INNOVATING FOR A HEALTHIER FUTURE

ROYAL COLLEGE OF SURGEONS IN IRELAND

Expert Group on Best Practice in Clinical Governance in Surgery

Final Survey Report

December 2025

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Foreword

Prof Deborah McNamara
RCSI President

Surgeons have long embraced clinical audit as a mechanism of quality assurance, dating back to the seminal contributions of Harvard orthopaedic surgeon Ernest Codman in the early 1900s. As healthcare practice has evolved in complexity, the standards and norms of clinical governance have likewise evolved.

For surgeons in Ireland, the recent pivot by the Health Service Executive towards a regionalised structure and the introduction of new infrastructure for scheduled care, such as surgical hubs and elective hospitals, are important changes that our clinical governance frameworks must adapt to. For this reason, I felt it was timely to capture the voice and the expertise of the surgical community in defining best practice in clinical governance for surgery in this new era.

The RCSI Expert Group in Best Practice in Clinical Governance in Surgery was convened in June 2024 under the leadership of Council Member, Mr David Moore (FRCSI). After bringing together a multispecialty expert group and a series of exploratory meetings, the expert group began an extensive stakeholder consultation.

This first report summarises the findings of their consultations and represents the largest distillation of surgical opinion on this subject in RCSI's history. I particularly commend the expert group for ensuring broad representation of perspectives across all regions, specialties and career stages. This extensive engagement provides a firm foundation upon which to define a Framework for Best Practice in Clinical Governance in Surgery, that we intend to publish in early 2026.

My sincere thanks to David Moore, the members of the Expert Group and all of those who contributed to the report. Thanks also to the Department of Surgical Affairs, especially Kieran Ryan and Daniel Howard, for supporting this work.

Professor Deborah McNamara
President, Royal College of Surgeons of Ireland

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Introduction

Mr David Moore
Chair of Expert Group on Best Practice in Clinical Governance in Surgery, RCSI Council Member.

In the ever-evolving landscape of healthcare, the surgical community plays a pivotal role in ensuring the highest standards of patient care and safety. A Short Life Working Group (SLWG) was tasked by the President of the Royal College of Surgeons in Ireland to make recommendations on Standards in Surgical Governance.

This report explores the critical importance of Multidisciplinary Team (MDT) meetings and Mortality and Morbidity (M&M) meetings within surgical practice in Ireland.

These collaborative forums serve not only as essential platforms for shared clinical decision-making but also as a conduit for fostering a culture of continuous learning and accountability. The insights gathered from the surgical community underscore the multifaceted impact of MDT and M&M meetings on their day-to-day operations, the overall quality of patient care, and the professional development of surgical teams. Through these gatherings, surgical teams engage in open dialogue, reflect on clinical outcomes, and rigorously review practices, ultimately striving to enhance patient safety and treatment efficacy.

Moreover, the feedback obtained reveals significant considerations regarding the provision of adequate resources necessary to effectively run these meetings. Participants articulated concerns about the availability of administrative support, the clarity of reporting pathways, and the allocation of sufficient time amidst demanding surgical schedules.

Addressing these issues is vital for maximising the effectiveness of MDT and M&M meetings and ensuring they serve their intended purpose of promoting excellence in surgical practice.

Mr David Moore
Chair of Expert Group on Best Practice in Clinical Governance in Surgery
RCSI Council Member, Consultant Surgeon (Trauma/Orthopaedic), Children's Health Ireland, Crumlin, Tallaght University Hospital and Blackrock Clinic

1. Methodology

In order to source the required information to sufficiently inform this study, the expert group decided to use an online survey to gather the insights and opinions of RCSI Fellows, Members, Trainers and Trainees from across the 26 counties of the Republic of Ireland.

This survey incorporated both qualitative and quantitative characteristics, through the utilisation of both free text and multiple-choice questions. Such an approach was adopted as it allowed the expert group to ascertain the nuanced challenges and operational shortcomings currently being experienced across surgical teams in Ireland.

A full list of the questions utilised in this survey can be found in Appendix 1 and end of this report.

The data gathered through multiple-choice questions is portrayed in various graphs throughout this report, while the information collected through the qualitative questions was analysed and categorised thematically, with the most prominent themes discussed contained in this report also. Every effort was made to protect the identity of the respondents involved, with their names, titles and professional achievements anonymised by the research team.

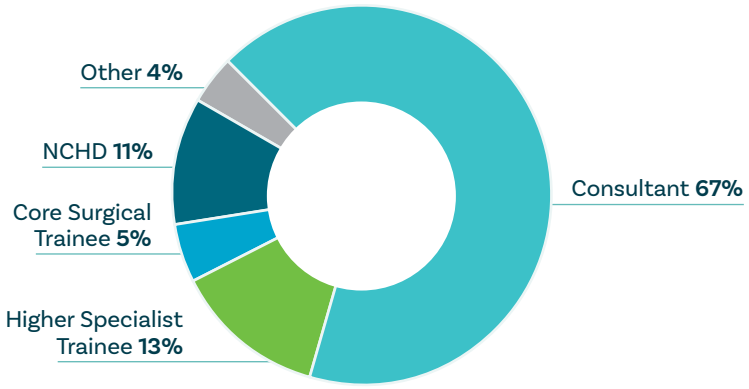
1.1 Overview of Respondents

The survey was circulated to a total of 2,407 RCSI Fellows and Members, of which 496 were Trainers and 500 were Trainees. In total, the research team received 343 fully completed surveys, which represents a response rate of 14.2%. There was a significant response rate by Core Surgical Trainees (5%), Higher Specialist Trainees (13%) and Non-Consultant Hospital Doctors (11%), with the largest cohort represented in this survey being Consultants at 67% (see *figure 1*).

All eleven surgical specialities recognised by RCSI are represented in this survey, with General Surgeons (33%) and Trauma and Orthopaedic Surgeons (24%) being the most represented specialties (see *figure 2*). Responses have also been gathered from across all of the hospital regions in the Republic of Ireland, with hospital regions situated in Dublin and the surrounding areas seeing the highest volume of responses, constituting 60% of the total responses gathered (see *figure 4*).

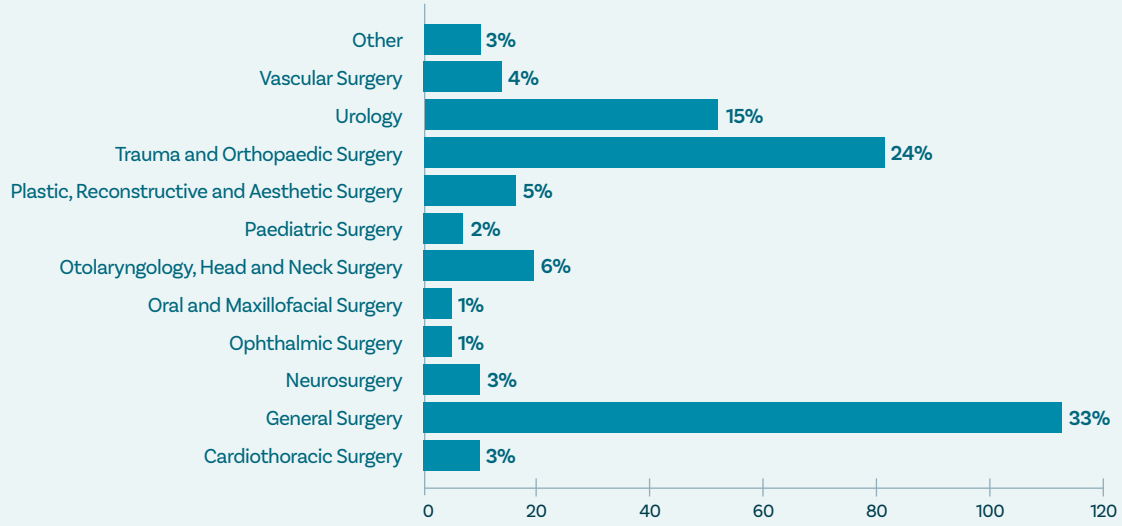
1.1.1 Responses by Role

Figure 1 Respondents who selected 'Other' identified their roles as either Clinical Directors within the ROI, as Fellows of RCSI, or as Retired.



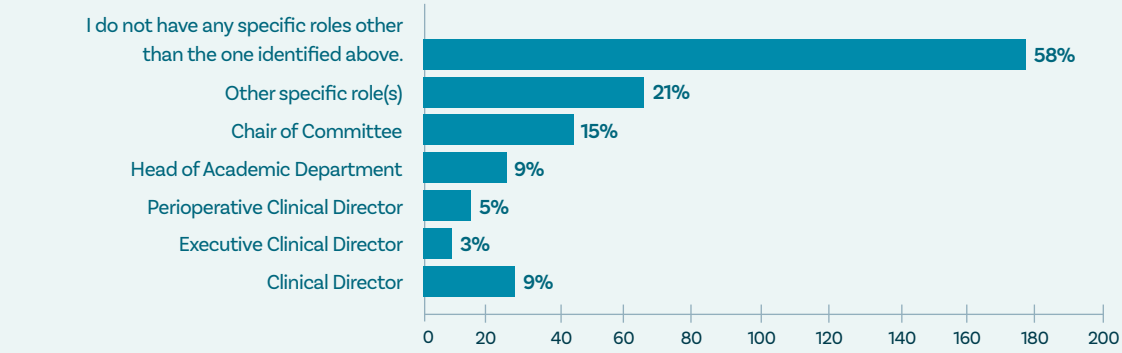
1.1.2 Responses by Specialty

Figure 2 Respondents who selected 'Other' noted their specialties in Emergency Medicine, Interventional Radiology and Anaesthesia.



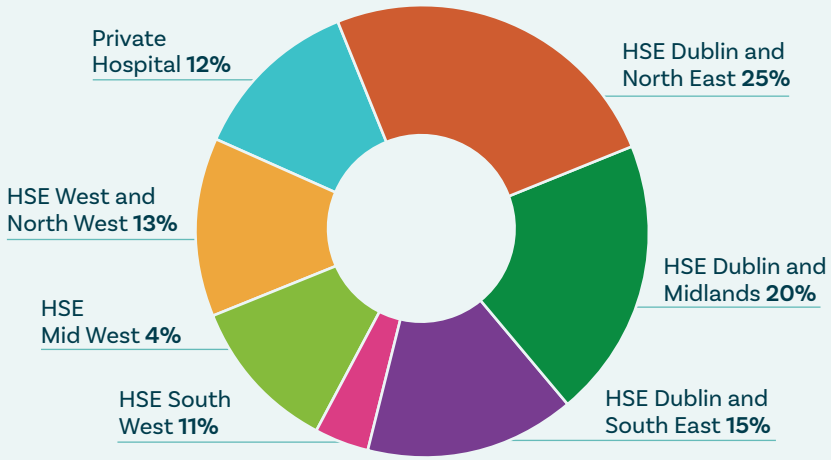
1.1.3 Other Specific Roles Held by Respondents

Figure 3 Roles held by respondents of the survey.



1.1.4 Responses by Region

Figure 4 The table above identifies the regions in which the respondents are situated, with 60% of respondents working in or around the wider Dublin area.



2. Multi-Disciplinary Team Meetings

2.1 Information Regarding Respondent Experiences of MDT Meetings

There was a noteworthy disparity between the number of MDT meetings attended by surgeons, with 64% attending 1-4 meetings, approximately 4% associated with 5 or more, and 32% not participating in any MDT meetings whatsoever (see *figure 5*). The majority of meetings occur weekly (70%), with 8% taking place on a monthly basis and 3% occurring every three months. 11% of respondents disclosed that they attend two or more MDT meetings on a weekly basis.

Figure 5 Indicates the number of MDT meetings respondents attend, differentiated by their role

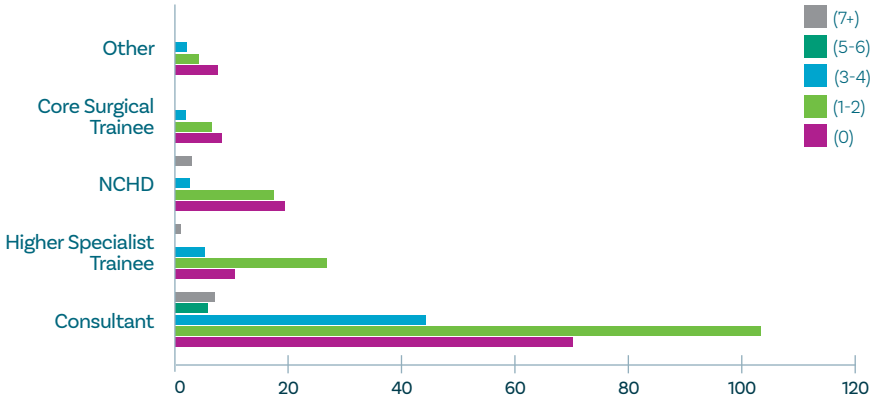
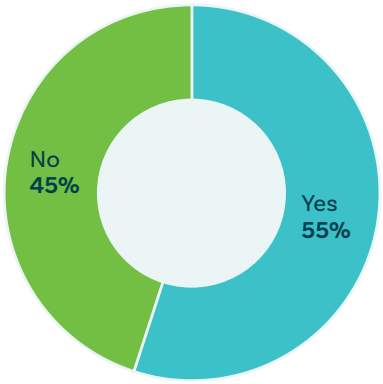


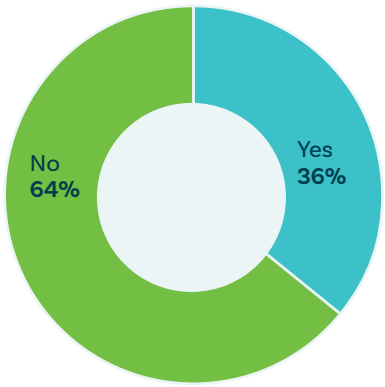
Figure 6 Indicates that almost half of MDT meetings are not provisioned with adequate administrative support.



In relation to the administrative operation of MDT meetings, 23% of surgeons highlighted that there is no clear set of criteria for the types of cases selected for presentation; and the same percentage (23%) highlighted that these meetings are not recorded by way of minutes or meeting notes.

Additionally, only 55% of MDT meetings are resourced with adequate administrative support (see *figure 6*); and 64% have no structured mechanisms to allow for feedback and quality improvement measures (see *figure 7*).

Figure 7 Indicates that almost two thirds of MDT meetings have no structured mechanisms to support the review of previous cases presented, allow for feedback on the actions taken regarding such cases, or to instigate quality improvement measures to advance future practices/procedures.



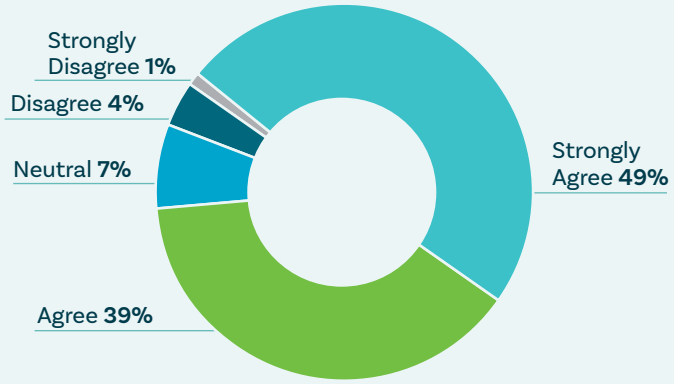
Key Points

- Almost 75% of MDT meetings have clear sets of criteria for the types of cases selected for presentation.
- Almost 25% of MDT meetings are not recorded by way of minutes or meeting notes.
- Almost half of MDT meetings (45%) are not resourced with adequate administrative and IT support.
- 64% of MDT meetings have no structured mechanisms to allow for feedback and quality improvement measures.

2.2 Importance and Effectiveness of MDT Meetings

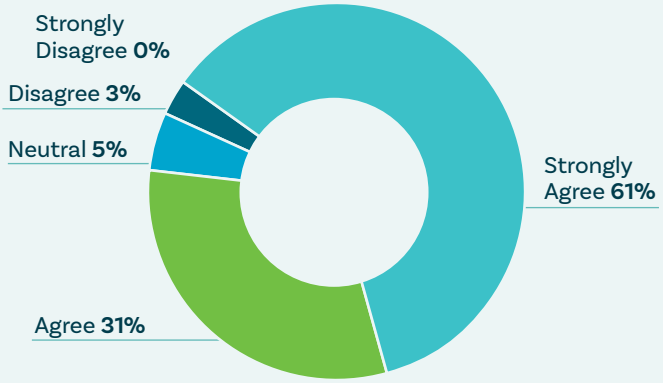
According to the data gathered by this survey, significant support and recognition for the effectiveness of MDT meetings was conveyed by the respondents. Almost 90% of surgeons believe that these meetings help to ensure that clinical decision-making follows evidence-based best practices (*see figure 8*), while 89% believe they aid in enhancing communication and collaboration between surgical teams and other specialties.

Figure 8 88% of respondents believe that MDT meetings help to ensure that clinical decision-making follows evidence-based best practices.



When asked if MDT meetings help to protect both patients and staff through structured reviews and decision-making, 86% of surgeons thought this to be the case, with only 6% either disagreeing or strongly disagreeing with this statement. Additionally, over 90% of the people surveyed believe that such meetings should be formally recorded and filed to enable reviews at a later date, with only 3% disagreeing that such an approach should be utilised (*see figure 9*).

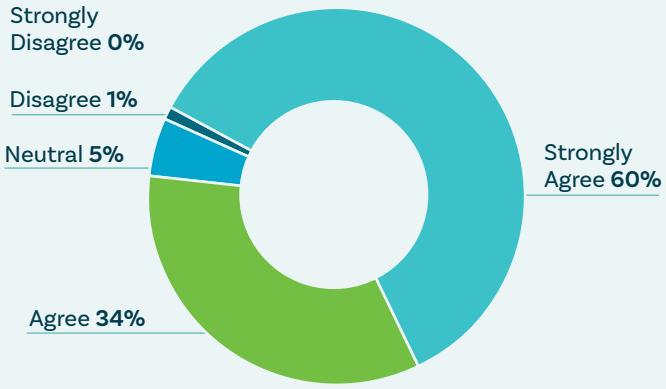
Figure 9 Over 90% of surgeons believe that MDT & M&M meetings should not be formally recorded and filed for review.



When asked to identify other ways in which MDT meetings have been effective in their experiences, respondents identified a number of valuable professional and patient centred attributes associated with this meeting type. The most prominent theme identified related to increased patient involvement in their treatment plans, recognising their individual perspectives and increasing transparency. Respondents also noted clear benefits to communication pathways between all relevant parties and key stakeholders (89% - Agree or Strongly Agree), therefore improving collaborative decision making and treatment strategies, with an increased focus on bettering patient outcomes (94% - Agree or Strongly Agree) (*see figure 10*).

Additionally, participants emphasised how MDT meetings help to foster a positive working culture across surgical and other healthcare professionals, therefore improving coordinated multidisciplinary management, aiding the transfer of knowledge and their ability to identify gaps in training and service provision.

Figure 10 94% of surgeons believe that MDT meetings are essential in ensuring appropriate and safe surgical patient care.



Surgeons highlighted how effective leadership, through both chairing and facilitation, are important to the effective operation of MDT meetings (96% - Agree or Strongly Agree) and stressed their importance in strengthening governance structures, developing clinical protocols, improving case reviews and increasing accountability and policy adherence.

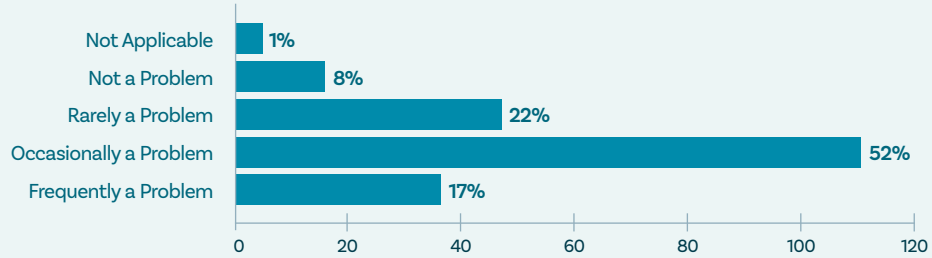
Key Points

- Almost 90% of surgeons believe that MDT meetings help to ensure that clinical decision-making follows evidence-based best practices.
- 94% of surgeons believe that MDT meetings are essential in ensuring appropriate and safe surgical patient care.
- Almost 90% of respondents believe that MDT meetings aid in enhancing communication and collaboration between surgical teams and other specialties.
- Effective MDT meetings help to identify gaps in training and service provision.
- Effective MDT meetings help to increase patient involvement in their treatment plans.
- Effective MDT meetings facilitate open communication, collaboration and transparency.
- Effective MDT meetings help to strengthen governance structures in hospitals.
- Effective MDT meetings help to improve clinical protocols and case reviews.
- Attendance at MDT meetings helps to increase accountability and policy adherence.

2.3 Weaknesses of MDT Meetings

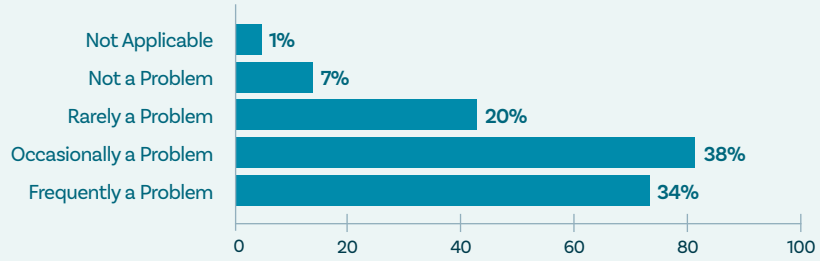
When asked to identify the main weaknesses of MDT meetings, surgeons identified a number of important characteristics that can hinder their effective operation. Firstly, access to complete and relevant information during meetings has been identified as occasionally or frequently a problem by 69% of surgeons (*see figure 11*). While 72% of surgeons have encountered similar problems with not having sufficient time to discuss complex cases at these meetings (*see figure 12*).

Figure 11 Highlights the frequency of meetings held without access to fully complete patient information.



Additionally, at least 46% of the surgeons surveyed have encountered instances of inadequate follow-up and implementation of agreed upon actions following the conclusion of MDT meetings. Also, 68% have encountered problems with not having the full participation of all relevant decision makers at such meetings (*see figure 13*).

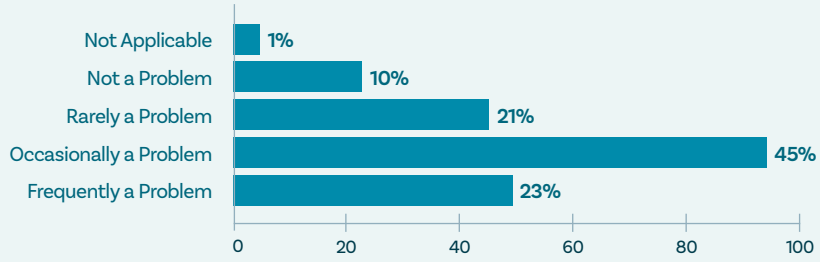
Figure 12 Highlights the frequency of meetings held without having sufficient time to discuss complex cases.



Finally, a range of other matters were also identified as having the potential to impede the effective operation of MDT meetings and these included:

1. **Not having protected time to attend and effectively participate in meetings.**
2. **Having inadequate administrative provision and access to reliable IT resources.**
3. **Adopting ineffective management and leadership practices.**

Figure 13 Illustrates that only 11% of respondents have never encountered any problems with having the full participation of all relevant decision makers at MDT meetings.



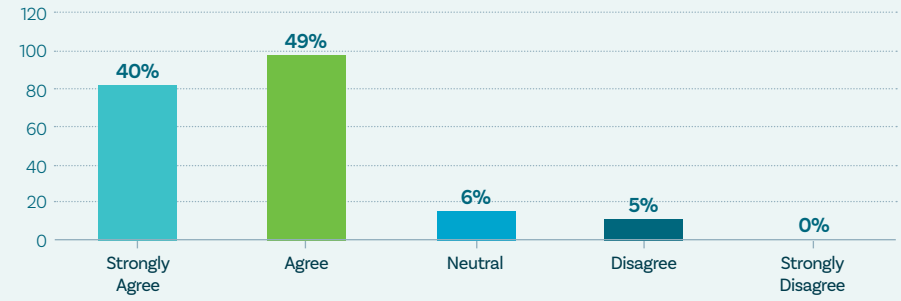
Key Points

- 69% of surgeons have attended MDT meetings where not having timely access to fully complete and relevant patient information has been described as frequently or occasionally a problem.
- 72% of surgeons have encountered problems with not having sufficient time to discuss complex cases at MDT meetings.
- 68% have encountered problems with not having the full participation of all relevant decision makers at meetings.
- 46% of surgeons have encountered instances of inadequate follow-up and implementation of agreed upon actions following MDT meetings.
- Insufficient protected time to attend and effectively participate in MDT meetings is a significant barrier.
- Inadequate administrative support and access to reliable IT resources is a barrier to the effective operation of MDT meetings.

2.4 Areas for Improvement & Other Issues for MDT Meetings

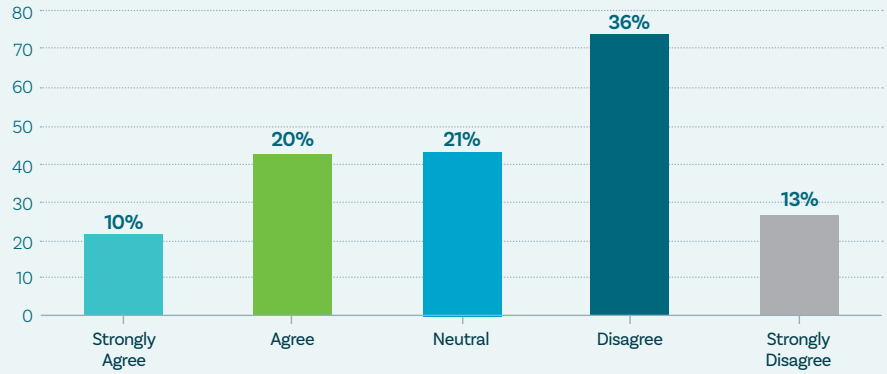
Upon discussing areas for improvement and other issues associated with MDT meetings in Ireland, the survey participants raised a number of interesting viewpoints in how to improve and maximise their operational effectiveness. Firstly, 74% of surgeons believe that technology such as AI or digital tools would improve the quality and efficiency of MDT meetings, while approximately 89% believe that the introduction of novel techniques, treatment strategies, technologies or devices should be presented at these meetings (*see figure 14*).

Figure 14 Illustrates that only 5% of surgeons believe that the introduction of novel techniques, treatment strategies, technologies or devices should not be presented at MDT meetings



Moving on to their administrative operation, approximately 82% of the surgeons believe that attendance at MDT meetings should be mandatory for all consultants, while 94% believe that these meetings should be formally recorded by way of meeting minutes and filed safely for review at a later date if needed. Additionally, 73% of surgeons stated that the Chair of MDT meetings should rotate between colleagues on an annual basis.

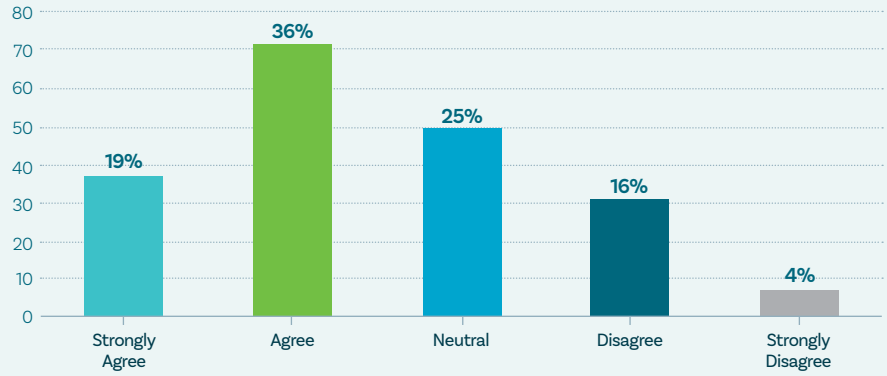
Figure 15 Indicates that only 30% of surgeons believe that they have enough protected time for meaningful participation in MDT meetings



When focusing on to the standard of surgical governance frameworks, only 37% of surgeons believe that current clinical governance frameworks adequately support MDT meeting processes in areas, such as the escalation of systemic risks or trends. Only 30% of surgeons stated that they have sufficient protected time to enable their meaningful participation in these meetings, with almost half (49%) disagreeing with this statement (*see figure 15*). Additionally, at least 32% of surgeons believe that all surgical specialities do not have equitable access to MDT meetings.

Finally, 89% of surgeons confirmed that they feel empowered to raise concerns or points of learning during these meetings, while there was a disparity between respondents as to whether MDT meetings currently promote a culture of psychological safety in Irish hospitals, with 55% agreeing with this statement, 20% disagreeing and 25% remaining neutral on this matter (*see figure 16*).

Figure 16 Illustrates the disparity between surgeons as to whether MDT meetings promote a culture of psychological safety.



When surgeons were asked what one thing they would change to improve the current standards and operational effectiveness of MDT meetings, significant emphasis was placed on improving the structure of meetings, with a need for a clear criteria for cases to be presented, access to fully complete patient documentation prior to meetings and clearly defined leadership structures and adherence to attendance protocols. Surgeons also emphasised the need for improved communication practices, dedicated administrative and IT support, dedicated time to effectively participate in meetings and increased opportunities for constructive feedback and case reviews. Other suggestions included: (1) improving standardisation for the types of cases presented and data sets used; (2) better utilisation of the expert knowledge present to facilitate ongoing education and training for trainees and less experienced professionals; and (3) stronger governance and oversight to ensure their ongoing operational effectiveness.

Key Points

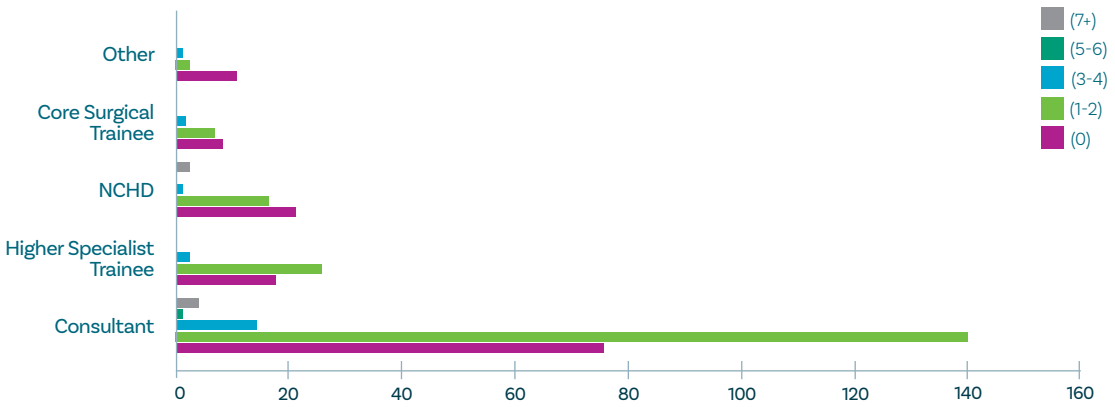
- 74% of surgeons believe that technology such as AI or digital tools would improve the quality and efficiency of MDT meetings.
- 89% of surgeons believe that the introduction of novel techniques, treatment strategies, technologies or other devices should be presented at MDT meetings.
- 82% of surgeons believe that attendance at MDT meetings should be mandatory for all consultants.
- 94% believe that these meetings should be formally recorded by way of meeting minutes and filed safely for review.
- 37% of surgeons agree that current surgical governance frameworks are adequate in supporting the effective operation of MDT meetings.
- Almost half of surgeons (49%) stated that they do not have sufficient protected time to enable their meaningful participation in MDT meetings.
- Surgeons emphasised the need for dedicated administrative and IT support for MDT meetings.

3. Morbidity and Mortality (M&M) Meetings

3.1 Information Regarding Respondent Experiences of M&M Meetings

Surgeons reported some significant differences between the number of M&M meetings they attend, with 61% participating in 1-4 meetings, only 2% associated with 5 or more, and 37% not participating in any M&M meetings whatsoever (*see figure 17*). The majority of M&M meetings occur monthly (44%), with 25% taking place every three months and 18% occurring on a weekly basis. Surgeons that selected 'Other' for this question noted that some M&M meetings are held every two months, others take place twice a year, while some are held "infrequently", are currently "suspended" or do not take place at all.

Figure 17 Indicates the number of M&M meetings attended by respondents, with the results differentiated by their role.



In relation to the administrative operation of M&M meetings, surveyed surgeons confirmed that approximately 31% of meetings operate with no clear criteria as to what type of cases are presented, while just under half (48%) of meetings are not recorded by way of notes or meeting minutes. Only 30% of M&M meetings are resourced with administrative support (*see figure 18*), while 65% have no structured mechanisms to enable feedback and enact quality improvement procedures *(see figure 19*).

Figure 18 Indicates that 70% of M&M meetings are not provisioned with adequate administrative support, according to respondents.

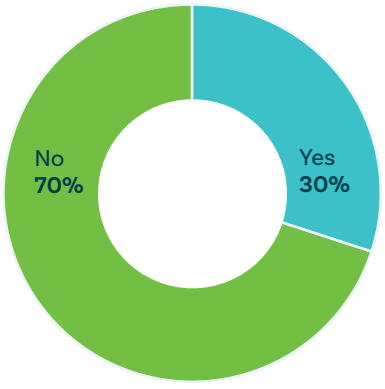
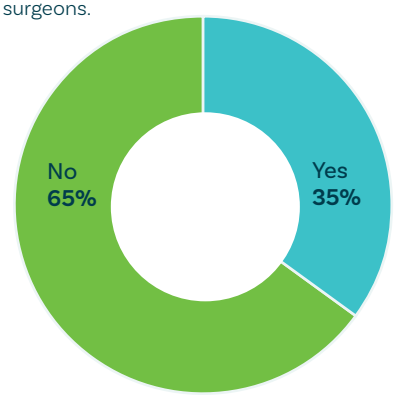
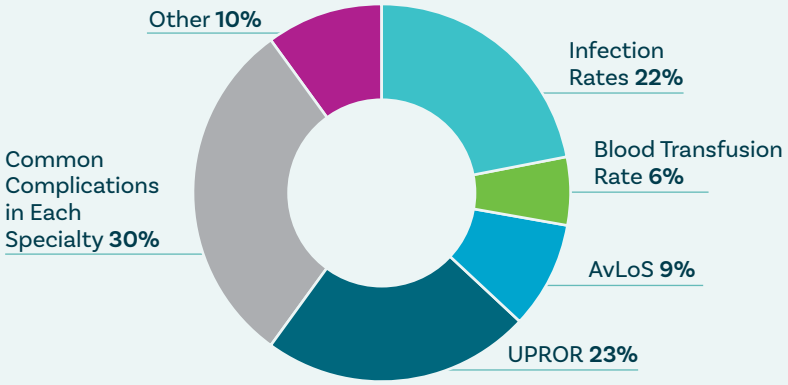


Figure 19 Illustrates that 65% of M&M meetings have no structured mechanisms to enable feedback and enact quality improvement procedures, according to surgeons.



Upon reviewing the types of data sets utilised in M&M meetings, common complaints (per respective specialities) account for 30%, while Unplanned Returns to Operating Rooms (UPROR) are assessed 23% of the time. Infection rates are reviewed at 22% of meetings, 9% assess the Average Length of Stay (AvLoS) and 6% review blood transfusions rates. Other data sets adopted across M&M meeting in Ireland according to surgeons include: planned and unplanned hospital transfers, cancellations and delays, cases of mortality and re-admission, rare and common complications and abnormalities, case load volume, case load variation, outpatient volume, haematoma rates, implant loss rates, waiting lists and waiting times for other services (*see figure 20*).

Figure 20 Highlights the types of data sets that are assessed at M&M meetings, according to the surgeons surveyed as part of this study.



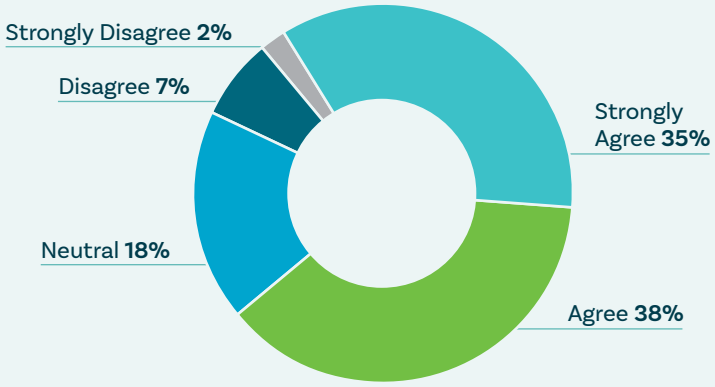
Key Points

- 31% of surgeons indicated that M&M meetings are operating with no clear criteria as to what type of cases are presented at them.
- Almost half (48%) of M&M meetings are not recorded by way of notes or meeting minutes.
- 70% of M&M meetings are not resourced with sufficient administrative support.
- 65% of M&M meetings have no structured mechanisms to enable feedback and enact quality improvement procedures, according to surgeons.
- There are noteworthy inconsistencies as to the types of data sets utilised in M&M meetings in Ireland.

3.2 Importance and Effectiveness of M&M Meetings

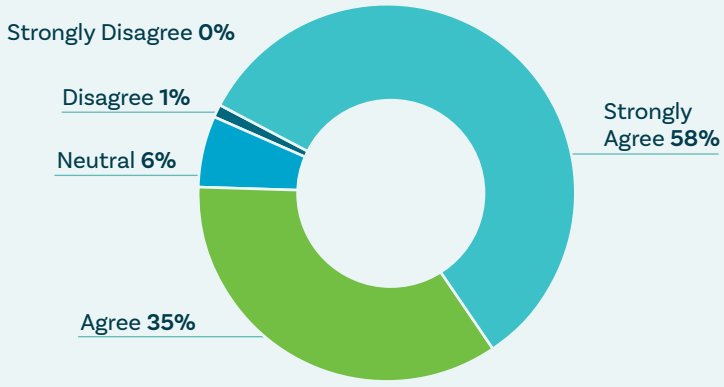
According to the data gathered by this survey, significant support and recognition for the importance and effectiveness of M&M meetings was conveyed by Irish surgeons. 86% believe that participation in such meetings helps to contribute to continuous learning and professional development, while 73% believe that they assist in identifying and addressing system-level safety issues in Irish hospitals (*see figure 21*).

Figure 21 Highlights that 73% of surgeons believe that M&M meeting contribute to identifying and addressing system-level safety issues.



When asked if M&M meetings help to protect both patients and staff through structured reviews and decision-making, 86% of surgeons agreed with this statement. Additionally, 92% of surveyed surgeons believe that such meetings should be formally recorded and filed to enable reviews at a later date; 96% believe that effective leadership is important to the successful operation of M&M meetings; and 94% stated that they are essential in ensuring appropriate and safe surgical patient care. Surgeons also emphasised the important role that M&M meetings have in fostering a culture of transparency and accountability in Irish hospitals, with 93% of respondents either agreeing or strongly agreeing with this statement (*see figure 22*).

Figure 22 Highlights that at least 93% of surgeons believe that participation in M&M meetings is important for fostering a culture of transparency and accountability.



When asked to identify other ways in which M&M meetings have been effective in their experiences, respondents identified a number of valuable attributes and insights associated with such meetings. Firstly, surgeons noted benefits to establishing clear communication pathways and decision-making processes between different healthcare professionals and key stakeholders.

Additionally, surgeons emphasised how effective M&M meetings help to foster a positive working culture across surgical and healthcare professionals, which in turn helps facilitate the transfer of knowledge and aid in their ability to identify gaps in training and service provision. Finally, respondents also highlighted how effective M&M meetings help to strengthen the governance structures within Irish hospitals, while also supporting clinical development, enhancing safety and quality standards and improving patient care.

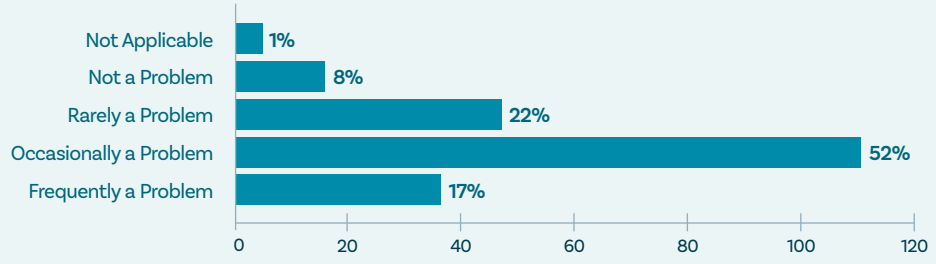
Key Points

- 73% of surgeons believe that M&M meetings assist in identifying and addressing system-level safety issues in Irish hospitals.
- 86% of surgeons believe that participation in M&M meetings helps to contribute to continuous learning and professional development in surgical practice.
- 86% of surgeons believe that M&M meetings help to protect both patients and staff through structured reviews and decision-making.
- 92% of surgeons believe that M&M meetings should be formally recorded and filed for review at a later date.
- 94% of surgeons stated that M&M meetings are essential in ensuring appropriate and safe surgical patient care
- 96% of surgeons believe that effective leadership is important to the successful operation of M&M meetings
- Effective M&M meetings benefit open communication, collaboration and transparency.
- Effective M&M meetings help to identify gaps in training and service provision.
- M&M meetings help to strengthen governance structures and clinical accountability.

3.3 Weaknesses of M&M Meetings

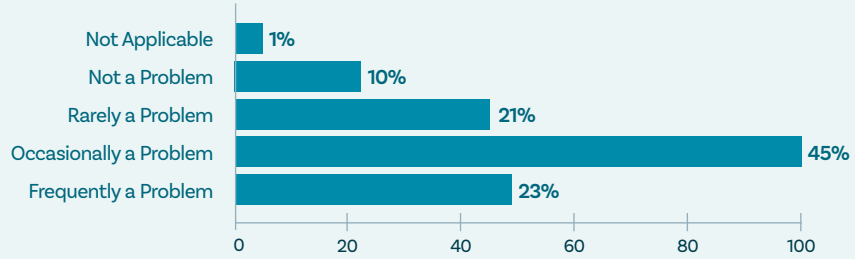
When asked to identify the main weaknesses of M&M meetings in their experiences, surgeons identified a variety of important characteristics that can disrupt their operational effectiveness. Firstly, 69% of respondents confirmed that they have attended M&M meetings without having timely access to fully complete and relevant patient information (*see figure 23*).

Figure 23 Highlights the frequency of meetings held without access to fully complete patient information.



Furthermore, 72% of surgeons have encountered issues with not having sufficient time to discuss complex cases at M&M meetings, and at least 46% have encountered instances of inadequate follow-up and implementation of agreed upon actions following their conclusion. Finally, 68% of surgeons have encountered problems with not having the full participation of all relevant decision makers at such meetings (*see figure 24*).

Figure 24 Illustrates that 68% of respondents have encountered problems with not having the full participation of all relevant decision makers at M&M meetings.



A range of other issues were also identified as having the potential to impede the effective operation of M&M meetings in Irish hospitals, including:

1. **Not having sufficient protected time to attend and effectively participate in M&M meetings.**
2. **Not having adequate administrative and IT resources to support these meetings.**
3. **Adopting substandard management and leadership practices.**

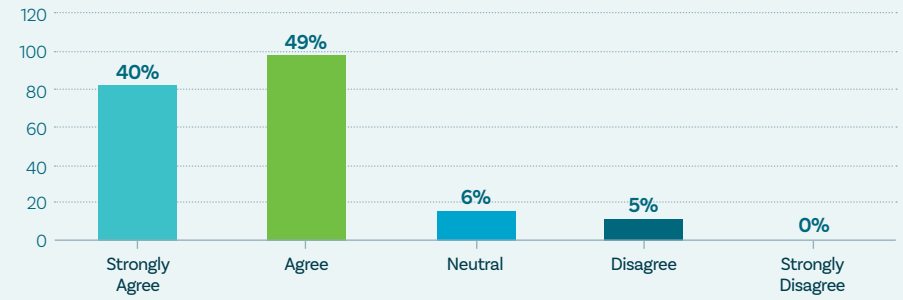
Key Points

- 69% of surgeons have attended M&M meetings without having timely access to complete and relevant patient information.
- 72% of surgeons have encountered problems with not having sufficient time to discuss complex cases at M&M meetings.
- 68% have encountered problems with not having the full participation of all relevant decision makers at M&M meetings.
- Surgeons highlighted that not having sufficient protected time to attend and effectively participate in M&M meetings is a significant problem.
- Inadequate administrative support and access to reliable IT resources is also a barrier to the effective operation of M&M meetings.

3.4 Areas for Improvement & Other Issues for M&M Meetings

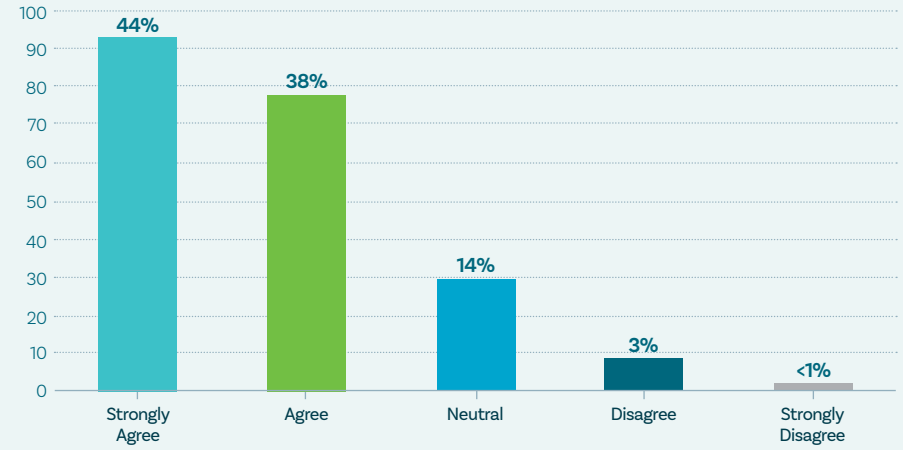
Upon discussing areas for improvement and other issues associated with M&M meetings in Ireland, participants offered a variety of interesting viewpoints in how to develop their potential and operational effectiveness. Firstly, up to 74% of surgeons believe that technology such as AI or digital tools could improve the quality and efficiency of M&M meetings, while approximately 89% believe that the introduction of novel techniques, treatment strategies, technologies or devices should be presented these meetings (*see figure 25*).

Figure 25 Illustrates that 89% of surgeons believe that the introduction of novel techniques, treatment strategies, technologies or devices should be presented at M&M meetings.



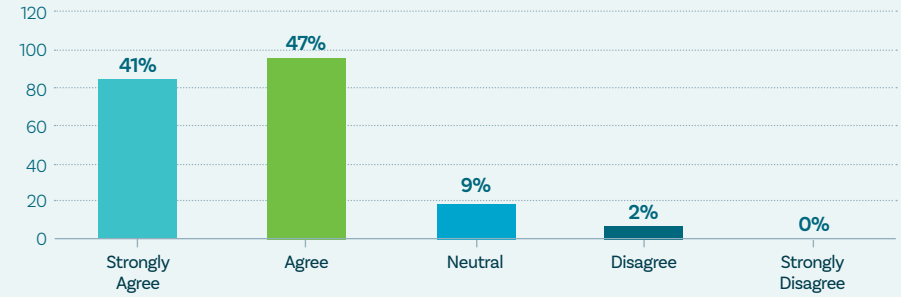
When discussing the operational standards of M&M meetings in Ireland, almost 82% of surgeons believe that attendance at M&M meetings should be mandatory for all consultants (*see figure 26*), while 94% believe that these meetings should be formally recorded by way of meeting minutes and filed safely for review at a later date. Additionally, 73% of surgeons stated that the Chair of M&M meetings should rotate between colleagues annually.

Figure 26 Highlights that 82% of surgeons believe that attendance at M&M meetings should be mandatory for all consultants



A little over a third of surgeons (37%) believe that current clinical governance frameworks adequately support M&M meetings and 49% stated that they do not have sufficient protected time to enable for their meaningful participation in such meetings. Finally, a significant proportion of participants (88%) believe that emergency or unscheduled care episodes should form part of M&M meetings in Irish hospitals going forward (*see figure 27*).

Figure 27 88% of surgeons believe that emergency or unscheduled care episodes should form part of M&M meetings in Irish hospitals.



When surgeons were asked what one change they would make to improve the current standards and operational effectiveness of M&M meetings in Ireland, significant importance was placed on surgeons having access to fully complete patient documentation prior to meetings. They also emphasised the need for improved communication practices and dedicated administrative and IT support, as well as being provided with dedicated protected time to effectively participate in these meetings. Other suggestions included: improving the standardisation for the types of cases presented and data sets utilised, while also advocating for stronger governance frameworks and leadership.

Key Points

- 74% of surgeons believe that technology such as AI or digital tools would improve the quality and efficiency of M&M meetings.
- 89% of surgeons believe that the introduction of novel techniques, treatment strategies, technologies or other devices should be presented at M&M meetings.
- 82% of surgeons believe that attendance at M&M meetings should be mandatory for all consultants.
- 94% believe that M&M meetings should be formally recorded by way of meeting minutes and filed safely for review.
- 73% of surgeons believe that the Chair of M&M meetings should rotate between colleagues annually.
- 37% of surgeons agree that current surgical governance frameworks are adequate in supporting the effective operation of M&M meetings.
- Almost half of surgeons (49%) stated that they do not have sufficient protected time to enable their meaningful participation in M&M meetings.
- 88% of surgeons believe that emergency or unscheduled care episodes should form part of M&M meetings.
- Surgeons also emphasised the need for dedicated administrative and IT support for M&M meetings.

4. Conclusion

The data gathered through this survey has provided the Expert Group on Best Practice in Clinical Governance in Surgery with valuable, insightful and comprehensive information relating to the functioning and operational effectiveness of both MDT and M&M meetings in Ireland. The high volume and standard of responses reflects the depth of experience and professional commitment among the participating surgeons, adding significant value to this report. This strengthens its potential to effectively inform the development, and set the standards of surgical governance in Ireland, both in the immediate and long-term future.

By capturing perspectives from surgeons across all surgical specialities, surgical roles, and from all hospital regions across the country, this survey represents a truly national viewpoint, documenting the breadth and diversity of lived experiences of Irish surgical clinicians. These attributes help to ensure that the conclusions drawn are reflective of the realities of surgical practice in Ireland and that any remedial recommendations are tailored to the current challenges within the Irish surgical landscape.

Surgeons consistently conveyed their belief that the effective operation of MDT and M&M meetings reinforces surgical practice standards, supports robust surgical governance and clinical accountability, and provides a pathway for the introduction of developing technologies, novel practices and surgical innovation. On the other hand, surgeons identified significant barriers impeding the efficiency and operational potential of MDT and M&M meetings, highlighting that a lack of dedicated admin and IT support; underutilisation of training and knowledge sharing opportunities; protected allocated time to attend meetings; and inconsistent operational and structural standards, as all noteworthy challenges to their optimisation.

As an analytical tool, this survey has provided valuable and detailed information that will influence and underpin the updated RCSI Framework for Surgical Clinical Governance. The Expert Group on Best Practice in Clinical Governance in Surgery would like to place on record, their sincere thanks and appreciation for the dedication and endeavour shown by the Irish surgical community, and indeed the clinicians who participated in this study, for their time and effort in aiding the development of this report.

Appendices

Appendix 1. Survey Questions

Section 0: Respondent Information

1 Responses by role

2 Responses by specialty

3 Other specific roles held by respondents

4 Responses by region

Section 1: Important Information Regarding Respondent Experiences of MDT and M&M Meetings

5 Please list the number of MDT meetings you are involved with?

6 How often do these MDT meetings occur?

7 Are there clear criteria for the types of cases that are selected for presentation at MDT meetings?

8 Are MDT meetings consistently recorded by way of minutes or meeting notes?

9 Are MDT meetings resourced with administrative support?

10 There is a structured mechanism (e.g. clinical audits) for feedback and quality improvement following MDT meetings?

11 Please list the number of M&M meetings you are involved with?

12 How often do these M&M meetings occur?

13 Are there clear criteria for the cases to be presented at M&M meetings?

14 Are M&M meetings consistently recorded by way of minutes or meeting notes?

15 Are M&M meetings resourced with administrative support?

16 There is a structured mechanism (e.g. clinical audits) for feedback and quality improvement following M&M meetings?

17 Please select the types of data sets that are assessed at M&M meetings?

Section 2: Effectiveness of MDT and M&M Meetings

18 MDT meetings help ensure clinical decision-making follows evidence-based best practices?

19 M&M meetings contribute to continuous learning and professional development?

20 MDT meetings enhance communication and collaboration between surgical teams and other specialties?

21 M&M meetings contribute to identifying and addressing system-level safety issues?

22 MDT and M&M meetings help protect both patients and staff through structured reviews and decision-making?

23 MDT & M&M meetings should be formally recorded and filed for review when necessary?

24 Are there other ways in which MDT or M&M meetings have been effective in your experience?

Section 3: Importance of MDT and M&M Meetings

25 MDT and M&M meetings are essential in ensuring appropriate and safe surgical patient care?

26 M&M meetings are important for fostering a culture of transparency and accountability?

27 Leadership (Chairing and Facilitation) is important in the effectiveness of MDT and M&M meetings?

28 In your view, what are the most important outcomes for patients from effective MDT and M&M meetings?

Section 4: Weaknesses of MDT and M&M Meetings

29 Availability of complete and relevant patient information during meetings?

30 Sufficiency of time to discuss complex patient cases in depth?

31 Participation of all relevant decision-makers in meetings?

32 Follow-up and implementation of agreed actions from meetings?

33 In your experience, what are the main weaknesses or limitations of current MDT or M&M meetings?

Section 5: Areas for Improvement and Other Issues for MDT and M&M Meetings

34 Technology (such as digital tools or AI) could help improve the quality and efficiency of MDT and M&M meetings?

35 Current clinical governance frameworks adequately support MDT and M&M meeting processes (e.g. escalation of systemic risks or trends)?

36 There is sufficient protected time allocated for meaningful participation in MDT and M&M meetings?

37 All surgical specialties in your hospital have equitable access to MDT and M&M meetings?

38 Attendance at MDT and M&M meetings by all consultants should be mandatory?

39 The Chair of MDT & M&M meetings should rotate between colleagues annually?

40 A formal note or minutes of MDT and M&M meetings should be recorded and filed safely?

41 The introduction of novel techniques, treatment strategies, technologies or devices should be presented at MDT meetings and the outcome recorded as to the consensus of the participants of the meeting?

42 Subject to agreed criteria, emergency or unscheduled care episodes should also form part of M&M meetings?

43 I feel empowered to raise concerns or learning points at MDT or M&M meetings?

44 MDT and M&M meetings promote a culture of psychological safety (e.g. blame-free environment, open discussions)?

45 If you could change one thing to improve MDT and/or M&M meetings, what would it be - and why?

46 Are there any other issues or suggestions you would like to raise regarding surgical clinical governance, MDT or M&M meetings?

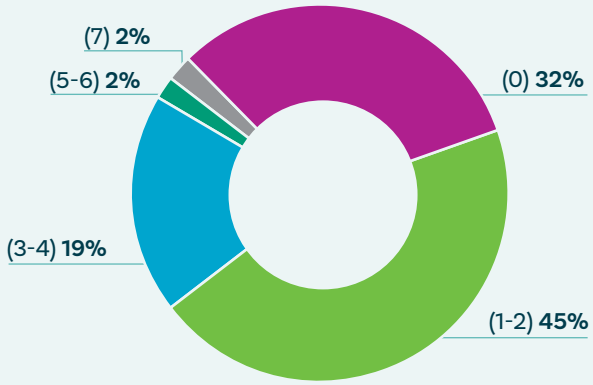
Appendix 2. Survey Graphs

The graphs in this section (Appendix 2) are a list of the graphs used in the Clinical Governance in Surgery survey, but are not represented visually in the final survey report above. However, the information and data documented in these graphs has been referenced in the final survey report.

Information Regarding Respondent Experiences of MDT and M&M Meetings

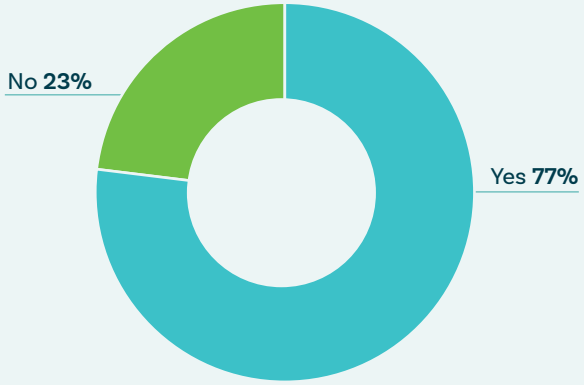
Q. *Please list the number of MDT meetings you are involved with?*

Appendix 2.1 Identifies the number of MDT meetings that respondents are involved in, with approx. 64% of respondents regularly participating in 1-4 MDT meetings.



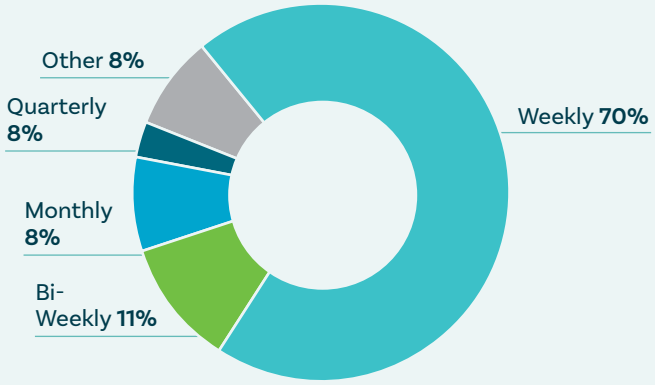
Q. *Is there clear criteria for the types of cases that are selected for presentation at MDT meetings?*

Appendix 2.3 Identifies that three-quarters of MDT meetings have clear criteria for the types of cases to be presented at such meetings. This indicates a lack of uniformity regarding case type selection, according to respondents



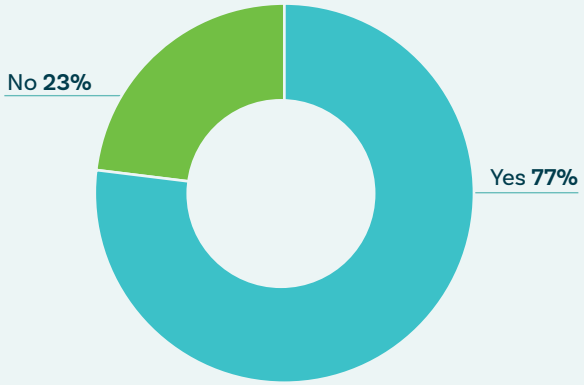
Q. *How often do these MDT meetings occur?*

Appendix 2.2 Respondents who selected 'Other' noted that MDT meetings occur every six weeks, every 6 months or "have not taken place for a number of years".



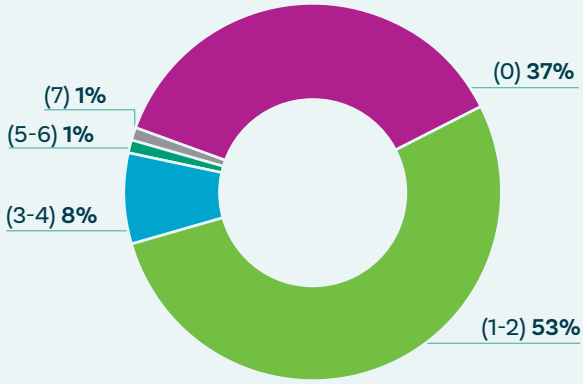
Q. *Are MDT meetings consistently recorded by way of minutes or meeting notes?*

Appendix 2.4 Illustrates the level to which MDT meetings are recorded by way of notes or meeting minutes, with a little over three-quarters of meetings being recorded, according to respondents. This indicates a lack of uniformity regarding data gathering and recording practices in such meetings across the sector.



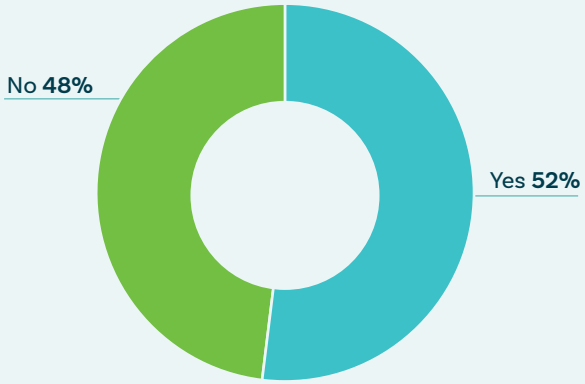
Q. *Please list the number of M&M meetings you are involved with?*

Appendix 2.5 The above table identifies the number of M&M meetings that respondents are involved in, with approx. 61% of respondents regularly participating in 1-4 M&M meetings. However, over a third of respondents did not participate in any M&M meetings.



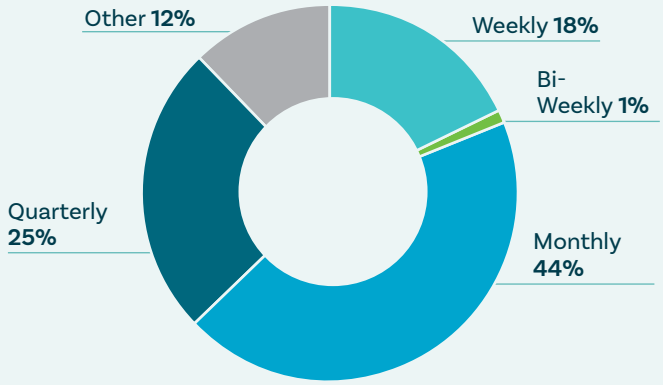
Q. *Are M&M meetings consistently recorded by way of minutes or meeting notes?*

Appendix 2.8 Illustrates that just over half of M&M meetings are being recorded by way of notes or minutes, indicating a significant discrepancy in how actions are captured and recorded in such meetings across the sector, according to respondents.



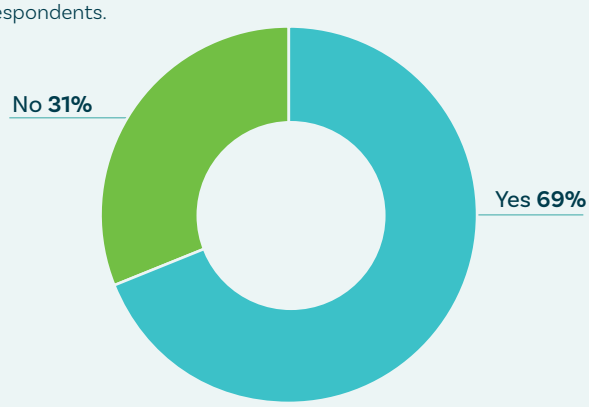
Q. *How often do these M&M meetings occur?*

Appendix 2.6 Respondents who selected 'Other' noted that M&M meetings are held every two months, twice a year, "infrequently", are currently "suspended" or on "hiatus" or that they do not take place at all.



Q. *Is there clear criteria for the cases to be presented at M&M meetings?*

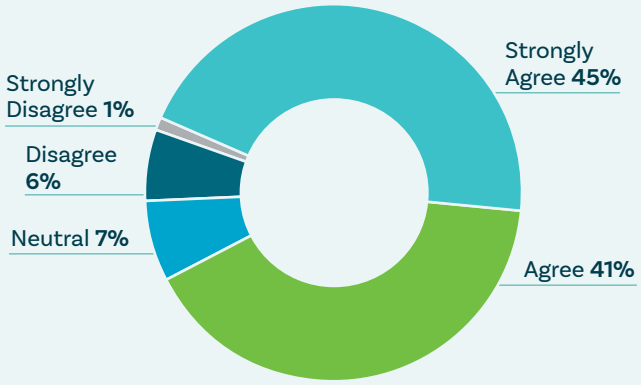
Appendix 2.7 Identifies that two-thirds of M&M meetings have clear criteria for the types of cases to be presented at such meetings. This indicates a lack of uniformity regarding case type selection, according to respondents.



Importance and Effectiveness of MDT and M&M Meetings

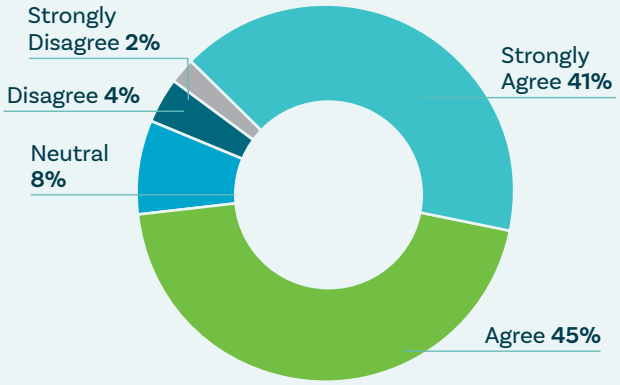
Q. *M&M meetings contribute to continuous learning and professional development?*

Appendix 2.9 Highlights that 86% of respondents believe that participation in M&M meetings helps to contribute to continuous learning and professional development for members.



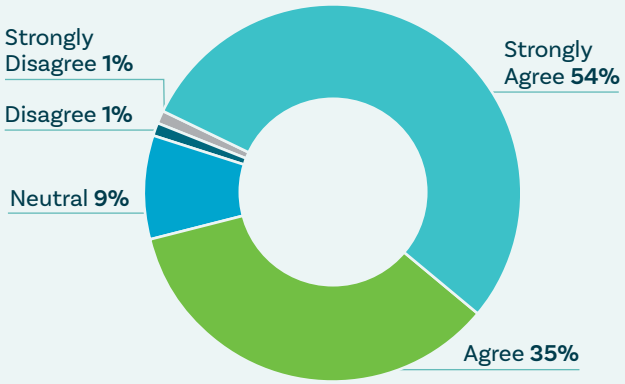
Q. *MDT and M&M meetings help to protect both patients and staff through structured reviews and decision-making?*

Appendix 2.12 Highlights that at least 86% of respondents believe that MDT and M&M meetings help protect both patients and staff through structured reviews and decision-making.



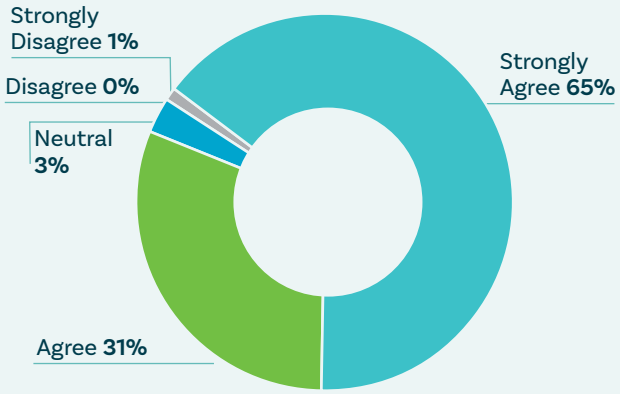
Q. *MDT meetings enhance communication and collaboration between surgical teams and other specialties?*

Appendix 2.10 Indicates that 89% of respondents believe MDT meetings enhance communication and collaboration between surgical teams and other specialties.



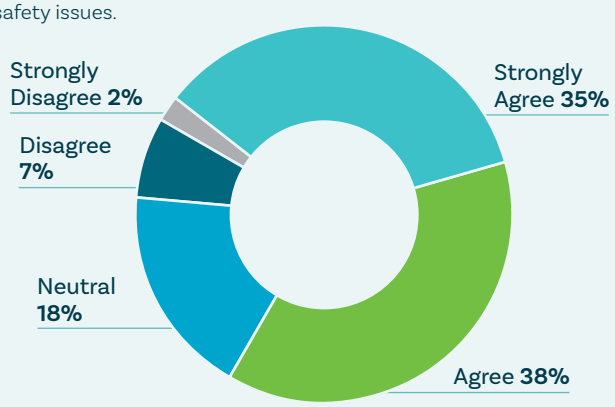
Q. *Leadership (Chairing & Facilitation) is important in the effectiveness of MDT and M&M meetings?*

Appendix 2.13 Indicates that 96% of respondents believe that effective leadership is important to the successful operation of MDT and M&M meetings.



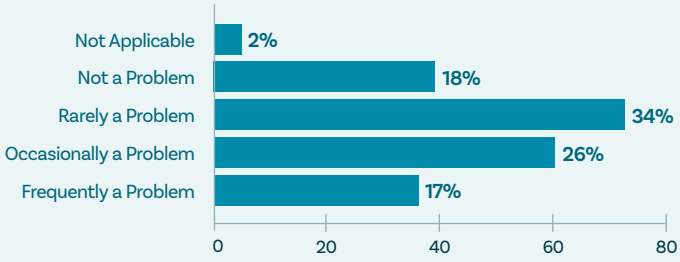
Q. *M&M meetings contribute to identifying and addressing system-level safety issues?*

Appendix 2.11 Indicates that only 7% of respondents believe that M&M meeting do not contribute to identifying and addressing system-level safety issues.



Weaknesses of MDT and M&M Meetings

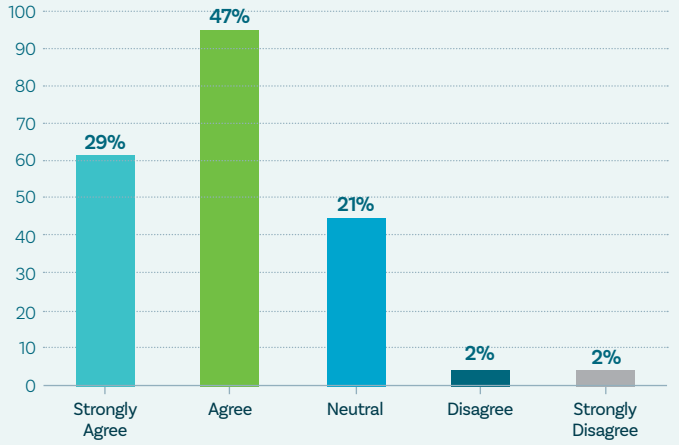
Appendix 2.14 Highlights that 80% of respondents have encountered at least some instances of a lack of appropriate follow-up and implementation of agreed upon actions in MDT and M&M meetings.



Areas for Improvement & Other Issues for MDT and M&M Meetings

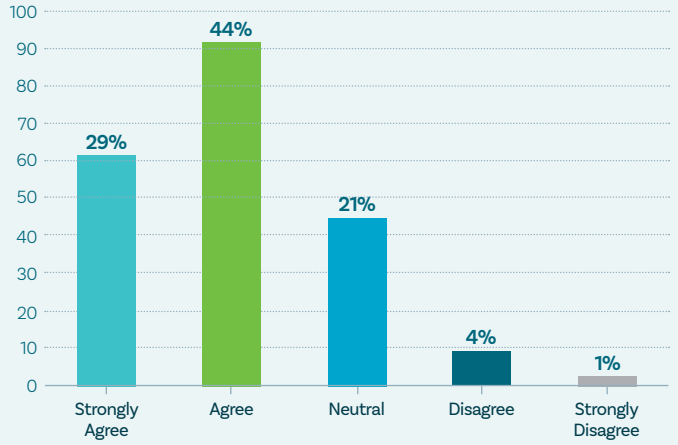
Q. *Technology (such as digital tools or AI) could help to improve the quality and efficiency of MDT and M&M meetings?*

Appendix 2.15 Indicates that only 4% of respondents believe that technology such as AI or digital tools would not improve the quality and efficiency of MDT and M&M meetings, this signifies almost unanimous support for the implementation of such technology.



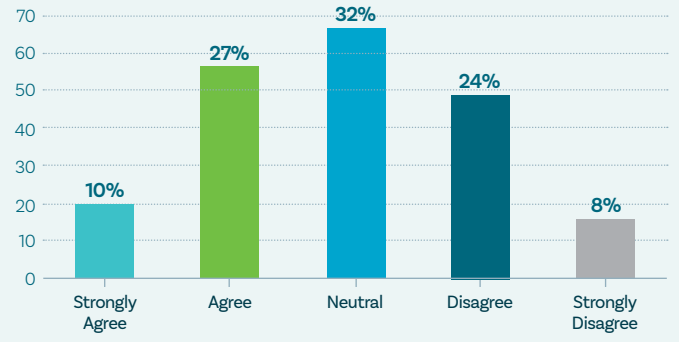
Q. *The Chair of MDT & M&M meetings should rotate between colleagues annually?*

Appendix 2.17 Reveals that only 5% of respondents believe that the position of Chair at MDT and M&M meetings should not alternate between colleagues annually. This represents widespread support for the implementation of such practices across specialities in Ireland.



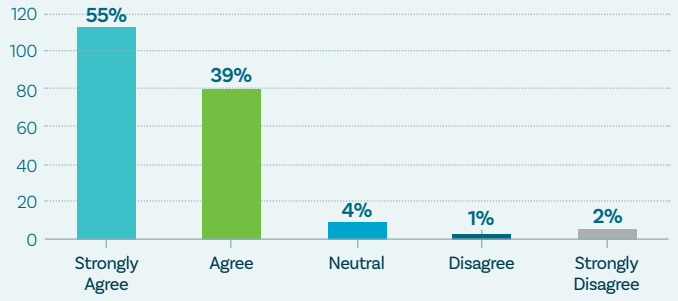
Q. *Current clinical governance frameworks adequately support MDT and M&M meeting processes (e.g. escalation of systemic risks or trends)?*

Appendix 2.16 Highlights that only 37% of respondents believe that current clinical governance frameworks adequately support MDT and M&M meeting processes.



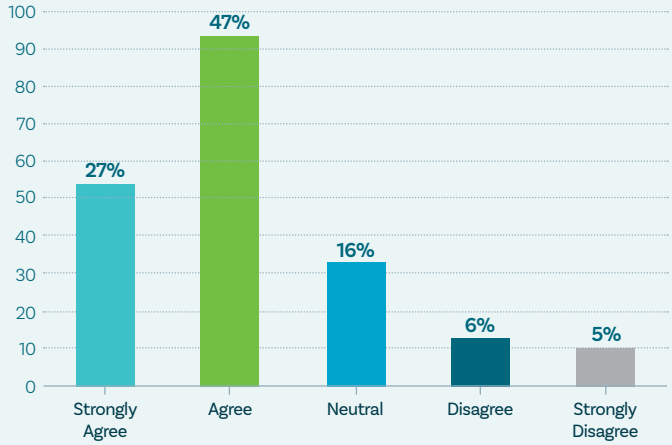
Q. *A formal note or minutes of MDT and M&M meetings should be recorded and filed safely?*

Appendix 2.18 Indicates that at least 94% of respondents believe that a formal note or minutes of MDT and M&M meetings should be recorded and filed safely. This highlights widespread support for the practice across specialities.



Q. *I feel empowered to raise concerns or learning points at MDT or M&M meetings?*

Appendix 2.19 Indicates that 74% of respondents feel empowered to raise concerns or learning points at MDT or M&M meetings.



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