video. Personal discussion with peers
40. Masterclasses which a few core members from the group attend
41. Interpersonal skills training
42. I don't know of any
43. Few if any
44. electronic data management
45. dont know

46. don't know
47. Communication skills.
48. Communication skills
49. Communication course
50. communication course
51. Clinical psychologist has input into the team
52. Cancer network has had training sessions but none recently
53. Advanced communication skills.

Final comments

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

61 surgeons responded to this question

1. You should tell us how you view a team to work. We work as individual surgeons and are all individually supported by the wider team. Is thiswhat you think we should do?
2. why measure ? target culture obsession impinging on good clinical care
3. When the funding runs out MDTs will fade away.
4. there is a risk that more training / audit requirements remove busy core members from their clinical work and add to the financial burden of the NHS
5. there is a big difference in mdt those for common conditions could use protocols but rare tumours cannot be protocol driven as every case is different, recognition of this should be given in job plans to allow more time to allow every case to be discussed
6. The most important thing for theb NHS is that pateints receive the same standard of treatment and consistent MDT decisions wherever they are, so that benchmarking against other similar MDTs would be important
7. The MDT is a high value meeting, not an 'necessary evil'. If well lead it improves pt care and keeps all it members at the forefront of their practice.
8. The group needs to be cohesive.
9. The best MDTs function without rigid guidlines but with well thought out evidence based protocols for treatment.They encourage full participation and should be'fun'! I have a good deal of experience with video conferencing (withNSSG meetings) and in my view it detracts from the good functioning of the meeting. I have often asked the question - If video conferencing is so good, why does my brother, a manager in an international company spend half his life travelling from the USA to South America and Southeast Asia For meetings?
10. Supporter of MDTs
11. since we have had a coordinator we have had very efficient meetings
12. Scrap the entire peer review process as it currently exists. It is far too cumbersome and bureaucratic, a needless paper exercise that contributes nothing to improving patient care. Let review teams come and sit in on MDT meetings and determine if the appropriate measures and services are in place and let us get on with caring for our patients.
13. regular meeting on MDM results should be done
14. Preperation should be mandatory for core members.This avoids wasting of valuable time.
15. performance of an entire MDT is difficult to measure but that does not mean that this forum is not valuble. If the teams works well together and knows how other team memebrs work then ironically the MDT will be less important as there is a virtal MDT in place.
16. People commetment, skills level and time availability

17. overall our mdt works well but need to address resource re new technology introduced eg data collection
18. our UGI MDt is very good, we all get on ,trust eachother and all we need is decent IT. We spend time and do not 'fit in in'.
19. Our MDT has improved and patients do all get discussed. We could do with minimum data sets being collectable electronically - an attempt at this by the hospital failed recently. Shear weight of numbers of patients is a problem.
20. our MDT feels chaotic and rudderless. decisions are not centrally recorded. investigations and plans are organised in a rush. i'm SURE it's suboptimal. once, we had to stop because there were no consultant surgeons there. it is a mess in comparison with GI cancer MDTs that i've been involved in.
21. One size fits all will not work. Teams that ain't bust don't need fixing!
22. None
23. NHS MDTs are a waste of time in a properly functioning unit.The bureacratic requirement to spend more and more time on this fascile exercise means less time to see and treat patients
24. MDT's are the single best advance in cancer care in the Uk in the last 30 years. They are vital and the model of all future medical care. Small MDT's should be closed as they are not multi-disciplinary - they shouls be confined to centres who have ALL the treatment options available. Good palliative care should be included so that sensible decisions about patients with advanced disease can be made.
25. Need to get appropriate groups for MDT under effective chairman who encourages comments from attendees.
26. MRI assessmment of rectal cancer stage and histological stage Audit of role of XRT Audit of surgical complications Audit of chemotherapy complications
27. MDTs waste massive resourses and you have not considered this. You seem to have automatically assumed that every case should be discussed yet this wastes time and demotivates the team who get tired
28. MDTs do not function well when there are dysfunctional doctors or nurses who dont get on with each other. Oncology attendance is notoriously poor
29. MDTs delay treatment for patients as clinicians reluctant to get on with treatment in straight foreward cases. DOG guidelines often out of date. MDT used as a combined clinic rather than a critical appraisal of the clinical situation
30. MDTs at present add advice and wider opinions to cancer management. Most cancer management is straight forward and protocol driven which makes discussing every tiny bladder cancer and small prostate cancer tedious. There are many benign conditions which are complex in urology and would benefit from the time and effort put into cancer MDTs such as complex bladder neuropathies/continence problems. The Cancer MDT cannot possibly presume to act as the principle clinician when dealing with individual patients which is why we have trained professionals running the clinics (doctors). The role of the MDT should be to present relevant choices of management suggestions for the clinician and patient to discuss.
31. independant and unbiassed central monitoring system for cancer free survival and patient satisfaction
32. If NHS wants to do all this we need to double number of core personel in Urology
33. I think this has been comprehensively covered in the questionaire. The key to succesful MDT working is that the core members do actually work together as a team.
34. I hope there is implementation of survey outcome
35. I believe it is possible to create a system which created both clinical excellence and managerial efficiency by developing dedicated software support to manage MDTs, collect data and recrod and publish decsions. We must develop these on a network wide scal
36. I am lucky belonging to a highly functional good MDT team. I am cancer director of a Trust however, where some of our teams are not so good, and we use best practice to visit each others MDT's and learn form the good.A dysfunctional team remains dysfunctional until the issues that make thenm this way are identified and addressed, and generic teaching is not going to stop this. Most health care professionals wnat to make patients better and they use the MDT to do this.

Anyone who does not usually has personal issues either with the process or other members of the team which need sensitive handing and things like e learning packages are not the answer!

37. I am fortunate to be the lead and a core member of a strong, enthusiastic and dedicated MDT. I worry about a number of the questions above and the potential direction they may be leading us. Special training above what we have already received is not required for the majority, awaydays, training days, extra measurement and benchmarking is time consuming with little benefit in this setting for the majority. Keep it simple, record outcomes as per NBOCAP - it takes many years of data to show an improvement or otherwise in patient outcomes.
38. I am currently a core member. I was the Clinical and MDT lead for over 2 years for a different region
39. Honesty. Accurate information. Patient satisfaction with decision making process. Transparency. Internal audit and feedback. Degree of confluence with National protocols.
40. high performing mdts have a high core member attendance rate and cordial but interractive discussion of cases.
41. High performing MDTs attract more work and are exhausting, need more adequate time resources and facilities for following up of more contentious or difficult decisions
42. Have guidelines but be flexible. Too much regimentation takes away performance.
43. Good leadership & team working Patient-centred approach Good administration
44. Good attendance at regular MDT meetings. Published/available outcome data (especially recurrence rates and 5 and 10 year survival figures)
45. for a succesful MDT working the most important people are a good MDT co-ordinator and a good chair. Then the clinicans of all specialties can give the best advice and come to the best conclusions
46. Embracing the concept of an MDT and dropping own agenda/posture
47. effective mdt working needs the time and support of all core members and the financial support of the trusts to give the clerical support needed.
48. Don't waste any more precious resources on management consultants
49. Don't know or have never experienced a high performance MDT.
50. Audit data collection remains a huge weakness in many Trusts and needs urgent substantial investment
51. Attendance at the weekly MDT should be an enjoyable and well as a useful professional experience.
52. As a national referral centre for pituitary disease, our excellent auditied outcomes are being denied to some patients because of local cancer networks. Pituitary disease is not cancer and this is completely mad
53. An mdt is only as good as it members and the quality of the information available both are mdt's are inefficient because patients are discussed before all information is available and sometimes after they have been treat or descisions made.There is no feed back mechanism for this as it is largely unrecorded so audit of the mdt can not be done.This leads to frustration and on occasion discord.Which is not helpful to team working.Most agenda's are to large to be dealt with effectively.
54. Already covered
55. all cancer pateints discussed and treatment plan recorded
56. Adequate organisational supports and investment in term of human and technology resources, Respect by all member to all, transparent honest discussion focusing on the real issue and every one should be able to share views, Quality leadership that lead by example the key to successful MDM. Time out for business meetings, audit and educational activities on controversial topics or recent developments is the key to success
57. accurate and current information, evidenced based decision, recrding decisions
58. A lot of the issues relate to inadequate resources and unbalanced use of existing resources. Many trusts are battling with financial issues and need support to help MDTs
59. A fantastic local meeting with excellent [regional audit] benchmarked results has been replaced with a shoddy under resourced regional meeting thanks to a

perception that larger groups are better at managing patients

60. A "standard" locally adaptable operational policy would be very helpful.
61. % of listed cases not discussed no of times a case is discussed / year