CanNET

Cancer Service Networks
National Demonstration Program

Linking regional and metropolitan cancer services for better cancer outcomes

Australian Government
Cancer Australia

SIGGINS MILLER

3rd CanNET National Workshop Report

Prepared by the CanNET National Support and Evaluation Service - Siggins Miller

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Acronyms and abbreviations

AGPN	Australian General Practice Network
AHS	Area Health Service
AYA	Adolescent and Young Adult
BSWRICS	Barwon South West Regional Integrated Cancer Service
CanNET	Cancer Services Networks National Demonstration Program
CCRC	Cancer Care Research Centre
CIPHER	Centre for Innovation in Professional Health Education and Research
CPD	Continuing professional development
EdCaN	National Cancer Nursing Education Project
GP	General practitioner
Hume RICS	Hume Regional Integrated Cancer Service
M	Mean (or average)
MDC	Multidisciplinary care
MDT	Multidisciplinary team
NBOCC	National Breast and Ovarian Cancer Centre
NEMICS	North Eastern Metropolitan Integrated Cancer Service
NSW	New South Wales
NT	Northern Territory
QASys	Oncology Analysis System
PMF	Patient Management Frameworks
SA	South Australia
SD	Standard deviation
QOOL	Queensland Oncology Online
RCG	Regional Cancer Group
WA	Western Australia

Cancer Services Networks National Demonstration (CanNET) Program

A report of the 3rd CanNET national workshop

22nd and 23rd May, 2008 at the Stamford Grand, Adelaide

1.1 Introduction and context

The Cancer Service Networks National Demonstration Program (CanNET) is funded by the Australian Government through Cancer Australia. It is being implemented in partnership with all states and the Northern Territory to increase access to quality cancer care and improve cancer outcomes, particularly for people in regional and rural areas. Internationally, clinical networks are being implemented to support the delivery of world's best practice cancer care because they have the potential to link '…groups of health professionals and organisations from primary, secondary, and tertiary care working in a coordinated manner, unconstrained by existing professional and [organisational] boundaries to ensure equitable provision of high quality effective services' (Scottish Executive Health Department, 2002).

The CanNET program has a number of key elements that will positively influence cancer care delivery for rural Australians, including active consumer involvement; formalised linkages between health professionals; continuing professional development; enhanced communication and data systems; quality improvement activities; and multidisciplinary care (MDC). Multidisciplinary teams (MDTs) are a critical component of MDC. It is widely argued in the literature that MDTs provide better care than individuals working in isolation (Carter, Garside & Black 2005; Ruhstaller *et al* 2006; Seek & Hogle 2007; Tuttle *et al* 2005; Zorbas *et al* 2003). Among the purported benefits resulting from effective MDT working are improved patient outcomes, better continuity of care and higher patient satisfaction (Chang, 1998; Carter, Garside & Black 2005; Maleshkin & Zalcberg 2006; Seek & Hogle 2007).

The CanNET National Support and Evaluation Service, provided by Siggins Miller aims to ensure that knowledge and resources are shared to maximise efficiency, prevent duplication of effort, and that a consistent evaluation approach is adopted nationally. As part of this role the CanNET National Support and Evaluation Service convene and facilitate the annual CanNET national workshops.

1.2 An overview of the 3rd CanNET national workshop

The CanNET National Support and Evaluation Service and Cancer Australia convened the 3rd CanNET national workshop on 22 and 23 May, 2008 at the Stamford Grand Hotel in Adelaide.

This workshop focused on issues associated with establishing and supporting MDTs. More specifically, it aimed to:

(a) Review the current state of play in relation to MDTs for cancer care across Australia;

(b) Exchange information and ideas, and develop an understanding of where each CanNET is up to in relation to establishing/supporting MDTs;

(c) Develop a better understanding of the range of processes and practical strategies to promote, implement and support MDTs within the networks; and

(d) Develop action plans to assist with establishing and/or enhancing MDTs within each CanNET.

A copy of the agenda for the CanNET national workshop has been included as Appendix A.

Network members from all States and the Northern Territory were invited to attend the workshop (We requested that each network send up to 5 members, including a consumer presentative, project team members and lead clinicians). Across the two days, the workshop was attended by 57 individuals, including consumer representatives, representatives from each of the networks, representatives from Cancer Australia, representatives from Cancer Australia's National Cancer Nursing Education (EdCaN) and Continuing Professional Development (CPD) projects, representatives from Siggins Miller, CanNET National Steering Committee members and a range of invited guest speakers. A full list of workshop participants has been included as Appendix B.

All participants were also invited to a private workshop dinner at the Stamford Grand Hotel in Adelaide on the evening of 22 May, 2008. Margaret McKenzie from CanNET Victoria was the guest dinner speaker: she spoke about her reflections on Professor Nora Kearney's visit to Victoria in March 2008 and strategies for active consumer participation. Professor Kearney is the Director of the Cancer Care Research Centre (CCRC), University of Sterling, Scotland and is internationally known for her work in consumer engagement.

1.3 The purpose and structure of the current report

The current report, prepared by the CanNET National Support and Evaluation Service, summarises the discussions and key outcomes from each of the sessions during the workshop.

Section 2 summarises the discussions and key outcomes from the workshop sessions on 22 May 2008. It begins with an overview of the preliminary sessions, including the opening address and consumers address. Next, the key points from each of the guest speaker and network presentations are presented. Section 2 also summarises discussions from the global café activity and cancer registry data sessions conducted in the afternoon of the first day.

Section 3 summarises the discussions and key outcomes from the workshop sessions on 23 May 2008. First, brief summaries of the second opening address and presentations of existing MDT resources, tool and templates are presented. This is followed by an overview of a guest speaker presentation that focused on MDT principles, criteria and outcome measures, and the associated small group discussions. Section 3 also summarises the aims and objectives of the MDT action plans that were developed by each network in the final session of workshop. Finally, Section 3 provides an overview of the concluding sessions, including the consumer reflections panel and closing address.

The final section of the current report (Section 4) summarises the findings from CanNET national workshop evaluation and presents concluding comments.

Overview of the discussions and key outcomes from workshop sessions on 22 May 2008

2.1 Preliminary sessions

The 3rd CanNET national workshop commenced with an official opening address, delivered by Professor David Currow (CEO, Cancer Australia). This was followed by a moving consumer address from Ashleigh Moore (Executive, Cancer Voices SA). More detailed information about these preliminary sessions is presented below.

2.1.1 Opening address

Professor David Currow welcomed all workshop participants, including all of the invited guest presenters. He noted that the workshop's focus was on MDTs (as requested by the CanNET networks) and that this is one of the key elements of the CanNET program. However, he also acknowledged that MDTs are only one critical aspect of MDC.

The key message from Professor Currow's opening address was that although there are many challenges associated with establishing MDTs, there are also enormous opportunities to be seized. Establishing effective MDTs is one important step towards ensuring that all cancer consumers receive current best evidence care that could potentially result in a 10 - 15% improvement in outcomes. Professor Currow concluded by saying "there is much collective wisdom and experience within this room around MDTs, so I encourage you to share your ideas, take some risks and to think outside of the box so that we can all optimise some of the opportunities that exist to make MDT a reality".

2.1.2 Consumer addresses

Ashleigh Moore's consumer address focused on the importance of MDTs to cancer consumers. He openly shared his experience of being diagnosed with advanced squamous cell carcinoma in the tonsil, tongue and neck. He discussed his frustration with 6 months of misdiagnosis and suggested that this might be avoided if primary health care providers are involved in MDTs for cancer patients. He also said that although the treatment and care of head and neck cancer requires the involvement of many specialities, and thus is well suited to a MDT approach, he only ever saw clinicians separately and had no indication of them working collaboratively. His treatment was very much a staged process - once each treatment was complete, he would simply report to the next clinician. There was no one individual assigned to coordinate his care - it seemed as though his case notes served as the only channel of communication between the various clinicians involved in his care. His personal circumstances were not taken into consideration in his treatment or care plans, and he was not offered any psychosocial, practical or rehabilitation support - problems that may have been avoided if his care was coordinated by a suitable MDT. Mr Moore discussed how his wife researched best practice treatment protocols for head and neck cancer, and amongst other things, found out about a new drug that could (and did) prevent permanent damage to his salivary glands from the radiotherapy. None of the clinicians involved in his care had suggested this option to him - he questioned if this (and many other poor decisions and oversights that put his health and safety at risk) would have occurred had his care been coordinated by a MDT. In closing, Mr Moore compared his cancer journey to a rollercoaster ride that he and his family had to take control of and steer a safer course. He suggested that MDTs for cancer patients would make their journeys less bumpy and lead to more consumers getting off the rollercoaster sooner and in one piece! He also said that consumers tend to think of multidisciplinary 'care' teams that relate to the whole person, in particular their physical, mental, emotional and social wellbeing - they should not just

be about the clinical treatment but equally the quality of care and support throughout the cancer journey, with a focus on living well afterwards.

2.2 Multidisciplinary care teams: The current state of play

Dr Karen Luxford (General Manager, National Breast and Ovarian Cancer Centre; NBOCC) as the first guest presenter focused on the current state of play in relation to MDTs across Australia and provided contextual framework for the workshop.

She discussed the benefits of MDTs for patients, clinicians and services/funders, as well as the characteristics of the most effective breast cancer MDTs - these characteristics include having a high team workload, a high volume of specialist surgeons and a high proposition of breast care nurses. Dr Luxford also reviewed the key barriers and enablers to implementing MDTs - the barriers discussed included competing demands on clinicians' time, lack of reimbursement for meeting attendance, medico-legal implications and practical issues; while the enablers discussed included clinical leadership, supporting infrastructure, involvement of all relevant disciplines and incentives to attend (eg education, food). A number of NBOCC resources that may help establish MDTs were discussed, including their multidisciplinary meeting guide for health service providers (NBOCC, 2005) and medicolegal implications workshop report (NBOCC, 2002). Dr Luxford concluded her presentation with a discussion of the NBOCC's recent audit of MDC across Australia. She presented some of the preliminary findings from the audit, however, noted that final report on the audit will be available via the NBOCC website in the near future (Website address: www.nbocc.org.au).

2.3 Network presentations

Each of the CanNET networks was asked to prepare a brief 10 minute presentation for the workshop, identifying their key achievements and challenges to date in terms of establishing and/or supporting MDTs through the CanNET program. They were given a PowerPoint template to help prepare these presentations. Table 1 provides an overview the each of the network's presentations.

After each network presentation, workshop participants were asked to identify one key, take home message from the presentation. Below is a selection of these key messages:

2.3.1 Key network messages

- Capitalise on existing good work and develop linkages with related projects
- Engaging GPs is important and difficult (there are some models where there is a GP representative at all MDTs even if one of their patients isn't being discussed)
- Educate consumers about the importance of MDTs as part of the change management process
- Start off small (eg focus on one tumour stream)
- MDT or cancer coordinators could provide administrative support to MDTs
- There are two purposes of MDTs: prospective care planning, and follow-up care planning/arrangements
- MDTs develop recommendations to propose to or discuss with the consumer - the final treatment plan is formulated in consultation with the consumer
- There are many 'case studies' of good approaches that could be used in other areas (Don't reinvent the wheel)
- There is a need for different MDT models in different settings
- MDTs do not have to be tumour stream specific (eg adolescents and young

adults; AYA MDT)

- Engaging clinical leaders/champions is critical
- There is a need for a common definition of MDC, MDTs and tumour boards
- MDTs are only one form or aspect of MDC
- It may be more effective to support existing MDTs to develop their own quality improvement aims and objectives
- The challenges that each CanNET network is facing are the same regardless of context
- It is important to develop links among MDTs because most cancer consumers are seen by more than one MDT throughout their journey
- There are different views about the need to obtain the patients' consent for MDT discussions

Table 1. Key achievements and challenges to date in terms of establishing/supporting MDTs through the CanNET program

CanNET Network	Key achievements	Key challenges
CanNET NSW	Convened a MDT learning session (75 participants) AHS and individual MDT aims established. Examples of some of these aims: • To invite 90% of patient's GPs to attend MDT meetings by July 2008 • To have 10% GPs attend (in person, or via tele- or videoconference) MDT meetings where their patients are discussed by September 2008 • To have 100% of lung patients presented at a MDT recommendations back to the patient within 1 day • Within 2 weeks of a patient being presented to an MDT, the specialist will send a standard letter with management plan to the patient's GP Developed palliative care linkages for a gynae-oncology MDT MDTs working towards achieving stage 1 of the NSW Cancer Institutes MDT standard by June 2008 Identifying gaps and creating new MDTs to fill these gaps	Working within historical and emerging contexts MDT billing: • Logistical and practical solutions • Differences between public and private sectors • Visiting medical officers Linking teams, filling gaps, and creating new teams: • Limited capacity of MDTs/clinicians • Matching teams to patient referral pathways
CanNET Victoria	Conducted an audit of MDTs across Victoria: • There are currently 27 MDTs within the CanNET Victoria region (NEMICS and Hume RICS) • There are also 11+ linkages into these meetings from external hospitals Consulted with consumers about MDC	No regional meeting for lung cancer patients No agreement among specialists about referral pathways Difficult to obtain accurate data about numbers of patients being discussed in MDTs Lack of agreement about which patients should be referred for MDT discussion Enabling technology to link into existing metropolitan meetings
CanNET WA	Albany MDT establishment Local referral process developed: • Involving GP's • MDT management plan Links to metropolitan service in Perth established (support and expertise)	Developing Terms of Reference (roles and responsibilities for new teams) Engagement of GP's in referral pathway and use of the MDT Lack of MDT database

CanNET SA	MDT considered core component of all cancer pathway development Development of a pilot statewide MDT for Upper GI cancers (CPD approach) Development of a pilot rural general oncology MDT (CPD approach) Acknowledgement of the complex MDT needs for AYA patients and the value of statewide approach	Lack of information/data on current MDTs: Having to survey each specialty in each health service Lack of admin/human resource support in the current system to co-ordinate team: • Clinician time • How will we sustain changes Lack of recognition of a need to change Silos, ownership and turf: • Health provider • Project overlap
CanNET Tasmania	Draft statewide multidisciplinary protocol prepared Developing MDTs for all prospective cases for lung and colorectal cancer consumers (working groups established to progress this work) Developing patient management frameworks (PMFs) for lung and colorectal cancer consumers Developing a model for care coordinators	Instilling the need for change and working with resistance Working with already established MDTs to make them more effective, structured and accountable Lack of resources: • No care coordinators • Lack of administration support • Infrastructure (equipment, data systems, logistics etc) • MBS rebate Leadership Upskilling the workforce (CPD needs) Workloads of clinicians and other health care providers Enabling clinicians from rural and remote areas to participate in MDTs Sustainability Challenge of bringing together multimodal health services GP engagement and involvement

CanNET NT	Well-organised, regular hospital-based MDT meetings in Darwin: • Oncology MDT • Haematology MDT • Head and neck clinic Progress on MDT development in Alice Springs: • Identified current method of working • Consumer consultation • Negotiation for formal multidisciplinary involvement locally and interstate • Involvement of service providers through Regional Cancer Groups (RCG) Planning to undertake MDT audit in near future	GP engagement and involvement Workforce and workload issues Difficulties with involving interstate health care providers in MDTs
CanNET Queensland	Conducted a statewide survey of MDTs in collaboration with the NBOCC Working with 12 teams (or working parties) across the existing AHS cancer networks that bring together professional disciplines, institutions, GPs & consumers. These teams will collaborate on issues relevant to them: referral pathways to MDTs; GP/consumer electronic clinical summaries; timely patient information (via Queensland Oncology Online - QOOL); enhancing communication (GP/specialist letters); GP involvement in ongoing management; promotion of cancer care coordination services; multidisciplinary meeting practices (checklists). Examples of current working parties and aims: • One statewide working party is focusing on enhancing communication in cancer care • A Southern AHS breast cancer working party is focusing on appropriate and timely referral to MDTs • A Central AHS working party is focusing on cancer care coordination Approach: Providing these teams with the relevant data/information and letting them decide for themselves how to contribute to the overall strategic priority of enhancing MDC	Various models of MDC currently being explored What is the link between MDTs & MDC?

2.4 Success stories

After the network presentations (see Section 2.3), a number of invited guest presenters shared their 'success stories' with workshop participants. More specifically, they discussed how they had been able to overcome a range of challenges to establish effective MDTs for cancer consumers.

2.4.1 MDT in Barwon, Victoria

Maggie Stowers (Cancer Coordination Manager, Barwon South Western Regional Integrated Cancer Service; BSWRICS) and Jacqui Hennock (Quality Manager, BWSRICS) presented the first success story.

First, they reviewed the benefits of MDTs for patients, clinicians and health services, and the range of associated challenges and barriers that they faced in their local area. Next, they discussed the processes used to establish MDC and MDTs in BSWRICS, Victoria. A dedicated MDC team was established to undertake this work - this team included a project coordinator and administrator. The MDC team developed a MDT policy manual which outlined: clear meeting aims; expected professional conduct; definitive objectives; criteria for patients to be discussed; a definition of core members and the chairperson's role; and the process for collecting data. The next step involved contacting core team members to establish suitable times for MDT meetings. A web-based MDT database was developed - the database enables MDT members to refer patients to a MDT, facilitates weekly MDT communications between all stakeholders and is used to record data pre and post MDT meetings. This was complemented by a videoconferencing communication model that links clinicians across the region and allows MDT attendees to view radiology and pathology from a number of different sites. This system is also used to deliver education forums across the region - it allows individuals to view PowerPoint presentations and interact with educators. A GP liaison program was also established which provides funding for GP representatives to attend MDT meetings in BSWRICS. The success story concluded with presentation of some evaluation data that illustrated the significant progress that has been made in BSWRICS - the number of MDT meetings per tumour stream and the number of patients discussed per meeting has significantly increased in recent years. In the future, the BSWRICS MDC team plans to enhance recognition within MDTs of the psychosocial issues that impact on treatment, increase MDT videolinking, develop MDT orientation packs and associated training programs, and continue to increase the number of patients being discussed in MDT meetings by further streamlining processes.

The BSWRICS MDC team kindly provided workshop participants with sample MDT meeting documentation and GP communications. Workshop participants were asked to ensure that they acknowledge the work of BSWRICS if they use any of the provided templates.

2.4.2 MDT for breast cancer at Royal North Shore Hospital, NSW

The second success story was presented by Dr Katrina Moore (Breast Surgeon, Senior Lecturer and Leader of MDT Breast Group, Royal North Shore Hospital).

Dr Moore started by acknowledging that there were a range of different MDT models that all dealt with the same issues and aimed to achieve the same end points. She outlined the composition of the breast cancer MDT that she leads at Royal North Shore Hospital, NSW. She also discussed a range of enabling factors which helped her establish this MDT:

- Ensuring the MDT meeting location is as central as possible
- Convening MDT meetings as regularly as possible
- Engaging all the key players (Strategies include: offering education sessions and

additional resources; promoting referral opportunities; ensuring effective leadership; and establishing ways to distribute the workload)

- Developing local guidelines
- Establishing standardised information and record keeping processes (ie designing a consent form and MDT meeting summary sheet)
- Developing effective tele- and videoconferencing linkages
- Developing processes to provide feedback to patients and their GPs
- Developing processes to involve GPs in the MDT meeting

Dr Moore also discussed how the members of the breast cancer MDT at Royal North Shore Hospital use the associated MBS items. She concluded her presentation by discussing the importance and value of quarterly business meetings which she convenes with the breast cancer MDT. During these meetings the MDT develops and reviews a 5 year plan which includes goals for the team as a whole, as well as individual goals for each member of the team.

Dr Moore kindly provided workshop participants with a copy of the multidisciplinary patient summary and consent form that are used by the breast cancer MDT.

2.5 Overcoming the challenges associated with establishing MDTs through the CanNET program: Global café activity

The global café strategy was used to facilitate small group discussions about potential strategies to overcome the challenges associated with establishing MDTs. This cooperative learning strategy allows groups to gather and share information quickly. Each of the tables in the workshop room became a café from a different location around the world (London, New York, Beijing, Moscow, Adelaide, and Rome). Each café was then given one category of the challenges associated with establishing MDTs to focus on and assigned a recorder, who remained at the café throughout the entire process to record the conversation. The remaining workshop participants spent 10 minutes at each of the cafés discussing potential strategies to overcome the challenges that the cafés were assigned. They were given a 'travel itinerary' that indicated the order in which they should move around the cafés. When the new café groups were formed, the recorders shared the key aspects of previous conversations with the new group before they continued the discussion. The activity concluded with a brief feedback session during which each of the recorders summarised the main discussion points at their café.

2.5.1 Key themes - identified challenges

In preparation for this session, the challenges identified in the network presentations were sorted into 6 broad categories using a fishbone diagram (see Appendix C), with the key themes being:

- Engaging the primary care sector and referral processes;
- Workforce and workload issues;
- MDT infrastructure data and logistics;
- Change management;
- Resourcing; and
- Developing linkages between different services, areas and MDTs.

2.5.2 Strategies to address the identified challenges[1].

Engaging the primary care sector and referral processes

[1] Please note: Potential strategies marked with an asterisk (*) are strategies that may be best progressed at a national level

The challenges discussed at this café included: GP involvement and inclusion; changing GPs referral pathways; matching MDTs to patient referral pathways; and agreeing on which patients should be referred to MDTs.

The potential strategies to overcome these challenges that were discussed included:

- Clearly defining GPs role in MDC and MDTs for cancer consumers so that they understand their value (Important to define GPs role at all stages in the patient journey)
- Developing links between cancer nurses and GPs
- Persistence in providing GPs with opportunities to engage in MDC and MDTs
- Providing GPs with the support they require (eg mentors, MDT protocols, Directories of Services which identify existing MDTs)

Workforce and workload issues

The challenges discussed at this café included: the limited number of health care providers; large workloads of health care providers; the lack of administrative (eg MDT coordinators); and the need for ongoing education and professional development about MDTs.

The potential strategies to overcome these challenges that were discussed included:

- Needs-based workforce planning, based on projected population growth etc*
- Developing caseload benchmarks*
- Establishing general oncology MDTs rather than tumour stream specific MDTs
- Developing effective succession planning processes
- Implementing professional development frameworks and programs
- Attracting overseas clinicians*
- Developing new and innovative roles (consider international models)*
- Piggybacking MDT meetings on existing meetings
- Reviewing career pathways and making sure they are attractive*
- Ensuring specialist rates of pay are consistent across Australia*
- Developing protocols and criteria about which cancer patients should be referred to a MDT
- Obtaining funding for administrative support for MDTs

MDT infrastructure, data and logistics

The challenges discussed at this café included: the lack of MDT information systems and databases; enabling technology (ie for virtual MDTs); MDT documentation and administrative protocols (eg Terms of Reference); and MDT logistics (ie when, where and how often to meet).

The potential strategies to overcome these challenges that were discussed included:

- Developing a national approach to MDT data collection (including a national database)*
- Sharing data systems
- Sharing MDT documentation and administrative protocols, tools and templates
- Using current technology to enable health care providers to link into MDTs from a range of different settings (ie videoconferencing through the internet)
- Further investigating the role of MDT coordinators to provide administrative support

Change management

The challenges discussed at this café included: identifying and engaging clinical leaders; MDT sustainability; working within historical and emerging contexts; working with resistance; and instilling the need for change.

The potential strategies to overcome these challenges that were discussed included:

- Developing an effective communication strategy
- Building trust and relationships
- Engaging clinical leaders/champions
- 'Selling' the personal benefits of participating in MDTs to clinicians
- Educating and engaging cancer consumers about the value/importance of MDTs (eg national education campaign*)
- Offering clinicians incentives for participating in MDTs (eg funding, tools, education, food)
- Considering the medicolegal implications of clinicians not participating in MDTs*
- Taking small steps (chunking) with a long term view
- Collecting data to show improvements along the way
- Considering sustainability from the start

Resourcing

The challenges discussed at this café included: Infrastructure costs; funding for visiting medical officers; the differences between public and private sectors; the MBS rebate; and MBS billing.

The potential strategies to overcome these challenges that were discussed included:

- Streamlining MDT billing processes
- Administrative support for MDT billing processes
- Legislative, regulative and/or policy changes*
- Developing 'how to' guides for MBS items* (see NBOCC website)
- Applying for grants
- Investigating strategies to provide funding for MDT infrastructure* (eg rural medical infrastructure fund)
- Including participation in MDTs into agreements/position descriptions for visiting medical officers
- Service mapping to identify resource gaps to prioritise available funding
- Effectively evaluating MDT related projects and programs to attract future funding
- Offering alternative incentives to clinicians for participating in MDTs (eg education, food)
- Investigating strategies to provide funding for consumer participation in MDTs (eg funding for transport, enabling technology)*

Developing linkages (between different services, areas and MDTs)

The challenges discussed at this café included: bringing together multimodal health services (silos, turf and ownership); the public/private spilt; developing linkages between rural/regional and metropolitan services; developing interstate linkages; and developing linkages between MDTs.

The potential strategies to overcome these challenges that were discussed included:

- Developing interpersonal linkages and relationships
- Developing protocols about communication in MDT meeting (to ensure that all

members input is valued)
- Developing supporting systems (ie systems to share data and patient information)*
- Creating a national patient ID number*
- Formalising informal linkages and MDTs
- Ongoing promotion and education to support and maintain linkages (involving consumers)
- Developing relationships between project teams for related initiatives
- Appointing cancer care coordinators that work across organisational boundaries
- Sharing resources, tools and templates
- Developing a system whereby larger, more developed states or services can support others (eg big buddy system)*
- Developing a national referral pathways for complex or rare cases*

We would like to sincerely thank the people who agreed to act as recorders during this activity: Associate Professor Tim Shaw (Director Workforce Development, Centre for Innovation in Professional Health Education and Research; CIPHER); Jackie Ross (Senior Project Manager, CIPHER); Cathie Pigott (EdCaN Project Manager); Dr Karen Luxford (General Manager, NBOCC); Robyn Thomas (MDT Project Officer, Cancer Institute NSW) and Rachel Yates (Director of Policy, Australian General Practice Network; AGPN).

2.6 Using the cancer registry incidence data to inform referral pathways and the establishment of MDTs

The final session on the first day focused on how cancer registry incidence data can be used to inform referral pathways and the establishment of MDTs for cancer consumers. This session was lead by Professor David Currow (CEO, Cancer Australia).

The session commenced with a brief presentation delivered by Professor Currow. He began this presentation by discussing how cancer registry data can provide valuable information for cancer consumers and health care providers. Consumers are often interested to know how many people with a specific type of cancer their health care providers have seen in the past year. This information is of little value because it needs to be considered in context - it needs to be interpreted as a percentage of the total number of people that are diagnosed with a specific type of cancer each year:

- *Numerator*: How many people with a specific type of cancer a particular clinician has seen in the past year
- *Denominator*: How many people that a specific type of cancer there are to see each year

Next, Professor Currow explained that cancer registry incidence data is also very useful for providers, services and systems because it is directly linked to numbers of patients who will require an initial consultation with a MDT. Therefore, cancer registry incidence data can, and should, be used to inform service planning. This is particularly important because a reasonably high throughput is required to improve cancer outcomes - we need to consider what is the minimum number of cases that should be seen by a MDT in week or a year to maintain best possible outcomes? One implication of this is that we may need to establish national MDTs for rare cancers. Another important consideration is what is the maximum number of cases that can (or should) be seen by a MDT in any given week or year to still maintain quality of care?

Following this presentation, workshop participants were given cancer registry incidence

data across four different tumour streams (testis, vulva, stomach, thyroid, liver and brain cancer) for a selection of the CanNET networks. Each CanNET group was asked to review this data and consider the following questions:

- What are the characteristics of:
  - People with cancer that may influence the caseload for quality care?
  - The biology of a cancer that may influence the caseload needed for quality care?
  - Cancer treatment that may influence the caseload for quality care?
- What is the influence of prevalence of cancer in planning for MDTs?
- Minimum and maximum case load to be considered?
- How do these figures define the need for interstate linkages?

During the brief feedback session that followed, workshop participants discussed a number of issues, including whether or not the availability of standard, evidence-based treatment protocols for particular tumour streams or treatments should influence recommended minimum caseloads for individual clinicians or MDTs. Similarly, they discussed whether or not five year survival rates should be taken into consideration when developing recommendations about minimum caseloads for individual clinicians or MDTs. Finally, it was also agreed that interstate or national MDTs may need to be developed for rare cancers and cancer that do not have a high prevalence in a particular region.

Overview of the discussions and key outcomes from workshop sessions on 23 May 2007

3.1 Opening address

Rita Evans (National Manager, Quality and Professional Development, Cancer Australia) opened the second day of the national workshop by giving a brief presentation showing how a hot air balloon analogy can be used to plan and review the development of MDTs in the CanNET program. The following elements were demonstrated (see Figure 1):

- What colour is your balloon - be clear about what are you trying to achieve (define the parameters of your MDT/s);
- Who needs to be in the hot air balloon basket/gondola - who will be important in making this happen (consider all the important players);
- What are the enabling factors (or ropes that connect the basket to the hot air balloon) that will assist you to achieving your goals - these are important, without them you will not be connected to your goal (you will need to use these again and again throughout the planning and development to ensure you keep all involved committed and focussed);
- What are the barriers (or ropes that anchor the basket to the ground and prevent it from taking off) that you will need to overcome; and
- What are the strategies that you need to put in place to untie those ropes that are keeping you from flying - each one needs to be addressed in detail (the national workshop has enabled many of these strategies to be shared).

All these elements are critical to ensuring a safe launch of your MDT. It is not an easy operation, however, it is possible - and it is worth it. In closing, Ms Evans encouraged the CanNET networks to “overcome their fear of flying and have a go”!

Figure 1. Hot air balloon

3.2 Existing MDT resources, tools and templates

Associate Professor Tim Shaw (Director Workforce Development, CIPHER) then gave workshop participants an online tour of the Cancer Learning website that has been developed through Cancer Australia's CPD project (Website address: http://www.cancerlearning.gov.au/). In particular, he showed participants where they could locate the resources relevant to establishing and supporting MDTs.

During the morning tea break, representatives from CanNET Queensland also gave workshop participants an online tour of the Queensland Oncology On-line (QOOL) and the associated Oncology Analysis System (OASys). QOOL is an innovative system that integrates existing data silos and makes available just-in-time clinical information for multidisciplinary case conferencing, service improvement, monitoring safety and quality and research. It has been developed specifically for facilitating MDT meetings. OASys is embedded in QOOL and provides access to clinical indicator reports, aggregate population data, and comparative and outcome analysis tools. Workshop participants were informed that they should contact the Queensland Cancer Care and Analysis Team (QCCAT) directly if they are interested in gaining further information about either of these systems.

3.3 Reflections on MDT development in NSW

The invited guest presenter on Day 2 was Ms Robyn Thomas (MDT Project Officer, Cancer Institute NSW). She delivered a presentation focused on MDT development across NSW.

Ms Thomas began by noting that the NSW Cancer Plan 2007-2010 stated that "by 2010 cancer practice in NSW should include wider use of multidisciplinary teams and more comprehensive patient support provided by skilled cancer professionals" (p. 59). She then discussed the wide range of projects that the Cancer Institute NSW has coordinated to support this objective.

In 2006, the Cancer Institute NSW coordinated a MDT survey to identify the current number and range of MDTs across NSW. The Institute also developed a set of MDT criteria/elements (and an associated rating scale) to assess how existing MDTs were functioning and assist them in developing further. These criteria were informed by previous work undertaken by the NBOCC, Victorian Government and the UK National Health Service and categorised as being 'essential', 'desirable' or 'high level'. Ms Thomas discussed a range of problems the Institute encountered in applying the MDT criteria. They noted that the ability of MDTs to meet certain criteria often depends on the location of the team and a number of system issues, including workforce shortages and patient flow. The relevance of the criteria will also vary by tumour stream and facility. In light of these issues, the Institute plans to review the relevance of the criteria to all tumour streams in the future. They have also recently begun to investigate MDT outcome measures and have canvassed the range of outcome measures that are currently being used by MDTs across NSW.

3.3.1 Small group discussion: Potential MDT outcome measures

During the session after Robyn Thomas's presentation, workshop participants were asked to discuss the potential MDT outcome measures that were identified by the Cancer Institute NSW in small groups. In particular, they were asked to consider the following questions:

- How relevant are they? (Are they really outcome measures or measures of team functioning?)
- How measurable are they? (How easy would it be to gather the data?)
- Are they relevant across different tumour streams and locations?

- Can you think of another possible MDT outcome measure?

An overview of participants' feedback about the potential outcome measures is presented in Table 2. The Cancer Institute NSW will take this feedback into consideration in terms of their ongoing work concerning MDT outcome measures.

Table 2. Feedback about potential MDT outcome measures

Potential outcome measure	Feedback
1. Each patient has a written treatment plan	• Process, rather than outcome, measure • Easy to measure • Relevant across all tumour streams
2. Treatment plan in medical records and available to team members	• Some groups felt that this was a process, rather than outcome, measure; while other groups said it was a relevant outcome measure
3. Treatment plan communicated to patient and GP	• Outcome measure • Easy to measure • Relevant across all tumour streams
4. Waiting time between diagnosis and treatment	• Not relevant; system issue/matter
5. Percentage of patients presented at MDT	• Outcome measure • Easy to measure • Relevant across all tumour streams
6. Referral patterns to psychosocial support	• Process, rather than outcome, measure • Easy to measure • Relevant across all tumour streams • Need to consider: what is ideal; what is practical/available; how relevant are the decisions to patient needs
7. Team satisfaction	• Process, rather than outcome, measure • Easy to measure • Relevant across all tumour streams
8. Patient satisfaction	• Process, rather than outcome, measure • Easy to measure • Relevant across all tumour streams
9. GP satisfaction	• Process, rather than outcome, measure • Difficult to measure (poor cost vs. benefit ratio); rather measure GP involvement/engagement • Relevant across all tumour streams
10. Number of MDT criteria met	• Not directly relevant; rather use associated higher order rating scale • Consider relevance of criteria to locality
11. Clinical trial participation	• Very relevant • Also consider the number of patients who are eligible to participate in clinical trials
12. Number of patients referred to allied health	• Some groups felt that this was a process, rather than outcome, measure; while other groups said it was a relevant outcome measure • Easy to measure • Relevant across all tumour streams
13. Comparison of patients undergoing pre and post chemo/radio therapy	• Outcome measure

14. Percentage of out of area patients discussed	• Process, rather than outcome, measure
15. Treatment plan implemented	• Process, rather than outcome, measure
16. Management of patients pre and post MDT	• Outcome measure

New MDT outcome measures that workshop participants suggested that the Cancer Institute NSW may like to consider included:

- Treatment plan/recommendations are evidence based
- Tumour stream specific MDT outcome measures (more clinical)
- Outcome measures about timeliness benchmarks (eg for access to radiotherapy)
- CanNET Queensland participants also suggested that there are a number of potential MDT outcome measures included the QCCAT 'Models of Care' report (2006)

3.4 Network level MDT action plans

During the final session of the national workshop, each state/territory CanNET project team was provided with an opportunity to reflect on the workshop and develop a network level MDT action plan that they could take back to their network and implement. They were provided with a MDT action plan template to assist with this task.

The aims and objectives of each of the network level MDT action plans that were developed during the workshop are listed in the table on the following page[2].

[2] Please note: CanNET NSW did not develop a MDT action plan because they had recently facilitated a their own MDT learning session ,during which similar action plans were developed

Table 3. Aims and objectives of network level MDT action plans

CanNET Network	Aims and objectives
CanNET Victoria	Aim: To create links between rural and metropolitan lung MDTs Associated objectives: • To provide rural cancer patients with access to MDTs • To ensure effective prospective care planning • To educate, upskill and support health care professionals • To improve outcomes through best practice care • To improve continuity of care for patients
CanNET WA	Aim: To improve the functioning of an existing MDT Associated objectives: • To review the MDT against Cancer Institute NSW MDT criteria • To define the roles and responsibilities of members, including clinical leader/s • To develop a meeting protocol and pilot MDT database • To improve communication processes • To address issues about informed consent and provide consumer with more information about MDTs • To improve GP engagement • To convene a MDT workshop • To provide professional development opportunities to MDT members
CanNET SA	Aims: • To investigate opportunities to use and build on a range of existing MDT resources that were presented during the national workshop • To conduct a detailed review of existing MDTs against Cancer Institute NSW MDT criteria • To pilot MDT coordinators for AYA and lymphoma MDTs (reviewing costs and benefits)
CanNET Tasmania	Aim: To develop a statewide multidisciplinary protocol This will involve: • Building on the existing information about criteria and elements of MDTs • Conducting a survey of key stakeholders to identify potential MDT criteria, specific to the local context
CanNET NT	Statewide aims: • To audit current MDTs in Darwin and Alice Springs Darwin aims: • To improve communication with community support services • To formalise existing MDT processes Alice Springs aims: • To include surgical and medical representatives in MDTs • To provide education about MDTs for cancer patients
CanNET Queensland	Aim: To narrow the gap between the primary care and acute care sector (with a focus on referrals)

3.5 Concluding sessions

Seven consumers were invited to be part of a consumer reflections panel during the second day of the national workshop: Sally Crossing (CanNET national Steering Committee consumer representative; Chair, Cancer Voice NSW); Ashleigh Moore (CanNET SA consumer representative, Executive, Cancer Voices SA); John Stubbs (CanNET national Steering Committee consumer representative; CEO, Cancer Voices Australia); Isobel Harvie (CanNET Victoria, consumer representative); Keith Harvie (CanNET Victoria, consumer representative); Jane Poynts (CanNET Queensland consumer representative; Secretary, Cancer Voices Queensland); and Lesley Reilly (CanNET NT consumer representative). These consumers discussed key take home messages from the workshop and reflected on what consumer need in terms of MDC and MDTs. In terms of MDC and MDTs, they said that cancer consumers need:

- Access to MDT assessment and review;
- An opportunity to 'opt in' to MDT assessment and/or review (informed consent)
- Emphasis on the full ambit of care that can be offered through MDTs (holistic care)
- Continuity of care (eg MDT coordinators)
- A contact point or resource that can provide information (in layperson language) about cancer related issues (including information about roles and benefits of MDTs, and the available practical/living support)
- Directories of MDTs with contact details for MDT team members
- GPs to be educated about optimal pathways and referrals to MDTs
- Access to their treatment and care plans (for both themselves and their GPs)
- To be regularly consulted about their MDT needs and expectations (consultation with both cancer consumer organisations and individual consumers is important)
- The role of carers and their needs to be recognised and addressed
- More research focusing on long term outcomes (≥ 5 years) of MDTs
- Assistance with cost of travel to access care (MDTs, GPs, secondary opinions etc)

The national workshop concluded with a closing address delivered by Professor David Currow (CEO, Cancer Australia), who sincerely thanked workshop participants for their input, time and attention. Professor Currow extended a special thanks to: all invited guest speakers, who had the courage to share both what is working and what is not working in their current processes; Siggins Miller, who effectively coordinated and facilitated the workshop; and to Jane Phillips (Program Manager, Quality and Professional Development, Cancer Australia) and Rita Evans (National Manager, Quality and Professional Development, Cancer Australia), who bring their energy and vision to the CanNET program on a day to day basis. Professor Currow also reflected on the ongoing synergies, relationships and conversations that the national workshop had created - another important step in terms of improving care across the system and developing MDTs. In closing, he encouraged CanNET project teams to "think outside the box, take some risks, build on the ideas that have been shared and deliver service improvements".

Conclusions

4.1 Workshop evaluation

Workshop participants were asked to complete a workshop evaluation form (see Appendix D). 37 completed workshop evaluation forms were returned by 28 females and 5 males (4 respondents did not specify their gender). Five of these were classified as consumer representatives, 25 as network representatives, 3 as CPD project members and two as other representatives (2 respondents did not respond to this question). Over all, evaluations of the workshop were very positive.

Participants were asked to rate a number of items relating to structure and content (see Table 4), and presentation and delivery (see Table 5), using a 5-point scale with higher scores indicating higher levels of satisfaction. As can be seen in the tables below, the evaluations were generally very positive. On the basis of this data, future national workshops may be able to be improved by allowing more time for workshop sessions, particularly more time for participants to interact and participate (ie make comments, ask questions).

Table 4. Average participant responses to items assessing their satisfaction with the structure and content of the workshop (using a 5-point rating scale)

Structure and content items:	Mean Response (SD)
I understood the purpose and objectives of the workshop………………………………………..	4.30 (0.62)
The workshop met my expectations…………………………………………………………………	3.97 (0.76)
The workshop was well organised………………………………………………………………...	4.21 (0.67)
There was enough opportunity to make comments or ask questions……………………………	3.68 (1.09)
There was enough opportunity for interaction and participation…………………………………	3.95 (0.91)
The time allowed for activities was adequate……………………………………………………….	3.70 (0.97)
The workshop stimulated interest and discussion…………………………………………………	4.32 (0.58)
The workshop maintained my interest………………………………………………………………	4.05 (0.78)
The workshop provided me with information I will use…………………………………………….	4.20 (0.76)
Over all mean for structure and content items:	**4.04 (0.58)**

Table 5. Average participant responses to items assessing their satisfaction with the presentation and delivery of the workshop (using a 5-point rating scale)

Presentation and delivery items:	Mean Response (SD)
Over all, the presenters were knowledgeable……………………………………………………	4.46 (0.51)

Over all, the presenters were well prepared and organised……………………………………	4.43 (0.50)
Over all, the presenters produced a good learning climate…………………………………….	4.15 (0.63)
Transitions between sessions were smooth……………………………………………………..	4.11 (0.66)
Over all mean for presentation and delivery items:	**4.29 (0.48)**

The participants were also asked to rate how useful they found the information presented during the workshop. On a scale from 1 to 5 (with 1 being not at all useful and 5 being very useful), the average response was 4.08 (*SD* = 0.80). Similarly, the participants were asked to rate how enjoyable they found the workshop. On a scale from 1 to 5 (with 1 being not at all enjoyable and 5 being very enjoyable), the average response was 4.19 (*SD* = 0.71).

Over all, qualitative comments from participants indicated that they were very satisfied with the venue and food - although they did comment on level of noise coming from the room next door on the second day of the workshop. Nevertheless, participants were able to articulate many ways in which they will be able to use what they learned during the workshop, for example:

> *"We have reestablished our MDT aims and objectives".*
>
> *"I will take the information back to my MDT group and try to apply promulgate/disseminate information on available technology and education resources".*
>
> *"I have been left with some invaluable contacts for other states who are experts in certain areas and will hopefully tap into their expertise in those areas. Consumer input was fantastic, as always".*
>
> *"I will use everything! I have only been a part of the team for a few months so have quite a lot to learn. This workshop helped me to understand where we (and other states) are and where we need to go to next in our project. Thank you so much for organising this".*
>
> *"The opportunity to discuss CanNET has identified some new ways to address some of the challenges. Over all, a chance to develop new approaches to old problems".*
>
> *"I have developed some ideas about MDT outcomes measures, GP involvement and a clear action plan".*

4.2 Summary

The 3rd CanNET national workshop brought a wide range of people together to discuss a key element of the program - developing a strong multidisciplinary approach to cancer control that actively includes allied health and primary care, and which supports rural and regional provision of cancer services. There was clear evidence of sharing, learning and networking throughout all sessions of the workshop. The workshop culminated in each CanNET project team collaboratively developing a MDT action plan to take back and implement in their network. In summary, the workshop built capacity in the area of cancer control in Australia by providing a venue to share knowledge and resources, and strengthen partnerships across states and territories and between a wide range of service providers and consumers.

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Appendix A: Agenda for 3rd CanNET national workshop

Australian Government

Cancer Australia

3rd CanNET National Workshop (Establishing Multidisciplinary Teams; MDTs)

Thursday 22nd & Friday 23rd May 2008

Venue: Ballroom 3, Stamford Grand, Moseley Square, Glenelg, Adelaide

Thursday 22nd May 2008 (8.30am - 5.00pm)			
8.30 am	*Coffee/Tea*		
9.00 am	1.	**Opening address** (CEO of Cancer Australia)	Prof David Currow
9.10 am	2.	**Consumer address**	Ashleigh Moore
9.20 am	3.	**Introductions and overview of workshop agenda**	Dr Mel Miller & Dr Crissa Sumner
9.40 am	4.	**Multidisciplinary care teams: The current state of play** (Presentation by the NBOCC on the findings from their recent audit on MDTs across Australia)	Dr Karen Luxford
10.00 am	5.	**Progress to date in relation to establishing MDTs through the CanNET program** 5.1 Network presentations about key achievements and challenges in relation to establishing MDTs *(Max. of 10 minutes/network; Followed by other networks identifying one key message from the presentation)*	CanNET Queensland CanNET Victoria CanNET Tasmania
10.45 am	*Morning Tea*		
11.00 am	5.	**Progress to date in relation to establishing MDTs through the CanNET program cont'd** 5.1 More network presentations about key achievements and challenges in relation to establishing MDTs *(Max. of 10 minutes/network; Followed by other networks identifying one key message from the presentation)*	CanNET SA CanNET NSW CanNET WA CanNET NT
12.00 noon	6.	**Success story #1: MDT in Barwon Victoria** (Presentation by the Cancer Services Manager from Barwon Integrated Cancer Services; Followed by each network identifying one *key* message from the presentation)	Maggie Stowers (& Jacqui Hennock)
12.30 pm	7.	**Success story #2: MDT for breast cancer (Using MBS items)** (Presentation by a breast surgeon from Royal North Shore Hospital; Followed by each network identifying one *key* message from the presentation)	Dr Katrina Moore
1.00 am	*Lunch (Promotional materials from networks on display over lunch)*		
1.30 pm	8.	**Overcoming the challenges associated with implementing MDTs through the CanNET program** 8.1 Global café activity (small group work): Brainstorming practical strategies to overcome challenges identified in network presentations	All
3.00 pm	*Afternoon Tea*		
3.15 pm	9.	**Overcoming the challenges associated with implementing MDTs through the CanNET program cont'd** 8.2 Recorders from global café activity report back and take questions/comments	Global café recorders Dr Mel Miller

		8.3 Session summary and discussion of strategies that could be taken up at the national level	
4.00 pm	9.	**Using cancer registry incidence data to inform referral pathways and the establishment of MDTs** (Presentation by CEO of Cancer Australia; Followed by related activity using cancer registry data)	Prof David Currow
5.00 pm	10.	**Summary and close** 10.1 Review of what we have achieved today 10.2 Overview of workshop agenda for tomorrow	Dr Mel Miller & Dr Crissa Sumner

Friday 23rd May 2008 (8.30am - 2.00pm)			
8.30 am	*Coffee/Tea*		
9.00 am	1.	**Welcome and overview of today's agenda**	Dr Crissa Sumner
9.05 am	2.	**Reflections on MDT development in NSW** (Presentation by the Cancer Institute NSW)	Robyn Thomas
9.30 am 10.00 am	3.	**Feedback on potential MDT outcome measure** 3.1 Small group work: Discussing potential outcome measures for MDTs and their relevance/applicability 3.2 Small groups report back *(5 minutes per group)*	All All
10.30 am	*Morning Tea*		
10.45 am 11.45 am	4.	**Developing MDT action plans for your CanNET** 4.1 Small group work: Developing network action plans 4.2 Small groups present their action plans to the larger group and field questions, comments and suggestions *(10 minutes per group)*	All Selected group representative/s
12.45 pm	*Lunch*		
1.15 pm	5.	**Consumer reflections panel** (Their reflections on the workshop and the take home messages/suggestions for improving MDC)	Consumer representatives
1.50 pm	6.	**Closing address**	Prof David Currow
2.00 pm	*Close*		

Appendix B: 3rd CanNET national workshop attendance list

Name	Affiliations	Contact details
Penny Adams	Manager, Models of Care	8374 5713 or penny.adams@cancerinstitute.org.au
Solange Altarac	Project Officer, CanNET Victoria	(03) 9496 3831 or Solange.altarac@austin.org.au
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Tim Shaw	Director Workforce Development, CIPHER	(02) 9351 8799
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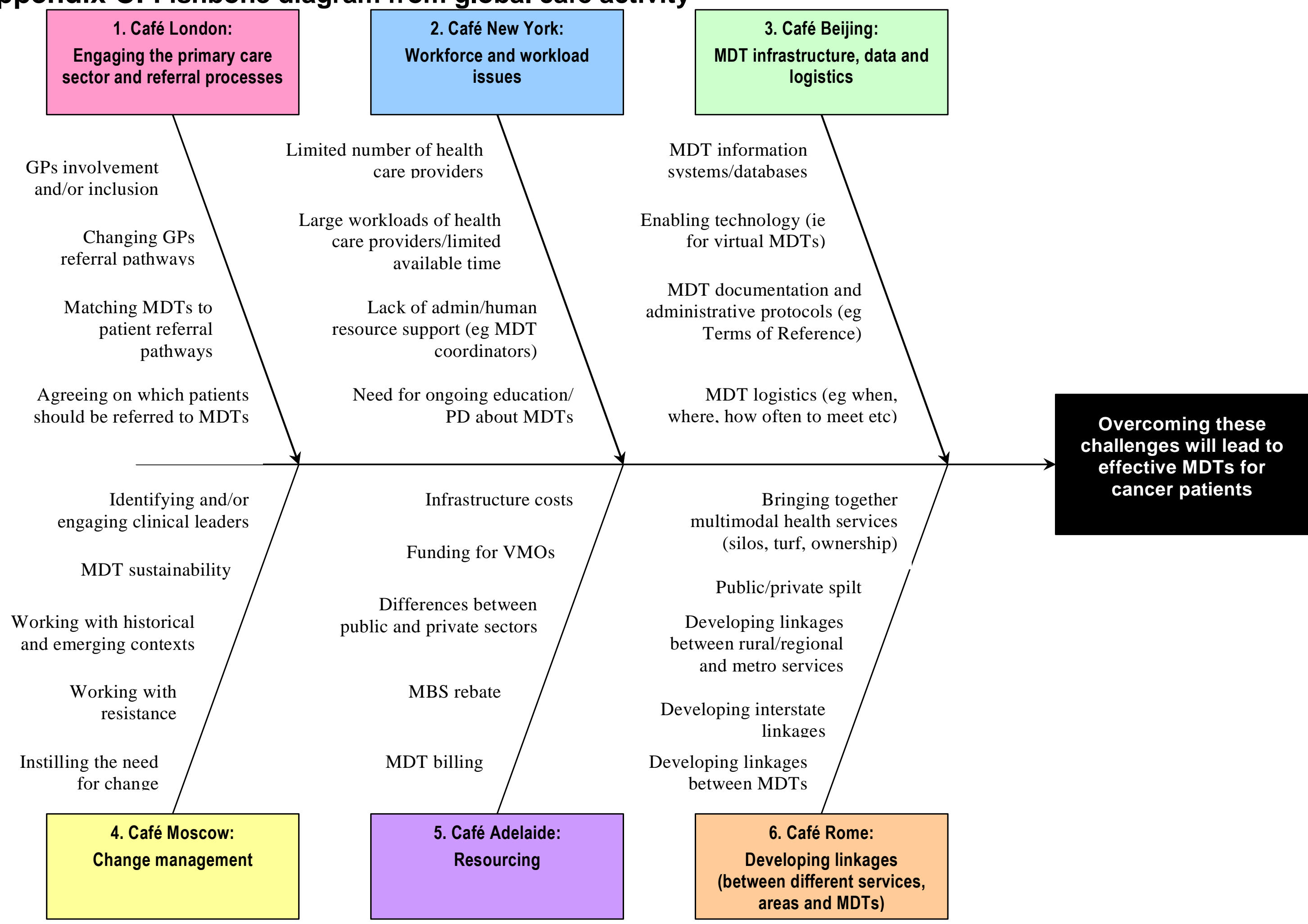
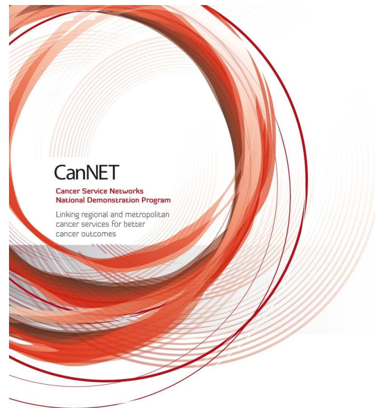
Rachael Yates	Director of Policy, AGPN	RYates@agpn.com.au

Appendix C: Fishbone diagram from global café activity



Appendix D: 3rd CanNET national workshop evaluation form



Australian Government

Cancer Australia

SIGGINS MILLER

3rd CanNET National Workshop Evaluation Form

Date: Thursday 22nd and Friday 23rd May, 2008
Venue: Ballroom 3, Stamford Grand, Moseley Square, Glenelg, Adelaide

Instructions: Please take a few minutes to complete this evaluation by answering the questions below and providing comments. When you have completed the evaluation, fold in half to keep your responses confidential and return it to one of the facilitators.

Personal Profile:

What is your gender (optional)? Male ☐ Female ☐

What is your age (optional)?

☐ 18 - 24 yrs ☐ 25 - 34 yrs ☐ 35 - 44 yrs
☐ 45 - 54 yrs ☐ 55 - 64 yrs ☐ 65 & over

Which participant category do you identify with?

☐ Consumer representative
☐ Network representative
☐ Cancer Australia representative
☐ National Steering Committee member
☐ CPD project team member
☐ Other (please specify): ____________________

Structure and Content Evaluation:

Please circle the appropriate number for each statement:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**	**N/A**
I understood the purpose and objectives of the workshop	1	2	3	4	5	N/A
The workshop met my expectations	1	2	3	4	5	N/A
The workshop was well organised	1	2	3	4	5	N/A
There was enough opportunity to make comments or ask questions	1	2	3	4	5	N/A
There was enough opportunity for interaction and participation	1	2	3	4	5	N/A
The time allowed for activities was adequate	1	2	3	4	5	N/A
The workshop stimulated interest and discussion	1	2	3	4	5	N/A
The workshop maintained my interest	1	2	3	4	5	N/A
The workshop provided me with information I will use	1	2	3	4	5	N/A

Presentation and Delivery Evaluation:

Please circle the appropriate number for each statement:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**	**N/A**
Over all, the presenters were knowledgeable	1	2	3	4	5	N/A
Over all, the presenters were well prepared and organised	1	2	3	4	5	N/A
Over all, the presenters produced a good learning climate	1	2	3	4	5	N/A
Transitions between sessions were smooth	1	2	3	4	5	N/A

Overall, the information presented during the national workshop was (please circle the appropriate number):

1	**2**	**3**	**4**	**5**
Not at all useful				Very useful

Overall, the national workshop was (please circle the appropriate number):

1	**2**	**3**	**4**	**5**
Not at all enjoyable				Very enjoyable

Do you have any specific comments about the venue or food?

Briefly describe how you will use what you have learned during the national workshop:

Do you have any additional comments you would like to make?

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Thank you for taking the time to complete this evaluation form.