Supplementary data - TABLES

Table 1 – Details the parameters, numbers of respondents and representative quotations to the role and purpose of the MDT in IBD care.

Table 1 The role and purpose of the IBD MDT		
PARAMETER	RESPONDENTS	REPRESENTATIVE QUOTATIONS FROM MDT MEMBERS
Question: Is there a role for an MDT in the care of patients with IBD?		
Yes	15	*"IBD is a complex medical condition (that) involves the input from a wide range of disciplines, hence 'multidisciplinary', and the decision-making is often not straightforward" CG7*
No	1	*"Resources, time and money are a huge issue, on that basis it's very difficult in my mind to justify MDTs...you need good team working with appropriate specialists and the physician and the surgeon and the patient, and the radiologist" CS2*
Question: If so, what should the purpose of the IBD MDT be?		
Improve patient outcome	15	*"...to give the best quality care to the patients...in IBD surgery it's to minimise emergency operations. I think that's its chief role. We know that the outcomes are much worse in that group of patients." CS4*
To share collective experience/expertise	21	
Provide consensus on decision making	17	*"It engenders a team-working approach and where decisions are difficult it's always good to bounce ideas off of colleagues…" CS4*
Clinical governance	12	*"...the MDT's also important because with the open publication of complications ... it protects not only the patient, but the individuals, the surgeons, the stoma therapists, everyone that's involved. And it's easier to go to a patient and say, "The team decision was…" And I think that's an important role that people forget from the MDT..." CS4*
MDT = Multidisciplinary Team; IBD = Inflammatory Bowel Disease; CS = Consultant Colorectal Surgeon; CG = Consultant Gastroenterologist		

Table 2 – Details the parameters, numbers of respondents and representative quotations for structural inputs and necessities required for an effective IBD MDT care.

Question: What factors are required for an effective IBD MDT to occur?		
PARAMETER	RESPONDENTS	REPRESENTATIVE QUOTATIONS FROM MDT MEMBERS
Good attendance	18	*"...surgical attendance can be quite variable.... we have radiology, pathology, medical gastro and occasional attendance of colorectal surgery... we definitely need to work towards getting more colorectal presence there because (of) joined up decision making." CG6*
Protected Time	14	*"...it lacks the pathology input because formally we are not scheduled to go. It's not part of our job plan to attend this meeting so it is only on a voluntary basis…" CP1*
Proactive multidisciplinary contribution	22	*"you're dealing with a lot of personalities....various methods (include) ... alternating the Chairperson so that it moves from one consultant to the next," NS4*
Provision for research and education	13	*"... (You can) introduce the concept of trials for people who don't understand, or who aren't aware of some of the trials that are ongoing at the time. It is the place where ideas can be generated based on difficult situations or situations that aren't necessarily straightforward. And so it is the cornerstone of research." CS4*
Specific question addressed	13	*"...in trying to make it an efficient process …there should be criteria of those patients who are clearly going to benefit …there should be a specific reason or a key question to be answered that can really only be answered by the MDT" CR2*
Ownership	13	*"…the person who is presenting that case should either write in the notes or ... write a letter to the patient or the GP saying, 'Your case has been discussed and this is the outcome.'.NS6*
Chair person	13	*"There must be a clear chairperson, who leads the discussion….there must be a question in mind, so a brief summary, someone to present a brief summary, and then a specific question in mind, so that it will run smoothly" CP2*
Documentation	15	*"MDT pro-forma, which is really useful and has everything about the patients all on a couple of sheets with all of their charts, history and everything else and up-to-date X-rays and everything else that we need, so that's really good." NS2.*
Appropriate resources	27	*"...infrastructure that worked. It would be incredibly frustrating if that were inadequate in any way... from a radiologist's perspective really good facilities for reviewing cases. ...so just a workstation with a means of beaming that...the pathologist would have their stipulations around microscopes and all that sort of thing...you need a coordinator, somebody who can record things. You want previous results flashed up." CR5*
Feedback on cases	13	*"feedback regardless of what you do is important, and I think it can be a learning opportunity as well…if we were going to audit the outcomes of the MDT you could feed that back to the clinical governance meeting that happens once a month, or someone could write a paper on the outcomes of an MDT" CR3*
MDT = Multidisciplinary Team; IBD = Inflammatory Bowel Disease; CS = Consultant Colorectal Surgeon; CR = Consultant GI Radiologist; CG = Consultant Gastroenterologist, NS = IBD Nurse Specialist; CP = Consultant Pathologist		

Table 3 – Details the parameters, numbers of respondents and representative quotations in logistical considerations required for an effective IBD MDT.

Table 3 - Logistics for an effective IBD MDT		
Question: What logistical considerations are required for an effective IBD MDT to occur?		
Parameter	Respondents	Representative Quotations from MDT members
Duration of one hour	10	*"It depends very much on the volume of the cases that go through your institution. If you only have one or two cases a week, a half an hour IBD MDT would be quite adequate...If you have to discuss 10 or 15 cases, you might need a two hour MDT. And depending on the complexity you need to add a factor in to that as well." CS4*
Scheduled once a week	16	*"You could argue that it should be once a week so if there are any inpatients that need to be discussed, you know, two weeks is too far apart. But if you're a small unit, or a small hospital, you know, an hour once a week, you know, there may be no patients to discuss, or one or two patients to discuss." CG7*
Selective process	19	*"in some places it might be that they can discuss all of their IBD cases; in others it might have to be selected to the higher risk ones, you know, such as the surgical ones and the non-surgical ones" CS6 "...some weeks people might feel that, you know, they might not have got their case across, but you, basically, bring your own cases and it's a bun fight for who gets to discuss their case first" CG7*
MDT = Multidisciplinary Team; IBD = Inflammatory Bowel Disease; CS = Consultant Colorectal Surgeon; CG = Consultant Gastroenterologist		

Table 4 - Details the parameters, numbers of respondents and representative quotations for the overall design of an effective IBD MDT.

Table 4 -Overall design of an effective IBD MDT		
Question: How would you redesign the IBD MDT to maximise potential?		
Parameter	Respondents	Representative Quotations from MDT members
Hub and spoke model	7	*"...it may be that if you had a regionalised one, you might have five surgeons there...I think that would be helpful... But if you've got five surgeons bringing five sets of cases, it might be five hours rather than one hour. So there has to be some happy medium there. It may be that two hospitals would be okay" CS6*
Single centre	10	*"I get quite nervous, I mean, we've had cases where consultants from elsewhere have provided us with clinical details and requested that a Registrar present their case at our MDT from a patient that we've never seen, never met and we're meant to be making decisions about what happens to them, and I get quite nervous about that" NS4*
IBD cases discussed only	11	
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