Evaluating cancer multidisciplinary team (MDT) meetings

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The Royal College of Radiologists

About RCR

The Royal College of Radiologists is the leading professional membership body for clinical radiologists and clinical oncologists, supporting doctors throughout their career so that they can make a real difference.

About this report

The insights in this report were generated in collaboration with Thiscovery.

About Thiscovery

Thiscovery are online health and care engagement specialists. Their work gathers knowledge and experience from people who use, deliver and influence health and care services.

Their unique approach draws on the expertise of an interdisciplinary team of academics, former clinicians and technical innovators, as well as their accessible online platform which leverages sophisticated research methods to engage a growing, diverse crowd of participants. The robust and reliable insights they deliver allows organisations to solve real problems by shaping clever and evidence-based solutions.

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We'd also like to give out sincerest thanks to all those who took time out of their busy professional working time to provide such thoughtful and constructive responses.

Executive summary

Introduction

Cancer multidisciplinary team (MDT) meetings are a cornerstone of cancer care in the UK, bringing together specialists to discuss patient cases and make treatment decisions. Despite their established value, concerns about operational efficiency and the pace of change have grown — particularly following the publication of NHS England's streamlining guidance in 2020.

The project set out to understand what is really happening in cancer MDTs across the UK — capturing the full picture of how professionals experience these meetings, what they value, what isn't working, and what they believe needs to change. Evaluating the implementation of the 2020 NHS England streamlining guidance formed part of this, alongside generating actionable insights to inform Royal College of Radiologists policy development and practical improvement across cancer pathways.

Undertaken by a multi-organisational team committed to generating evidence that can drive practical improvement in cancer MDT working, the project brought together:

Dr Kath Halliday (Consultant Paediatric Radiologist, GIRFT Lead and Former RCR President, Nottingham University Hospitals)

Dr Nicky Thorp (Consultant Clinical Oncologist, The Christie NHS Foundation Trust and Vice-President, Clinical Oncology, Royal College of Radiologists)

Professor Niels Peek (Professor of Data Science and Healthcare Improvement, THIS Institute, University of Cambridge)

Mr Ben Lamb (Consultant Urological and Robotic Surgeon, Barts Health and University College London Hospitals NHS Foundation Trust)

Dr Tayana Soukup Ascensao (Chartered Psychologist and Research Fellow in Human Factors, Imperial College London)

The team's breadth of clinical, academic, and research expertise — spanning radiology, oncology, surgery, data science, and human factors — was central to shaping a survey that was both methodologically robust and firmly grounded in the real-world experiences of cancer MDT staff.

Their collective insight ensured the questions asked were the right ones, and that the findings reflect what genuinely matters to the professionals working within these systems.

The research was facilitated by Thiscovery, led by Dr Jenni Burt (Chief Scientific and Innovation Officer) and Lorna Jacobs (Senior Insight Programme Manager). Thiscovery share the project team's commitment to driving meaningful change in health and care through robust, evidence-based engagement.

Report overview

Between May and July 2025, Thiscovery collaborated with the project team to conduct a nationwide online survey of healthcare professionals attending cancer MDT meetings across the UK.

Contributions from 1,455 participants — including radiologists, pathologists, clinical oncologists, clinical nurse specialists, surgeons, physicians, medical oncologists, administrative staff, and allied health professionals — provided comprehensive insights into current practices, operational challenges, and priorities for improvement.

Key insights

1. **MDTs are highly valued for their clinical benefits:** 87% of participants agreed that MDT meetings ensure diagnosis and management follows best practice. High levels of agreement were also recorded for reducing unwarranted variation in care (84%), enhancing communication within teams (82%), and reassuring staff about patient management decisions (85%). 70% felt MDT meetings were the most effective mechanism to achieve positive patient outcomes.
2. **Operational inefficiencies are widespread:** The most frequently cited problems affecting MDT effectiveness were insufficient details on referral forms (44% of respondents), excessive repeat discussions of the same patients (44%), and unavailable pathology results

(40%). Technology availability issues affected over one-third of respondents (34%), while 37% reported insufficient time to discuss patients adequately.

3. **Awareness and implementation of streamlining guidance remains low:** Only 46% of participants were aware of the 2020 NHS England streamlining guidance, with significant variation by professional role (58% of clinical oncologists versus 31% of administrative staff). Among those aware, just 13% reported full implementation in the MDTs they attended, while 51% were implementing recommendations only to some extent.
4. **Time burdens are substantial, particularly for those on multiple pathways:** 46% of participants attended more than one cancer pathway MDT. For the 22% attending three or more pathways, total weekly commitments from meetings and preparation could range from 6 to 12 hours or more — a significant and often underreported burden.
5. **Attitudes toward technology and AI are cautious but open:** 327 responses expressed openness to trialling AI, while 281 expressed uncertainty and 85 indicated dislike of AI use. The most frequently mentioned concern was the need to address basic digital infrastructure before considering advanced technological solutions.

Recommendations for improvement

Five priority themes were highlighted by participants when asked what could make cancer MDT working better:

1. **Appropriate selection of cases for MDT discussion** — focusing specialist time on complex cases while managing routine patients through standardised pathways and addressing the defensive medicine practices that drive unnecessary discussions.
2. **Ensuring core team attendance and engagement** — requiring clinicians who refer patients to attend discussions and ensuring that hybrid or remote attendance translates into active participation rather than passive presence.
3. **More effective and focused case discussions** — improving time management, mandating preparation by presenters, and concentrating discussions on treatment decisions rather than administrative or information-gathering tasks.
4. **Protocol-driven pathways for routine care** — expanding the use of standardised care pathways with robust safeguards, freeing MDT time for the cases that genuinely require multidisciplinary input.

5. **Improved referral processes and digital infrastructure** — establishing clear, consistent standards for MDT referrals and investing in reliable basic technology before pursuing more advanced solutions.

Next steps

The findings from this survey provide an evidence base to inform Royal College of Radiologists policy development and to support MDT improvement initiatives across cancer pathways in the UK.

The project team will use these insights to drive forward practical recommendations that reflect the priorities of the healthcare professionals who contributed — professionals who, even in their most critical responses, demonstrated a deep commitment to delivering better outcomes for their patients. On behalf of the entire project team, thank you for taking the time to contribute to and read this report.

Dr Kath Halliday

1. Who took part?

The insights in this report represent views and experiences from 1,455 healthcare professionals attending cancer MDT meetings across the UK, of whom 892 provided complete demographic information.

Professional Role

There was representation from across a broad spectrum of professionals who are involved in Cancer MDTs, with the majority of those providing information about role
(926) being Radiologists (212, 23%), followed by Pathologists (126, 14%) (see Figure 1.)

Figure 1. Breakdown of survey respondents' professional role (n= 926).
** Other includes allied health professionals, interventional radiologists, other medical specialties, other nursing roles, and other healthcare professionals*

Most respondents were core team members (68%), with smaller proportions serving as coordinators (11%), chairs/leaders (9%), and extended team members (9%).

Geographic representation

Responses came from across the UK, with strongest representation from:

- East of England (213 respondents, 23%)
- North West (143 respondents, 16%)
- London (116 respondents, 13%)
- North East and Yorkshire (108 respondents, 12%)

Scotland, Wales, and Northern Ireland were represented but with smaller sample sizes (26, 27, and 26 respondents respectively).

Cancer pathway participation

Respondents attended a diverse range of cancer pathway MDTs, with the most common being:

- Colorectal (208 attendees, 14% of pathway responses)
- Upper GI cancers (194 attendees, 13%)
- Breast (184 attendees, 13%)
- Lung (175 attendees, 12%)
- Genitourinary (172 attendees, 12%)

Analysis of pathway attendance patterns among 1,018 participants with valid data revealed that multiple pathway attendance was widespread. While 54% reported attending a single cancer pathway MDT, 46% were members of multiple teams: 24% attended two pathways, 13% attended three pathways, 4% attended four pathways, and 4% attended five or more pathways.

Multiple pathway attendance varied by professional role; 74% of clinical oncologists reported attending multiple pathways, along with 68% of pathologists and 60% of radiologists. In contrast, 22% of surgeons and 16% of clinical nurse specialists reported serving multiple pathways.

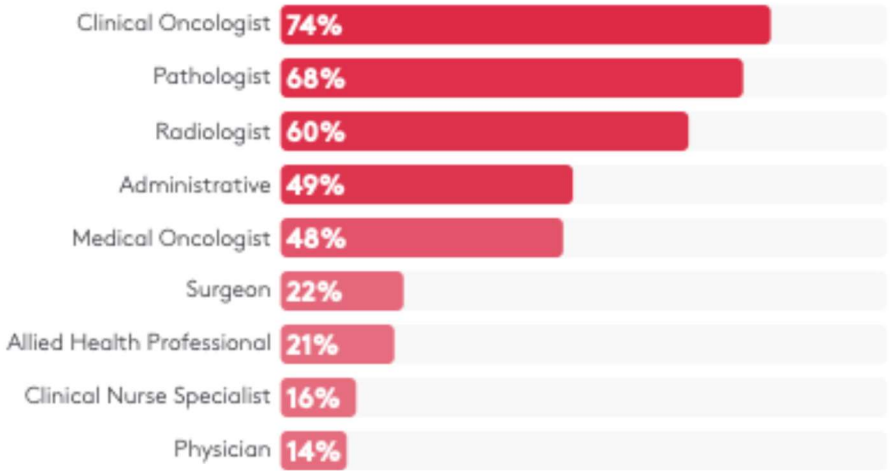

Figure 2. Multiple cancer pathway attendance by professional role. (n= 1,018) survey respondents with valid pathway data.

2. How did we hear from them?

Healthcare professionals were invited to complete surveys through the Thiscovery secure online platform (www.thiscovery.org) as part of a nationwide consultation undertaken on behalf of a team representing the Royal College of Radiologists, THIS Institute at the University of Cambridge, The Christie NHS Foundation Trust, Barts Health and University College London Hospitals NHS Foundation Trust and Imperial College London.

What questions were asked?

We developed a comprehensive questionnaire in consultation with Royal College of Radiologists staff, the project team and cancer care professionals. The survey was designed to evaluate implementation of the 2020 NHS England streamlining guidance and gather insights into current practices, challenges, and opportunities for improvement.

The questionnaire used a combination of structured rating scales and free text questions covering:

- Professional background and MDT involvement - roles, specialties, pathways attended, and geographic location
- Perceived benefits and effectiveness - structured questions using 5-point agreement scales about the value and impact of MDT meetings
- Operational characteristics - meeting size, duration, patient numbers, preparation time, and weekly commitments
- Efficiency challenges - multiple choice questions about problematic aspects and open text for solutions
- NHS England guidance - awareness, implementation status, and experiences with streamlining recommendations
- Suggestions for improvement - extensive free text opportunities to share ideas for enhancing MDT effectiveness

3. Survey findings

The value and structure of cancer MDTs

Healthcare professionals demonstrated strong consensus about the perceived value of cancer MDT meetings, while outlining variation in how these meetings are structured and delivered across different cancer pathways. Agreement on their important role in clinical decision-making coexisted with thoughtful critical perspectives that indicated clear opportunities for improvement.

Overwhelming support for core clinical benefits

There was remarkable consistency in participants' views about the essential clinical benefits of MDT meetings. The strongest agreement was for ensuring best practice, with 87% of 1,285 responding professionals agreeing that "MDT meetings ensure diagnosis and management follows best practice" (mean score 4.28 out of 5)

Figure 3. Percentage of respondents agreeing with each MDT benefit (n=1,285)

This pattern suggests that whilst many MDT members highly value the clinical decision-making aspects of MDTs, they see room for improvement in how meetings function.

Professional perspectives on MDT benefits

Open text responses centred on four main themes explaining the value professionals place on MDT meetings:

Facilitate and support collective clinical decision making

Professionals most frequently described MDTs as enabling collaborative decision-making processes. Reaching consensus on management plans was mentioned 328 times,
while facilitating multidisciplinary input into decisions appeared 207 times. As one pathologist explained:

> "As a pathologist, the MDT is a key tool for me having confidence that my report is being interpreted in the overall clinical context, not just read and acted on blindly. There is also an important workflow benefit - e.g. I can flag up to the MDT that whilst the report might not formally be ready, when I've not found tumour on a biopsy but am awaiting levels, they might want to be teeing up an alternative biopsy strategy, which can be stood down if the levels come good. It's a two-way conversation."

Another professional described MDTs as:

> "...a safe place to express their views and perspective, but in the end, everyone has agreed on an outcome which is deemed best for that patient."

Optimise patient diagnosis, treatment and care

The most frequent theme on this topic was tailoring treatment to individual patient needs and preferences (mentioned 353 times). Other important patient outcomes included ensuring patients receive an accurate diagnosis (115 times) and promoting evidence-based decision making (112 times). However, participants also identified important gaps in current practice, most notably the absence of the patient voice and consideration of what the MDT approach might feel like for them. As one participant wrote:

> "MDTs miss one major component: the patient or a representative of the patient's interests, objectives and priorities. They are not there. Hence, they are often seen and used as instruments for data collection and box ticking. They have mostly an administrative role of helping to track cancer journeys."

Strengthen teamwork and communication

Supporting team working and relationship building was mentioned 340 times, while facilitating open communication appeared 157 times. As one participant described the communication benefits:

> "Enhance collaborative and team working in geographically dispersed teams - interacting with surgeons etc regularly in this formal setting means I know them and we have a good working relationship, so when there is a challenging situation, we can work effectively outside/alongside formal MDT meetings to solve it."

Provide education and professional development

Learning opportunities for team members were indicated in 187 responses, with 112 emphasising a valuable role for knowledge sharing across disciplines. Participants noted that MDTs improved confidence and job satisfaction (52 comments) and supported skill development for junior team members (20 comments).

Critical perspectives on current MDT effectiveness

When asked specifically about whether cancer MDT meetings are the most effective mechanism to achieve the outcomes they described, 70% (n = 704) of participants stated yes, whilst 9% (n = 90) disagreed and 20% (n = 198) were not sure. Free text responses presented more outlying views that deserve consideration alongside the generally more positive perspectives.

Diverse operational models across cancer pathways

Analysis of MDT characteristics indicated variation in how meetings are structured across different cancer specialties (see Figure 2). Most cancer pathways operated with similar core structures: typical attendance of 11–20 participants, standard duration of 1–2 hours for most specialties, and typically 21–40 patients discussed per meeting.
Breast cancer MDTs showed distinct characteristics — discussing 61–80 patients per meeting, running for 2–3 hours, and requiring 1–2 hours of preparation time. Head and Neck MDTs demonstrated different patterns with larger team attendance (21–40 attendees).

Cancer pathway	Median number of attendees	Median duration	Median number of patients	Median prep time
Breast	11 to 20	2 to 3 hours	61 to 80	1 to 2 hours
Lung	11 to 20	1 to 2 hours	21 to 40	1 to 2 hours
Colorectal	11 to 20	1 to 2 hours	21 to 40	2 to 3 hours
Upper GI	11 to 20	1 to 2 hours	21 to 40	1 to 2 hours
Genitourinary	11 to 20	2 to 3 hours	41 to 60	1 to 2 hours
Head & Neck	21 to 40	1 to 2 hours	21 to 40	1 to 2 hours
Haematological	11 to 20	2 to 3 hours	21 to 40	Less than 1 hour
Paediatric	11 to 20	1 to 2 hours	1 to 10/11 to 20	Less than 1 hour
Skin	11 to 20	1 to 2 hours	21 to 40	1 to 2 hours
Other	11 to 20	1 to 2 hours	21 to 40	1 to 2 hours

Figure 4. Heat map table showing relative intensity of reported team size, meeting duration, patient volume, and preparation time by cancer pathway

Time commitments and pressures

Weekly meeting attendance data showed most clinical professionals spend below 5 hours per week in MDT meetings (84% of radiologists, 93% of surgeons, 70% of clinical oncologists). However, this data excludes preparation time and does not fully represent the time commitments for the 46% of professionals who attend multiple pathway MDTs.

Participant responses indicated that each MDT typically requires 1-2 hours of meeting time plus 1-2 hours of preparation. For healthcare professionals attending three pathway MDTs (13% of the sample), total weekly commitments therefore ranged from 6 to 12 hours. For the 9% attending four or more pathways, commitments potentially could reach 8 to 16 or more hours weekly.

Insufficient preparation time was mentioned 93 times in open responses as a key concern, with a number of participants noting it is also the inefficiencies in preparation which compound the problem.

Inefficiencies and operational challenges

Healthcare professionals identified clear and consistent patterns of inefficiency that they felt prevented MDTs from reaching their full potential effectiveness.

Major operational pain points

When asked to identify frequently problematic aspects of cancer MDT meetings, participants showed remarkable consensus on several key issues. Information availability problems dominated concerns:

Figure 5. Problems affecting MDT effectiveness — % of respondents citing each issue

Infrastructure and technology barriers

The technology challenges affecting over one-third of respondents were frequently described as creating barriers to effective communication and decision-making. One professional provided a detailed account of these issues:

> "Equipment can be unreliable. Some MDT coordinators are not trained to troubleshoot when equipment fails… When linking in via MS Teams to MDT it is very difficult to hear clearly. This is concern as people linking in via Teams could mishear something important."

System coordination and preparation failures

The most frequently mentioned concern was improving the efficiency of meeting discussions (94 times). Ensuring relevant patient information was available for meetings was the most frequently mentioned solution (95 times). Capping the number of cases discussed per meeting was mentioned 90 times, while ensuring meetings stay within allocated time appeared 85 times.

Attendance and participation issues

Ensuring all relevant core members attend meetings was mentioned 103 times. The attendance challenges had the potential to create cascading problems. Several participants also noted that "attendance" (particularly with hybrid or fully remote meetings) did not guarantee participation:

> "As majority attended online, they are often doing other work at the same time and not listening. Therefore, information has to be repeated. Staff dip in and out. Often falls to the same people to make decisions."

NHS England guidance awareness and implementation

The 2020 NHS England "Streamlining Multi-Disciplinary Team Meetings: Guidance for Cancer Alliances" showed limited penetration across participants, with variation by professional role and minimal full implementation.

Limited overall awareness

Only 46% of healthcare professionals (421 out of 924 valid responses) were aware of the NHS England streamlining guidance. Awareness varied by professional speciality, from 58% of clinical oncologists and 57% of surgeons, down to 35% of pathologists and 31% of administrative staff.

Minimal implementation despite awareness

Among the 412 participants aware of the guidance, implementation levels were low:

Figure 6. Implementation levels of those aware of guidelines (n=412 responses)

Combined, only 64% of guidance-aware professionals reported any level of implementation.

Implementation experiences and challenges

Respondents who reported some awareness of guidance implementation were asked to write a little more about the streamlining reforms or changes which were being made in response to the guidance.

Streamlining approaches being implemented

Changes to focus on more complex cases in MDT meetings were mentioned 44 times, representing the most frequently mentioned streamlining approach. Using or introducing standardised treatment protocols for routine cases was mentioned 30 times. Reflections on the experience of introducing streamlining were mentioned 29 times, with varied implementation outcomes:

> "We've followed the NHSE MDT streamlining guidance to reduce unnecessary re-discussions and focus MDT time on complex, treatment-defining cases. That's meant empowering CNSs, triaging cases better, and tightening referral processes so everything needed is there the first time. It's working: fewer relists, better flow, and more time for the patients who truly need it. But it only works in teams where there's trust. Where roles are respected, streamlining is transformative. Where they're not, it falls flat. For me, streamlining isn't just about process, it's about culture. Empower the right people, and the pathway improves. Every time."

Implementation barriers and resistance

Resistance to change and new protocols was mentioned 24 times as a barrier to implementation. Coordination challenges were mentioned 22 times and insufficient resources were mentioned 21 times as an implementation constraint.

Implications for policy effectiveness

The combination of limited awareness (46%) and minimal full implementation (13% of aware respondents) suggests that the 2020 streamlining guidance has achieved limited impact to date. Resistance to change (mentioned 24 times) and coordination challenges (mentioned 22 times) are identified as potential barriers.

Priorities for improvement

Healthcare professionals provided extensive suggestions when asked: "Do you have any thoughts or ideas on what could make cancer MDT working better?"

Figure 7. Top improvement priorities — number of times mentioned in open-text responses

Appropriate selection of cases for MDT discussion

Ensuring appropriate selection of cases requiring MDT discussion was mentioned 410 times, representing by far the most frequently suggested improvement. The general principle of focusing MDT time on complex cases while managing routine cases through standardised pathways was expressed consistently across responses. One professional articulated this as an '80/20 rule', suggesting that approximately 80% of cases could follow standard pathways.

> "Too many non-complex routine patients are discussed - diluting attention from the most important cases. There should be a cap on the numbers as all too often we have 2/3/4 minutes only to prep and then present, and this can lead to errors of omission as everyone is rushing"

Core team attendance and engagement

Ensure sufficient and appropriate attendance of all core MDT members was mentioned 164 times. Many responses addressed challenges with hybrid and remote attendance, noting that online participants often engaged in other activities during meetings, requiring information to be repeated and undermining discussion quality.

> "Make it essential that a person who has asked for discussion on the MDT and knows the patient details actually attends the meeting."

Focused and effective case discussions

Facilitating effective and focused discussions on each case was mentioned 143 times. Time management emerged as critical, with professionals noting that brief, focused discussions for appropriate cases allowed adequate time for complex cases requiring extended multidisciplinary input.

"MDT team must be brutal about time management of each case. All presenters must know their case and present succinctly. Prolonged discussion on a case should be avoided (unless exceptional reasons). Discussion should focus on treatment decision and next steps, not needless discussions"

Protocol-driven pathways for routine care

Using protocol driven pathways for standard care patients was mentioned 101 times. Participants called for clear criteria and oversight mechanisms to distinguish between routine cases suitable for protocols and complex cases requiring multidisciplinary discussion.

Referral processes and systems

The need to improve and enforce referral process and systems was mentioned 76 times. Participants described the need for clear pathways and consistent standards for MDT referrals.

"Better referral process to MDT, clear pathway for that tumour site. Patients should be referred when ready for an MDT discussion - not as a safety net before investigations have been completed"

Technology solutions and digital tools

Participants expressed measured, but often cautious, interest in technological solutions, particularly artificial intelligence and digital tools.

Figure 5. Attitudes toward AI and technology in cancer MDT working (n=693 responses)

Identified use cases for AI and technology

Professionals identified specific applications where technology could support MDT functioning:

- Assisting with clinical decision making (123 mentions)
- Providing administrative and logistical support for meetings (113 mentions)
- Streamlining and protocolising routine cases (84 mentions)
- Summarising discussions and documenting and tracking outcomes (75 mentions)

Technology implementation challenges

The most frequently mentioned concern was the need to address basic digital infrastructure before considering advanced solutions - this was noted 78 times. Other implementation concerns included: concerns about accuracy of AI (35 times), NHS has poor history of implementing technology well (34 times), and AI not yet sufficiently advanced to help in the right ways (30 times).

Additional improvement priorities

The need to consult on appropriate meeting length and frequency was mentioned 75 times. The need to improve time management was mentioned 64 times, whilst the requirement for strong and effective chairing was mentioned 63 times

4. Reflections

This report presents findings from a comprehensive survey of 1,455 healthcare professionals attending cancer MDT meetings across the UK. The data reveals strong recognition of the potential clinical value delivered by MDT meetings alongside extensive and complex operational inefficiencies. More importantly, it captures the authentic and committed voices of professionals who remain ambitious to improve patient care despite systemic challenges.

Healthcare professionals demonstrated overwhelming consensus on the fundamental clinical benefits of MDT meetings, with 87% agreeing that MDTs ensure best practice adherence and 84% agreeing they reduce care variation. However, this strong support coexisted with thoughtful criticism and clear frustration about operational inefficiencies, particularly around information availability and coordination.

The survey identified gaps in awareness and implementation of NHS England streamlining guidance, with only 46% of professionals aware of the 2020 guidance and just 13% of those aware reporting full implementation in meetings they attended.

The qualitative analysis revealed four main themes regarding MDT value: facilitating collective clinical decision making, optimising patient care, strengthening teamwork, and providing professional development opportunities. These themes suggest why professionals remain committed to the MDT model despite operational challenges.

Improvement priorities identified through open text responses focus on practical operational changes: improving meeting discussion efficiency, ensuring information availability, providing adequate preparation time, and implementing better triage processes.

Healthcare professionals showed widely varying engagement with technology solutions, with a balance of comments expressing openness to trails of AI use alongside those remaining uncertain. The emphasis on getting "basic digital tools right first" came through strongly.

This survey clearly captures the views of professionals who care deeply about their patients and their work. Even the most critical perspectives come from individuals whose responses indicated they were keen to seek better ways to deliver care.

What are the limitations of this survey?

This survey used purposive sampling through professional networks and voluntary participation, meaning the sample may not be fully representative of all UK cancer MDT participants. Those who responded may be more engaged with MDT quality issues than the broader population.

Response rates varied by survey section (from 88% to 46%), particularly dropping for later questions about guidance and final reflections. This pattern suggests either survey fatigue or reluctance to engage with policy-related questions.

Geographic representation, while UK-wide, was strongest from certain English regions and may under-represent experiences in Scotland, Wales, and Northern Ireland.

The cross-sectional design captures perspectives at a single point in time and cannot establish causal relationships between identified factors and MDT effectiveness.