

## The Experiences of Specialist Nurses Working Within the Uro-oncology Multidisciplinary Team in the United Kingdom

Geoffrey Punshon, BSc(Hons) ■ Ruth Endacott, PhD, MA, DipN(Lond), CertEd, RN ■  
Phillippa Aslett, BA(Hons), RGN ■ Jane Brocksom, BSc(Hons), RN, EN ■  
Louisa Fleure, MSc, PGDip, BSc(Hons), RN ■ Felicity Howdle ■ Morven Masterton, MA, BA(Hons) ■  
Anita O'Connor, MSc, BSc(Hons) ■ Adrian Swift ■ Paul Trevatt, MSc, RGN ■ Alison Leary, PhD, RN, FRCN

### Purpose:

United Kingdom prostate cancer nursing care is provided by a variety of urology and uro-oncology nurses. The experience of working in multidisciplinary teams (MDT) was investigated in a national study.

### Design:

The study consisted of a national survey with descriptive statistics and thematic analysis.

### Methods:

A secondary analysis of a data subset from a UK whole population survey was undertaken ( $n = 285$ ) of the specialist

nursing workforce and the services they provide. Data were collected on the experience of working in the MDT.

### Results:

Forty-five percent of the respondents felt that they worked in a functional MDT, 12% felt that they worked in a dysfunctional MDT, and 3.5% found the MDT meeting intimidating. Furthermore, 34% of the nurses felt that they could constructively challenge all members of the MDT in meetings. Themes emerging from open-ended questions were lack of interest in nonmedical concerns by other team members, ability to constructively challenge decisions or views within the meeting, and little opportunity for patients' wishes to be expressed.

### Conclusions:

Despite expertise and experience, nurses had a variable, often negative, experience of the MDT. It is necessary to ensure that all participants can contribute and are heard and valued. More emphasis should be given to patients' nonmedical needs.

### KEY WORDS:

clinical decision making, clinical nurse specialist, multidisciplinary team, nursing cancer, prostate cancer, urology, workforce

**Author Affiliations:** Visiting Fellow (Mr Punshon), School of Health and Social Care, London South Bank University; Professor in Clinical Nursing (Critical Care) (Prof Endacott), Plymouth University/Royal Devon and Exeter Hospital Clinical School; Senior Urology Nurse Specialist and BAUN President (Ms Aslett), Basingstoke and North Hampshire Foundation Trust, Hampshire; Urology & Continence Nurse Specialist (Ms Brocksom), St James's University Hospital, Leeds; Lead urology clinical nurse specialist/prostate cancer advanced nurse practitioner (Ms Fleure), Guy's and St Thomas' NHS Foundation Trust; Workforce Analyst (Ms Howdle), Mouchel Management Consulting Limited and Centre for Workforce Intelligence; Head of Outreach (Ms Masterton), Prostate Cancer UK; Research Assistant (Ms O'Connor), Centre for Health and Social Care Innovation, Plymouth University; Consultant (Mr Swift), Mouchel Management Consulting Limited and Centre for Workforce Intelligence; Lead, Cardiovascular, End of Life Care (Mr Trevatt), London Region, NHS England; and Chair of Healthcare & Workforce Modelling (Prof Leary), School of Health and Social Care, London South Bank University, London, UK.

The authors report no conflicts of interest.

**Correspondence:** Geoffrey Punshon, BSc(Hons), London South Bank University, FSHSC K2 Bldg, 103 Borough Rd, London SE1 0AA, UK (punshongeoff@yahoo.co.uk).

This is an open-access article distributed under the terms of the Creative Commons Attribution-Non Commercial-NoDerivatives License 4.0 (CCBYNC-ND), where it is permissible to download and share the work provided it is properly cited. The work cannot be changed in any way or used commercially without permission from the journal.

**DOI:** 10.1097/NUR.0000000000000308

According to Cancer Research UK, for the last 40 years, prostate cancer incidence rates in UK have more than tripled. There were 47 300 new cases of prostate cancer diagnosed in the United Kingdom in 2013. It is the second most common cause of cancer in the United Kingdom, and more than half the cases (54%) are in men 70 years and older causing around 11 300 deaths in the United Kingdom in 2014. It has been estimated that, worldwide, more than 1.11 million men were given a diagnosis of prostate cancer resulting in more than 307 000 deaths in 2012.<sup>1</sup>

The National Cancer Patient Experience Survey in England has demonstrated that patients with cancer

who have access to a clinical nurse specialist (CNS) generally report better experiences and understanding of the disease.<sup>2-5</sup> Despite the known benefits of access to a specialist nurse, the distribution of specialist nurses and incidence-to-nurse ratios vary enormously indicating that there is an inequity of access. Unlike other cancers, prostate cancer nursing care in the United Kingdom is rarely provided by a prostate CNS.<sup>6,7</sup> This is corroborated by the national cancer nursing census, which shows that only 2% of the specialist nursing workforce in England are prostate specific, approximately the same number as a rare cancer such as sarcoma.<sup>8</sup>

In the absence of a dedicated prostate cancer nursing workforce, prostate cancer care in the United Kingdom is provided by a variety of urology and uro-oncology nurses alongside specialists from other fields including bladder, kidney, testicular, and penile cancer, as well as benign disease. As a consequence, there are a variety of service arrangements and intersections with a number of multidisciplinary teams (MDTs).<sup>6,7</sup>

Cancer care in the United Kingdom is delivered by collaborative MDTs consisting of a core set of professionals, which includes oncologists, surgeons, and CNSs.<sup>9</sup> In the United Kingdom, patients are not generally present at MDT meetings. Because this study was carried out in the UK NHS, all staff are salaried and do not receive a fee for service.

The national cancer peer review program, launched in England in 2001, provided measurable standards to assess teams' adherence to the best practice guidance.<sup>9,10</sup> These standards reflect best practice drawn from a combination of research evidence, national consensus, and expert opinion, and central to this approach was the MDT. The MDT was promoted as the best practice in cancer care as a means of achieving more holistic cancer care delivered in a timely way by a team of experts rather than isolated individuals.<sup>11</sup>

The impact of working in MDT on team members is not well understood,<sup>12</sup> and the limited body of knowledge seems to be contradictory. In a national survey of team members carried out in the United Kingdom in 2014 (n = 2054), most respondents (90%) agreed that working in MDTs was beneficial to the well-being of members, and 81% agreed that it improves job satisfaction.<sup>13</sup> There is, however, anecdotal evidence of autocratic practice and hierarchical boundaries making teams dysfunctional and participation stressful.<sup>14</sup> Interviews with MDT members in primary care (n = 121) identified sources of conflict and barriers to conflict resolution, alongside team and individual strategies to resolve conflict.<sup>15</sup> However, an intervention study conducted with teams in general internal medicine did not achieve improvements in communication or collaboration because of lack of senior staff support or positive role modeling,<sup>16</sup> whereas an observational study revealed hierarchical behaviors in interprofessional teams, despite

team leaders (physicians) espousing collaborative leadership values.<sup>17</sup> Much of the research is focussed on the MDT meeting and its function or validity. A study of 370 MDT meetings,<sup>18</sup> which looked at different long-term conditions including cancer, found substantial diversity. This diversity existed in the purpose, structure, processes, and content of MDT meetings. Greater multidisciplinary was not necessarily associated with more effective decision making and MDT decisions (as measured by decision implementation). Decisions were also less likely to be implemented for patients living in more deprived areas.<sup>18</sup> There is little presented in the literature specifically about experiences of CNS in the MDT; however, the work of Taylor and Ramirez<sup>13</sup> for the National Cancer Action Team provided very detailed responses from cancer nurses as a subgroup. There seems to be no work on the experiences of specialist nurses working in uro-oncology who will also cover benign diseases.<sup>6</sup>

A detailed survey of the specialist uro-oncology nursing workforce<sup>6</sup> was undertaken in 2014 to look at many facets of the role and gather demographic information about the workforce providing care to men with prostate cancer in the United Kingdom. Specific questions about the experience of working in the MDT were included in the survey, and respondents were offered the opportunity to share their experiences of MDT working through a free text option where respondents could add detail and depth to their responses. The original survey revealed a rich data set of experiences of working within the MDT, and these have been subjected to secondary analysis by the research team.

## METHODS

A cross-sectional survey was undertaken using a census of the workforce similar to that used in the specialist cancer workforce.<sup>19,20</sup> A secondary analysis of a subset of the original data relating to experience of working in an MDT was then carried out.

## Sample

This is a whole population sample study. The available population of specialist nurses working in uro-oncology was determined by the British Association of Urological Nurses membership and the previous national census<sup>8</sup> to be between 300 and 350 by headcount.

## Data Collection Methods

A 24-item survey questionnaire, exploring demographic data, caseload and workload, and experience of MDT working, was developed for this population by consensus using clinical, patient, and academic experts.<sup>7</sup> The questionnaire was designed to gather data on activity and complexity of specialist nursing services provided including work left undone and used a format similar to the national optimum caseload modeling project.<sup>21</sup> This was

transferred to an online survey tool (administered using a Survey Monkey secure account). Ethical approval was sought and granted by Plymouth University Ethics Committee. The survey was developed during April and May 2014 and pilot tested with a small sample from the study population. The survey link was distributed through formal and informal networks; mailing lists; the nursing press; targeted interest groups such as the British Association of Urological Nurses, NHS CHAIN (Contact, Help, Advice and Information Network), and the UK Oncology Nursing Society; and social media (Twitter) during June and July 2014. Participants could only submit a single response from each computer. Analysis of the survey took place in November 2014 to January 2015. The secondary analysis of the original data<sup>7</sup> used in this study took place in Autumn/Winter 2015.

The survey presented a number of consensus statements. Of the 24 questions in the survey, three specifically related to the experience of working in MDT. The first question relating to the experience of working in MDT consisted of 13 statements regarding MDT working, which respondents could “agree” with or not (Table 1).

The other 2 questions relating specifically to the experience of working in MDT were open, free text questions, which were included to allow participants to provide additional information or raise any other issues they felt relevant.

The responses were examined overall and, in addition, by length of time in prostate cancer care and by pay band.

## Data Analysis

Data were exported into Excel and modeled using descriptive statistics, for example, demographics, pay band, and length of service. Free text comments were analyzed using thematic content analysis.<sup>22</sup> Thematic content analysis is the approach best suited to free text questions in an otherwise quantitative questionnaire because it does not rely on interpretation of data but instead reflects a “low hovering over the data.”<sup>22</sup> Each comment was coded, and themes emerged from the codes. Data excerpts are included hereinafter alongside quantitative findings to provide context. Excerpts are annotated according to job title and pay band (eg, CNS/band 6). The secondary analysis presented here is confined to the subsection of the survey, which examined the experience of working in the MDT. To determine whether responses were equal across different sectors of the workforce, responses were broken down by pay band and by years of experience. These are reported hereinafter.

## RESULTS

There were 302 respondents in total. After cleaning, the data from 285 respondents were used. Seventeen records were removed because they were incomplete submissions or submissions from countries outside the United Kingdom. Assuming the higher total of CNS working in uro-oncology in the United Kingdom to be 350, this suggests a response rate of 81% after data cleaning. The most common job title was CNS (n = 185). The responses were further broken down by the “Agenda for Change” pay band of their post. Agenda for Change is the process in the NHS by which nursing roles are allocated to 1 of 9 pay bands on the basis of the knowledge, responsibility, skills, and effort required for the post after a job evaluation. In general, the higher banding requires greater knowledge, responsibility, and skills.<sup>23</sup> The most common band was Agenda for Change band 7 (n = 174). However, in Scotland, 50% of the respondents stated that they were paid on band 6. More than half of the respondents (n = 158) had worked in prostate cancer care for more than 10 years. Few (n = 48) had come into specialist posts from a specific specialist nurse development role.

The results of the study are reported in full elsewhere,<sup>6,7</sup> and the results that specifically address working in the MDT are reported here. The MDT is a key component of cancer care delivery and is enshrined in English cancer policy<sup>24</sup>; however, increasing workload and cultural differences seem to present barriers for effective MDT working. The breakdown of respondents by country is shown in Table 2.

## Overall Responses to the Survey

The overall response to the survey can be seen in the Figure. Two themes emerged from the results: first, the functionality

**Table 1. The Statements Presented as Options in the Survey**

• I work in a functional and efficient MDT.
• I work in a dysfunctional MDT where views are not respected.
• The MDT meeting pays attention only to medical issues.
• I am not always told of new patients by members of the MDT.
• Attending the MDT meeting is not applicable to my role.
• I do not attend the MDT meeting.
• I would constructively challenge all members of the MDT in the meeting.
• I would constructively challenge some members of the MDT in the meeting but not others.
• I would constructively challenge members of the MDT after the meeting/separately in private.
• I wait until after the meeting to challenge because there is not enough time during the meeting.
• There are some members of the team I feel uncomfortable challenging in or outside the meeting.
• I do not feel it's my role to challenge other members of the MDT.
• I find the MDT meeting intimidating.
<i>Abbreviation: MDT, multi-disciplinary team.</i>

Country in the United Kingdom	Responses
England	243
Northern Ireland	3
Scotland	22
Wales	17
UK total	285

and operation of the MDT, and, second, the confidence or ability of the respondents to constructively challenge other members of the MDT. Quantitative findings are presented hereinafter in relation to these 2 themes; data excerpts from the free text responses are provided alongside the quantitative data.

### Functionality and Operation of the MDT

Less than half of the respondents (n = 128, 45%) agreed that they worked in a functional and efficient MDT. Respondents agreed that they worked in a dysfunctional MDT where views were not respected in 12% of responses (n = 35), and 14% (n = 40) agreed that the MDT meeting only paid attention to medical issues, whereas 27% (n = 76) agreed that they were not always told of new patients by members of the MDT.

The free text comments (n = 42) were most extensive in the questionnaire, with most comments expressing concerns about conduct of the MDT meeting. Common areas of concern relate to the lack of interest in nonmedical concerns:

I don't feel my views are valued at the MDT; they certainly don't ask for a nursing opinion. (CNS, band 7)

The MDT is driven by medical diagnosis, due to the number of patients we have to discuss. (CNS, band 7)

The most common issue expressed by the respondents is a lack of time—large numbers of patients are commonly discussed, and problems such as “the consultant sometimes goes off-script” or “sometimes it can get quite heated” were seen to contribute to the ineffective working of the MDT. The lack of buy-in at an organizational level was reflected in 1 comment:

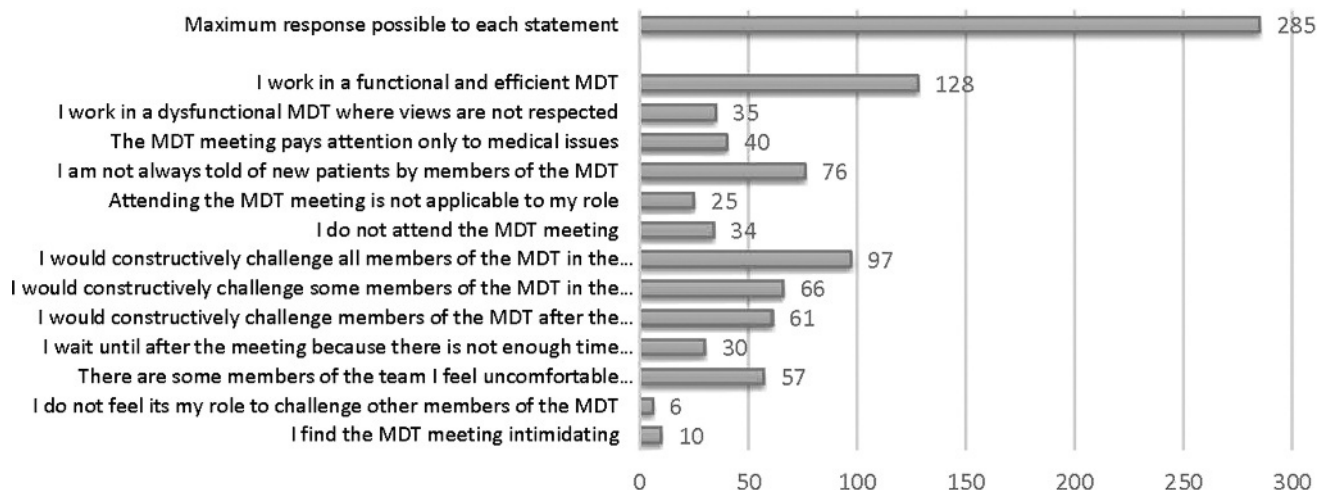
[The MDT meeting is] often disorganised, poorly attended at consultant level. No team cohesion with clerical staff/management. Management do not respect the importance of MDT often double book the consultants which forces poor attendance. (CNS, band 6)

The changes to cancer care delivery and multisite MDT meetings also presented challenges, for example:

While our local MDT works well, there are conflicts and issues within the larger MDT which includes [name of hospitals] Hospitals. I would rarely speak up in these teleconference meetings. With the NHS changes and changes to the Cancer Networks the momentum for change and progress has been compromised. (specialist nurse, band 6)

When reviewed by pay band (see Table 3), the percentage of respondents agreeing that they worked in a functional and efficient MDT increased for each pay band (20% at band 5, 35% at band 6, 49% at band 7, 54% at band 8a, and 80% at band 8b). The percentage of respondents agreeing that they worked in a dysfunctional MDT was relatively constant as was those who agreed that the MDT paid attention only to medical issues.

To see whether responses were affected by the number of years of experience the respondents have, the responses were broken down into 5 categories by length of experience (<1, 1–3, 4–6, 7–10, and >10 years) (see Table 4). There were only 11 responses from nurses with less than a year's experience so it was difficult to draw any conclusions from this group.



**FIGURE.** Agreed statements about MDT meeting (number indicates number of respondents out of 285 agreeing with the statement).

**Table 3. Agreed Statements About MDT Meeting by Pay Band**

Agreed statements about MDT	Pay Band						Total Number Agreeing With Statement (N = 279) <sup>a</sup>
	Bands 1-4 (n = 1)	Band 5 (n = 5)	Band 6 (n = 66)	Band 7 (n = 174)	Band 8a (n = 28)	Band 8b-8d (n = 5)	
Functionality and operation of the MDT							
I work in a functional and efficient MDT.	0	1 (20%)	23 (35%)	85 (49%)	15 (54%)	4 (80%)	n = 128
I work in a dysfunctional MDT where views are not respected.	0	0	11 (17%)	19 (11%)	5 (18%)	0	n = 35
The MDT meeting pays attention only to medical issues.	0	1 (20%)	5 (8%)	31 (18%)	2 (7%)	1 (8%)	n = 40
I am not always told of new patients by members of the MDT.	0	2 (40%)	14 (21%)	57 (33%)	3 (11%)	0	n = 76
Attending the MDT meeting is not applicable to my role.	0	0	15 (23%)	8 (5%)	2 (7%)	0	n = 25
I do not attend the MDT meeting.	0	3 (60%)	11 (17%)	18 (10%)	2 (7%)	0	n = 34
Freedom to challenge within the MDT							
I would constructively challenge all members of the MDT in the meeting.	0	1 (20%)	13 (20%)	65 (37%)	13 (46%)	5 (100%)	n = 97
I would constructively challenge some members of the MDT in the meeting but not others.	0	0	11 (17%)	49 (28%)	6 (21%)	0	n = 66
I would constructively challenge members of the MDT after the meeting/separately in private.	0	0	9 (14%)	48 (28%)	2 (7%)	2 (40%)	n = 61
I wait until after the meeting because there is not enough time during the meeting.	0	0	7 (11%)	22 (13%)	1 (4%)	0	n = 30
There are some members of the team I feel uncomfortable challenging in or outside the meeting.	0	1 (20%)	13 (20%)	39 (22%)	4 (14%)	0	n = 57
I do not feel it's my role to challenge other members of the MDT.	0	0	4 (6%)	2 (1%)	0	0	n = 6
I find the MDT meeting intimidating.	0	0	2 (3%)	8 (5%)	0	0	n = 10

Abbreviation: MDT, multi-disciplinary team. Percentages relate to the percentage of respondents at each band who agreed with the relevant statement. <sup>a</sup>Missing data, n = 6.

**Table 4. Agreed Statements About MDT Meeting by Years of Experience**

Agreed Statements About MDT	Years of Experience				
	<1 (N = 11)	1-3 (N = 21)	4-6 (N = 38)	7-10 (N = 53)	>10 (N = 158)
Functionality and operation of the MDT					
I work in a functional and efficient MDT.	1 (9%)	12 (57%)	14 (37%)	25 (47%)	75 (48%)
I work in a dysfunctional MDT where views are not respected.	3 (27%)	2 (10%)	9 (24%)	5 (9%)	15 (10%)
The MDT meeting pays attention only to medical issues.	3 (27%)	3 (14%)	5 (13%)	11 (19%)	18 (11%)
I am not always told of new patients by members of the MDT.	4 (36%)	7 (33%)	12 (32%)	13 (24%)	39 (25%)
Attending the MDT meeting is not applicable to my role.	3 (27%)	2 (10%)	0	4 (8%)	15 (10%)
I do not attend the MDT meeting.	2 (18%)	2 (10%)	5 (13%)	6 (11%)	18 (11%)
Freedom to challenge within the MDT					
I would constructively challenge all members of the MDT in the meeting.	1 (9%)	5 (24%)	7 (18%)	18 (34%)	66 (42%)
I would constructively challenge some members of the MDT in the meeting but not others.	1 (9%)	7 (33%)	13 (34%)	12 (23%)	31 (20%)
I would constructively challenge members of the MDT after the meeting/separately in private.	2 (18%)	4 (19%)	7 (18%)	15 (28%)	33 (21%)
I wait until after the meeting because there is not enough time during the meeting.	2 (18%)	4 (19%)	6 (16%)	6 (11%)	12 (8%)
There are some members of the team I feel uncomfortable challenging in or outside the meeting.	3 (27%)	6 (28%)	10 (26%)	13 (24%)	24 (15%)
I do not feel it's my role to challenge other members of the MDT.	1 (9%)	0	2 (5%)	2 (4%)	1 (1%)
I find the MDT meeting intimidating.	1 (9%)	0	1 (3%)	2 (4%)	6 (4%)

Abbreviation: MDT, multi-disciplinary team.

Percentages relate to the percentage of respondents at each experience level who agreed with the relevant statement.

The percentage of nurses who agreed that they worked in a functional and efficient MDT varied from 57% for the group with 1 to 3 years of experience, 37% for the group with 4 to 6 years of experience, 47% for the group with 7 to 10 years of experience, and 48% for the group with more than 10 years of experience. However, looking at the number of nurses who agreed that they worked in a dysfunctional MDT, there was a higher response (37%) from those with 4 to 6 years of experience than those with 1 to 3 (10%), 7 to 10 (9%), and more than 10 (10%) years of experience.

As regards the MDT paying attention only to medical issues, there was a relatively constant response between the experience groups (11%-19%). When looking at respondents being told of new patients by members of the MDT, there seems to be a divide between nurses with 1 to 3 or 4 to 6 years of experience (33% and 32%, respectively) being less likely to be informed of new patients compared with those with 7 to 10 or more than 10 years of experience (24% and 25%, respectively). Positive responses to attending the MDT meeting not being part of their role and not attending the MDT meeting were very similar over all the experience groups.

### Freedom to Challenge

Looking at the ability to constructively challenge other members of the MDT during the meeting, 34% of the respondents (n = 97) felt able to constructively challenge all members of the MDT during the meeting. Although 23% (n = 66) felt able to constructively challenge some members of the MDT in the meeting but not others in 20% of responses, they (n = 57) agreed that there were some members of the team they felt uncomfortable challenging in or outside the meeting, and 4% (n = 10) found the meeting intimidating. Only 2% (n = 6) agreed that it was not their role to challenge other members of the MDT. As regards challenging after the meeting, 21% (n = 61) agreed that they would constructively challenge members of the MDT after the meeting or separately in private, whereas 10% (n = 30) agreed that they would wait until after the meeting because there was not enough time in the meeting.

Another theme that emerged from the free text responses was the ability to constructively challenge decisions or views within the MDT meeting.

MDT can be difficult, I would usually challenge during the MDT, but don't always get heard, either due to the general discussion (sometimes quite

heated) I feel ignored though sometimes, I don't have access to all MDT members to challenge outside the MDT meeting. Within the meeting however, I think I have more of a voice than the other nurse members, I suspect they challenge some individuals outside the meeting. I believe I am there to advocate on behalf of patients and hope if ever I needed discussed in an MDT the CNS would speak up for me. (CNS, band 7)

It would depend on who was at the MDT as dynamics change when certain members are not there. (CNS, band 6)

Finally, 9% (n = 25) agreed that attending the MDT meeting was not applicable to their role, whereas 11% (n = 34) did not attend the MDT meeting.

Responses were reviewed by pay band (see Table 3). Looking at the ability to constructively challenge all members of the MDT in the meeting, there is an increase in the percentage agreeing with this statement, with increasing band after 6 (20% at band 5, 20% at band 6, 37% at band 7, 46% at band 8a, and 100% at band 8b), whereas the percentage of respondents agreeing that there are some members of the team they feel uncomfortable challenging is relatively constant across bands 5 to 8a (20% at band 5, 20% at band 6, 22% at band 7, and 14% at band 8a) (see Table 3).

Responses were also reviewed by years of experience (see Table 4). There is again an observed difference between those with 1 to 3 or 3 to 6 years of experience (24% and 18%, respectively) and those with 7 to 10 or more than 10 years of experience (34% and 42%, respectively), with the longer service band feeling abler to challenge. Those with 1 to 3 or 4 to 6 years of experience were more likely to agree that they would challenge some members of the MDT in the meeting but not others (33% and 34%, respectively) compared with those with 7 to 10 or more than 10 years of experience (23% and 20%, respectively). The rate of agreeing that there were some members of the team they felt uncomfortable challenging in or outside the meeting was consistent among the groups with 1 to 3, 4 to 6, and 7 to 10 years of experience (28%, 26%, and 24%, respectively) and slightly reduced in the group with more than 10 years of experience (15%). The responses to not feeling that it was part of their role to challenge in the MDT meeting and finding the MDT meeting intimidating were similar across all the experience groups.

## DISCUSSION

The results obtained in this study demonstrate that there is a variety of perceptions of the experience of working in MDT across urology nurses in the United Kingdom. Because the MDT is a cancer standard in England with a proscribed membership, the MDT meetings are often large, and many patients are reviewed. A number of studies have been carried out into the effectiveness of MDT meet-

ings and the contribution of nurses to the MDT meeting since MDTs were introduced.

Atwal and Caldwell<sup>25</sup> looked at nurses' perceptions of MDT work in acute healthcare. They reported that 3 barriers hindered teamwork: (1) differing perceptions of teamwork, (2) different levels of skill acquisitions to function as a team member, and (3) the dominance of medical power that influenced interaction in teams.

A study by Fosker and Dodwell<sup>26</sup> looked at attendances, time spent on the MDT meeting, and the number of patients discussed in the MDT for 14 cancer MDTs during a single week. The results obtained showed that an average of 10 consultants, less than 1 junior doctor (0.7/meeting), and 3 "others" (nurses, pharmacy staff, radiographers, and clerical) attended each meeting. An average of 31 patients was discussed at each MDT, and the average time allocated was 2.14 hours (approximately 4 minutes per patient). The time spent did not include preparation time.

Lamb et al<sup>27</sup> analyzed the contributions of surgeons, oncologists, radiologists, pathologists, and clinical nurses to MDT and reported that surgeons and radiologists had contributions of higher than average compared with histopathologists and nurses, which were rated lower than average.

Other studies have found that the CNS is often the team member assessing the holistic needs of the patient and acting as the key worker,<sup>28</sup> and the same group reported that nurses' contributions to MDT meetings may be limited.<sup>27</sup>

Patient involvement in treatment decisions is central to UK health policy and a key part of the NHS constitution, with the phrase "No decision about me without me" being used to describe the importance of the patient viewpoint. Taylor et al<sup>29</sup> carried out a qualitative interview study looking at "No decision about me without me" in the context of MDT meetings. The researchers conducted semistructured interviews with 9 current cancer care patients and 12 MDT members from the teams managing their care. Findings showed that most MDT members felt that the patients had a limited understanding about the MDT and that, at most, they might understand that recommendations for treatment were the result of an MDT discussion between groups of different health professionals. Three patients in the study recalled being given information about the MDT verbally by the CNS, and members of the MDT described the importance of the CNS in relation to information giving due to their level of contact with the patient. The study also reported instances where patients were presented at the MDT without team members having previous knowledge of them and suggested that, if nobody in the MDT knows the patient, it was more likely that the treatment plan would not be correct.

Eigenmann,<sup>30</sup> in a personal view, suggests that crucial decisions are often made in the MDT without seeing the

patient and suggests that the MDT should always include an advocate for the patient such as the patient's general practitioner or a hospital generalist. He further states that the opinion of the patient through his/her advocate should carry the same weight as the specialist opinion.

Multidisciplinary team working should facilitate excellence through collaborative working and be the cornerstone for patient-centered care. However, the poor experience of MDT working and meetings reported by many nurses in this study is very concerning with less than half of the respondents agreeing that they worked in a functional and efficient MDT. Lack of time, disorganization, and the high numbers of patients to be discussed were all reported as barriers to efficient MDT working. The ability of nurses to challenge in the MDT meeting is also very important because all members of the MDT team should feel able to challenge in the meeting if appropriate, but again, our findings give cause for concern. All members of the MDT should feel able to challenge in the meeting if appropriate, yet around a quarter of nurses reported that there were some members of the MDT they felt uncomfortable challenging in or outside the meeting.

Patient advocacy is a significant part of the role of CNS, and many prostate CNSs are instrumental in helping patients come to decisions regarding their treatment options, as well as managing the aftereffects of these treatments. The American Association of Critical-Care Nurses' "Scope and Standards for Acute Care Specialist Nurse Clinical Practice" report recommends that advocacy, communication, and responding to diversity are key roles of the CNS,<sup>31</sup> and this is emphasized by Gurzick and Kesten<sup>32</sup> who looked at the impact of CNS on clinical pathways with regard to the application of evidence-based practice.

Therapies for prostate cancer often result in significant quality-of-life issues, which can impact on their survivorship long after treatment has ended. In addition, men with relapsing or progressing illnesses often have very significant physical, psychological, and social issues, which need to be taken into account in treatment paths. Several studies have demonstrated the vital role the CNS can play to identify these issues<sup>33</sup> and ensuring that they are addressed when formulating care plans. Another area in which the CNS can have an important impact is in facilitating family intervention for patients with prostate cancer because many of the issues facing men with prostate cancer impact on spouses, as well as the patient.<sup>34</sup>

Again, the results of this study suggest that there is a need for these issues to be taken into account and that this may not always be the case at present, with 14% of the respondents agreeing that the MDT only took account of medical issues and 27% agreeing that they were not always told of new patients before the MDT. This may make it difficult to present nonmedical issues, although the CNS is often the most appropriate member of the team to do this.

## CONCLUSIONS

It is apparent that many of the issues raised by previous studies, which repeatedly arise into the experience of nurses at MDT and their contribution to the MDT, still need to be addressed. It is recommended that all teams review the time allocated for MDT to ensure there is adequate dedicated time both to present each patient and for preparation. This time should be protected for all members of the MDT. The wider body of evidence cited here indicates that this needs to be addressed at an organizational level, as well as by the local teams.

The structure of meetings should also be reviewed to ensure that all members' contributions are heard and valued. More emphasis needs to be given to patients' nonmedical needs to ensure that "No decision about me without me" becomes a reality rather than a catchphrase, and it is believed by the authors of this study that the CNSs are the most appropriate person to represent the patients' views in the MDT given that they tend to have the most contact with the patient. This would have a significant impact on patient care and experience and also use the skills and abilities of the CNS, increasing their job satisfaction. The increased emphasis on interprofessional learning includes teamwork as a key theme; our findings suggest that this needs to move beyond undergraduate curricula and become embedded into mandatory training and education.<sup>35</sup>

In conclusion, safe, effective, and efficient teamwork requires empowered membership,<sup>36</sup> and examining ways of MDT working will be key to improving the experience of MDT working in the future.

## Acknowledgments

The authors thank the President, committee, and members of the British Association of Urological Nurses; Steve Candler, Senior Network and Domain Manager, Thames Valley Strategic Clinical Networks, NHS England; Doreen Smulders and Dale Rominger, Prostate Cancer UK volunteers; Jaqueline Goodchild and Sophie Townsend, Macmillan Cancer Support; The NHS/NHIR Contact, Help, Advice and Information Network; the President and members of the United Kingdom Oncology Nursing Society; and Frances Pickersgill and Janet Snell, Nursing Standard.

## References

1. Cancer Research United Kingdom. Prostate cancer statistics. <http://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/prostate-cancer/incidence>. Accessed October 21, 2016.
2. Department of Health. National cancer patient experience survey programme. <https://www.gov.uk/government/publications/national-cancer-patient-experience-survey-programme-2010-national-survey-report>. Accessed October 9, 2014.
3. Department of Health. National cancer patient experience survey. <http://tinyurl.com/crpdaxx>. Accessed October 9, 2014.
4. National Health Service England. Cancer patient experience survey 2012–13. <http://tinyurl.com/ntxeh52>. Accessed October 23, 2014.



5. NHS England. Cancer patient experience survey 2014. Web site. <http://tinyurl.com/oz96j68>. Accessed October 23, 2014.
6. Prostate Cancer UK. The specialist nursing workforce caring for men with prostate cancer in the UK. [http://prostatecanceruk.org/media/2491517/2631-urology-nurse-workforce-research-report\\_web.pdf](http://prostatecanceruk.org/media/2491517/2631-urology-nurse-workforce-research-report_web.pdf). Accessed December 15, 2015.
7. Leary A, Brocksom J, Endacott R, et al. The specialist nursing workforce caring for men with prostate cancer in the UK. *Int J Urol Nurs*. 2016;10(1):5–13.
8. Macmillan Cancer Support. Census of the specialist cancer nursing workforce (England). <http://www.macmillan.org.uk/Documents/AboutUs/Research/Researchandevaluationreports/Macmillan-Census-Report-England.pdf>. Accessed November 4, 2015.
9. Department of Health. The manual for cancer services. [http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4135597.pdf](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4135597.pdf). Accessed October 23, 2014.
10. Department of Health. The cancer reform strategy. [http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Cancer/DH\\_091120](http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Cancer/DH_091120). Accessed October 10, 2014.
11. National Cancer Action Team. Excellence in cancer care: the contribution of the clinical nurse specialist. <http://webarchive.nationalarchives.gov.uk/20130513211237/http://www.ncat.nhs.uk/sites/default/files/work-docs/Excellence%20in%20Cancer%20Care.pdf>. Accessed January 10, 2016.
12. Taylor C, Munro AJ, Glynne-Jones R, et al. Multidisciplinary team working in cancer: what is the evidence? *BMJ*. 2010;340:c951.
13. Taylor C, Ramirez AJ. Multidisciplinary team members' views about MDT working: results from a survey commissioned by the National Cancer Action Team. [www.ncin.org.uk/view?rid=137](http://www.ncin.org.uk/view?rid=137). Accessed October 23, 2014.
14. Kagan AR. The multidisciplinary clinic. *Int J Radiat Oncol Biol Phys*. 2005;61(4):967–968.
15. Brown J, Lewis L, Ellis K, Stewart M, Freeman TR, Kasperski MJ. Conflict on interprofessional primary health care teams—can it be resolved? *J Interprof Care*. 2011;25(1):4–10.
16. Rice K, Zwarenstein M, Conn LG, Kenaszchuk C, Russell A, Reeves S. An intervention to improve interprofessional collaboration and communications: a comparative qualitative study. *J Interprof Care*. 2010;24(4):350–361.
17. Lingard L, Vanstone M, Durrant M, et al. Conflicting messages: examining the dynamics of leadership on interprofessional teams. *Acad Med*. 2012;87(12):1762–1767.
18. Raine R, Wallace I, Nic a' Bhàird C, et al. Improving the effectiveness of multidisciplinary team meetings for patients with chronic diseases: a prospective observational study. *Health Serv Deliv Res*. 2014;2(37):1–172.
19. National Cancer Action Team. Quality in nursing. clinical nurse specialists in cancer care; provision, proportion and performance. A census of the cancer specialist nurse workforce in England 2010. [http://alisonleary.co.uk/docs/Clinical%20Nurse%20Specialistsin%20Cancer%20Care\\_%20Provision.pdf](http://alisonleary.co.uk/docs/Clinical%20Nurse%20Specialistsin%20Cancer%20Care_%20Provision.pdf). Accessed January 10, 2016.
20. Trevatt P, Leary A. Commissioning the specialist cancer nursing workforce. *Cancer Nurs Pract*. 2010;5:23–26.
21. National Cancer Action Team. Alexa caseload tool: user guide. <http://journals.rcni.com/doi/abs/10.7748/cnp2013.02.12.1.5.p10456?journalCode=cnp>. Accessed January 10, 2016.
22. Anderson R. *Thematic Content Analysis (TCA). Descriptive Presentation of Qualitative data*. Institute of Transpersonal Psychology: Palo Alto, CA; 1997.
23. NHS Employers. How agenda for change works. <http://www.nhsemployers.org/your-workforce/pay-and-reward/pay/agenda-for-change-pay/how-agenda-for-change-works>. Accessed December 20, 2016.
24. Department of Health. Improving outcomes: a strategy for cancer. [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213785/dh\\_123394.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213785/dh_123394.pdf). Accessed October 23, 2014.
25. Atwal A, Caldwell K. Nurses' perceptions of multidisciplinary team work in acute health-care. *Int J Nurs Pract*. 2006;12(6):359–365.
26. Fosker CJ, Dodwell D. The cost of the MDT. <http://www.bmj.com/rapid-response/2011/11/02/cost-mdt>. Accessed October 23, 2014.
27. Lamb BW, Wong HW, Vincent C, Green JS, Sevdalis N. Teamwork and team performance in multidisciplinary cancer teams: development and evaluation of an observational assessment tool. *BMJ Qual Saf*. 2011;20(10):849–856.
28. Lamb BW, Sevdalis N, Arora S, Pinto A, Vincent C, Green JS. Teamwork and team decision-making at multidisciplinary cancer conferences: barriers, facilitators, and opportunities for improvement. *World J Surg*. 2011;35(9):1970–1976.
29. Taylor C, Finnegan-John J, Green JS. “No decision about me without me” in the context of cancer multidisciplinary team meetings: a qualitative interview study. *BMC Health Serv Res*. 2014;14:488.
30. Eigenmann F. Multidisciplinary team meetings encourage overtreatment. *BMJ (Clin Res Ed)*. 2015;351:h4630.
31. American Association of Critical-Care Nurses. AACN scope and standards for acute care specialist nurse clinical practice. [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213785/dh\\_123394.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213785/dh_123394.pdf). Accessed October 21, 2016.
32. Gurzick M, Kesten KS. The impact of clinical nurse specialists on clinical pathways in the application of evidence-based practice. *J Prof Nurs*. 2010;26(1):42–48.
33. Giesler RB, Given B, Given CW, et al. Improving the quality of life of patients with prostate carcinoma: a randomized trial testing the efficacy of a nurse-driven intervention. *Cancer*. 2005;104(4):752–762.
34. Northouse LL, Mood DW, Schafenacker A, et al. Randomized clinical trial of a family intervention for prostate cancer patients and their spouses. *Cancer*. 2007;110(12):2809–2818.
35. Thistlethwaite J, Moran M. Learning outcomes for interprofessional education (IPE): literature review and synthesis. *J Interprof Care*. 2010;24(5):503–513.
36. West MA. *Effective Teamwork: Practical Lessons from Organizational Research*. 3rd ed. West Sussex, UK: Wiley-Blackwell; 2012.