



Improving Outcomes: A Strategy for Cancer
Stakeholder engagement report

January 2011

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Introduction

1. Significant progress has been made on cancer services and outcomes since the publication of the Calman-Hine report in 1995, with the NHS Cancer Plan (2000) and the Cancer Reform Strategy (CRS - 2007) contributing to this progress. Cancer mortality has fallen, survival rates are improving for many cancers and patients' experience of their care has improved.
2. Despite the considerable progress, survival rates in England for many cancers are currently lower than in many comparable countries. The Coalition Government therefore wants to tackle this, and to focus on improvement in quality and outcomes for cancer patients. The aims of developing *Improving Outcomes: A Strategy for Cancer* were to:
 - align cancer strategy with the White Paper, *Equity and excellence: Liberating the NHS*
 - set the direction for the next 5 years, taking account of progress since the CRS was published in December 2007
 - show how outcomes can be improved despite the difficult financial position
3. The development of the Strategy concentrated on the key issues in the White Paper *Equity and Excellence: Liberating the NHS*: putting patients and the public first (“No decision about me, without me”); improving quality and healthcare outcomes; autonomy, accountability and democratic legitimacy; and cutting bureaucracy and increasing efficiency.
4. The Department of Health could not have developed the new Strategy alone, and a large numbers of organisations and individuals have been involved in the review. In order to consult as many stakeholders as possible, an extensive stakeholder engagement plan was developed.

Details of stakeholder engagement

5. The stakeholder engagement plan included the following:
 - a. Setting up a mail box, and alerting all subscribers (over 1,500) to the National Cancer Programme Newsletter to the review and the mailbox address;
 - b. Using existing events to consult on the review;
 - c. Using existing advisory group meetings to consult on the review;
 - d. Through the CRS Advisory Group, working closely with multiple cancer charities, GP commissioners, cancer networks and Royal Colleges;
 - e. Ensuring we sought the views of patients; and
 - f. Updating the cancer type visions which were developed for the CRS

Strategy development mailbox

6. Over 200 submissions were received to a mailbox which was established to ensure that stakeholders could contribute their views to the development process. A summary of the respondents is included in Box 1.

Box 1 – summary of submissions to the mailbox

In total 202 submissions were received to the mailbox, broken down as follows:

- 15 from NHS organisations
- 13 from other professional organisations, such as Royal Colleges
- 106 from Individual Healthcare Professionals
- 33 from charities or coalitions of charities
- 13 from commercial suppliers to the NHS, such as pharmaceutical companies
- 12 from users or patient groups
- 10 from individuals

7. Many organisations devoted a great deal of constructive thought to how cancer policy should develop in the context of the reformed NHS, including:

- Action on Bladder Cancer
- Afiya Trust
- Beating Bowel Cancer
- Brain Tumour Research Campaign
- Breakthrough Breast Cancer
- Breast Cancer Campaign
- Breast Cancer Care
- Bowel Cancer UK
- Cancer 52
- Cancer Campaigning Group
- Cancer Research UK
- Clic Sargent
- GistSupport UK
- Independent Cancer Patients
- International Brain Tumour Alliance
- Leukaemia Care
- Leukaemia & Lymphoma Research
- Lymphoma Association
- Macmillan Cancer Support
- Melanoma Taskforce
- Myeloma UK
- Oesophagael Patients Association
- Ovarian Cancer Action
- Pancreatic Cancer UK
- Pharmaceutical Oncology Initiative (on behalf of the healthcare industry)
- Rarer Cancers Foundation
- Roy Castle Foundation
- Samantha Dickson Brain Tumour Trust
- Target Ovarian Cancer
- Teenage Cancer Trust
- The British Lung Foundation

- The Prostate Cancer Charity
- United Kingdom Lung Cancer Coalition
- World Cancer Research Fund

Existing events

8. As the timescale for undertaking the review was tight, there was not the time or the resources to set up major dedicated conferences or workshops. Instead conferences and workshops that were already planned were used to consult on the review. These included the Health Service Journal Cancer Care Conference held in Manchester on the 15th and 16th September and the Cancer Network Development Programme in Manchester on 13th and 14th October 2010. We would like to thank the organisers of these events for making time on their busy agendas for us to consult on the development of the new Strategy.

9. However, we were also able to set up some specific events to inform the review. On 20th October we held a roundtable discussion with GPs and primary care specialists in London to discuss how the new GP commissioning arrangements could best be applied to cancer and what could be done to improve cancer commissioning. The roundtable consisted of 16 participants. The key messages from the meeting were as follows:

- Information is crucial for excellence in cancer commissioning. However, there are still significant gaps in data collection;
- GPs differ in their views about what they do and do not want to commission, though the majority do not want to commission for rare cancers; and
- Cancer networks should be retained in some form for the commissioning expertise they hold to assist commissioners through the transitional period

10. On 23rd September 2010, British In-Vitro Diagnostics Association (BIVDA) and Cancer Research UK held a small roundtable meeting in London on molecular diagnostics to feed in to the review. Meeting attendees highlighted the importance of improved pathology services to support the use of molecular diagnostics in the NHS. They also highlighted the potential of molecular diagnostics to improve cancer outcomes by helping to stratify patients for specific treatment regimes.

Existing advisory groups

11. The National Cancer Programme is supported by a range of expert advisory groups. The following groups met at least once to discuss the development of the new Strategy, giving members of the groups the opportunity to input their expertise into the process:

- Bowel Cancer Advisory Group
- CRS Breast Cancer Advisory Group
- Lung Cancer and Mesothelioma Advisory Group
- Prostate Cancer Advisory Group
- Children and Young People's Improving Outcomes Guidance Advisory Group

- National Chemotherapy Implementation Advisory Group
- National Radiotherapy Implementation Group
- Bowel Screening Advisory Committee
- Advisory Committee on Breast Cancer Screening
- Advisory Committee on Cervical Screening
- National Cancer Equality Initiative Implementation Advisory Group
- CRS Patient Experience Advisory Group
- National Awareness and Early Diagnosis Steering Group
- National Cancer Survivorship Steering Group

CRS Advisory Board

12. The CRS Advisory Board held an extraordinary meeting on 23rd July to discuss the development of the new Strategy. The Board discussed the issues around the review, particularly the challenges and opportunities for cancer services in the reformed NHS, and commissioned four papers to inform further thinking. These were on:

- Measuring outcomes in cancer
- Commissioning
- Levers for change
- Priorities for service development and opportunities for cost saving

13. The four papers were discussed at a further meeting of the Board on 8th October 2010, and subsequently formed the basis for drafting the new Strategy. The membership of the CRS Advisory Board is at Annex Q.

Service Users

14. Two service user workshops were held specifically to feed in to the development of the Strategy, to look at what service users would need to know in order to feel confident in the quality of their cancer treatment and care. The first workshop of 37 participants was held during the October Network Development Programme meeting in Manchester, and attended by Partnership Forum participants – informed and active service users and network service user facilitators from across England. The second workshop of 17 participants was convened by the Cancer Campaigning Group and held in London - participants were people affected by cancer some of whom were experienced patient advocates but for many of whom this was the first experience of attending a policy event.

Box 2 - Key messages from the service user workshops:

- For information to be meaningful it should be standardised and comparable e.g. What clinical outcomes for my condition are achieved here compared with other hospitals?
- Standardised information should be expressed in ways which are as patient centred as possible e.g. How well do patients with my type of cancer rate their experience of care?

- Information about access to the care and treatment environment needs to be embedded and offered within a clinical setting e.g. questions about travelling for chemotherapy and radiotherapy. The clinical team needs to pay more attention to issues related to travelling for treatment and the scheduling of appointment times to match times when the patient has access to resources such as a friend being able to take them to hospital.

- In both workshops, a number of issues emerged which are relevant to the quality and performance of multi-disciplinary teams. For example: Will I have continuity of care? Do they communicate well? How good are clinicians at listening to patient preference in treatment? Do all staff have communication training? Will I be able to attend the MDT when they discuss my case?

- Service users were readily able to suggest ways to measure the things that matter to them e.g. Percentage of patients with my cancer who receive a written care plan after holistic assessment.

- Workshop participants were particularly concerned about cancer expertise necessary for effective commissioning. This concern was further reinforced by the delays or difficulties in diagnosis experienced by workshop participants: their priority concern is speedy access to cancer specialists and they were concerned whether GP consortia will have the necessary expertise to be effective commissioners of high quality cancer services.

Visions

15. When the original CRS was being developed, groups of experts, patients and voluntary sector representatives met to discuss their visions for particular cancers and made predictions about how cancer treatment and services would change by 2012. As part of the development of the new Strategy, the 15 visions have been updated by the same groups and now reflect how they think services should look by 2015. The timescale of the review and resources did not allow for all the groups to meet, so in most circumstances the visions were updated by correspondence. The visions make clear that they are not meant to be government policy but provide useful information on how certain cancer services may look in 2015.

16. Visions have been updated on the following areas, which can be viewed as separate annexes to this document on the DH website:

- Annex A - Bowel cancer
- Annex B - Brain and central nervous system cancers
- Annex C - Breast cancer
- Annex D - Gynaecological cancers
- Annex E - Haematological cancers
- Annex F - Head, neck and thyroid cancers
- Annex G - Lung cancer and mesothelioma
- Annex H - Prostate cancer
- Annex I - Sarcoma

- Annex J - Skin cancer
- Annex K – Upper GI cancers
- Annex L - Urological cancers
- Annex M - Children and young people with cancer
- Annex N - Cancer genetics
- Annex O - Screening

Conclusion

17. The Department of Health could not have developed the new Strategy alone, and we are very grateful to the hundreds of individuals and organisations who have contributed over a tight timescale. Hopefully many of your ideas and suggestions are reflected in the new Strategy, and we look forward to continuing to work with you to improve cancer outcomes in England to make them amongst the best.

Summary of responses to key stakeholder questions

Question 1 – Are there particular priority areas for action which need to be addressed if cancer outcomes are to be improved?

- **IOGs** - full implementation of Improving Outcomes Guidance (IOG's) should be delivered
- **Screening** – flexible sigmoidoscopy (FS) roll out, extension of age roll out, better management of call/re-call, consistent turn around times of 14 days for all cancers
- **23 hour breast surgery** – roll out
- **Prevention** – continued investment and development of anti-smoking and quit initiatives
- **Clinical Nurse Specialists** – access for all cancer patients to CNSs
- **Staging Data** – mandatory collection of staging data should be implemented
- **National Awareness and Early Diagnosis Initiative (NAEDI)** – further investment on this for both public and professionals, including wider focus beyond GPs to pharmacists.
- **GPs and NAEDI** – develop QOF to incentivise early diagnosis by GPs
- **Commissioning needs cancer support** – cancer expertise essential support for commissioners, this should be pathway focused
- **Post treatment care planning** – should be rolled out
- **Information prescriptions** – to be rolled out providing improved information to enable choices to be made by patients
- **End of life care** – care should be coordinated 24/7 and patients should be given choice to die at home
- **Radiotherapy** – investment in Radiotherapy needed to provide better access to patients and to ensure that old equipment is updated. The way it is commissioned should be reviewed
- **NICE Quality Standards** – to be developed quicker and to include whole pathway, clinical and non clinical.

Question 2 - What opportunities are there for delivering efficiencies or saving money in cancer care?

- **CNS** - increased roll out and use of CNS to enable savings in other areas
- **NAEDI** – earlier diagnosis to reduce burden and in particular to prevent cost of emergency admissions
- **Better use of technology** – for patients follow up via telephone, email support via CNS, better use of video conferencing for MDT effectiveness
- **Local community support** – increased follow up nearer to people’s homes, including chemotherapy delivered locally
- **FS** - FS roll out
- **Laparoscopic surgery** - increased use of Laparoscopic surgery
- **Enhanced Recovery Programme** – further roll out
- **Radiotherapy** – better commissioning and more effective delivery
- **Better coordinated care** – avoiding duplication of effort, reducing costs to patient and NHS
- **Digital mammography** – roll out
- **Prevention** – continued investment in this, particularly anti-smoking
- **More efficient diagnostic services** – one stop diagnostic clinics
- **More efficient breast surgery** – roll out of 23 hour breast surgery model
- **Better communication with patients** who do not attend appointments (DNAs)
- **Multi-disciplinary teams (MDTs)** – review ways of working to increase efficiencies
- **District nurse role** – further develop for symptom management and end of life care
- **Self-management for patients** – rolled out to reduce burden on NHS.

Question 3 - How best can quality and outcomes in cancer care be measured?

A range of more detailed measures/indicators has been proposed in addition to those summarised here.

- **PROMS** - develop per cancer type and include quality of life / end of life measures
- **Peer Review Measures** - to be continued but a number of people suggested process could be streamlined
- **National Cancer Patient Experience surveys** - should be done on an annual basis
- **Regular clinical audits** - should be mandatory
- **Measurement of 'never events'** - such as wrong site surgery, wrong site chemo/radiotherapy
- **Staging data** - collection should be mandated
- **2 week wait** - measurement should continue
- **Quality standards** - for cancer should be produced
- **Quality account** - for cancer should be developed
- **Over 75's data** - should be included for 1 year survival indicators
- **Data analysts/assistants** - required locally to get analysis right
- **Significant Event Audits** - should be used
- **QOF** - cancer indicator should be introduced
- **Embed Peer Review** - measurement with CQC

Question 4 - What further action is required to improve patients' experience of treatment and care?

- **Co-ordination of care** - transition between hospital and home requires development and improvement
- **Laparoscopic surgery** - further roll out required
- **Information prescriptions** - roll out and development
- **Psychological support** - service improved access needed
- **Ward nurses** - ensure enough trained cancer nurses on general and cancer wards
- **CNSs** - access should be for all cancer patients
- **Radiotherapy** - improved access to and delivery of this service
- **Chemotherapy** - outreach services need developing further
- **Patient experience** - feedback requires more emphasis and should include feedback to GPs
- **Quality Standards** – interim standards for cancer if NICE are not going to deliver until 2015
- **Survivorship** - services roll out
- **Training** - provision for non cancer health professionals
- **Drugs** - fair access for patients to receive 'near label' drugs
- **Private health care** - regulation of providers
- **Parking** - free parking for cancer patients

Question 5 - Examples of good practice in cancer service delivery which could be replicated?

- **Barnet & Chase, St Mary's Paddington** - information for patients to prepare for first consultant appointments
- **Chemotherapy** - various chemotherapy in the community/at home initiatives
- **CNSs** - involvement in telephone follow up
- **Technology** - video linked MDTs
- **Poole** - primary care nurse team
- **Survivorship** – various pilot services
- **The Christie** - network of ambulatory radiotherapy centres
- **'Train the trainer'** – various initiatives for symptom and prevention messages in local communities
- **Marie Curie** - delivering choice programme
- **Transforming Inpatient Care Programme**
- **Skin cancer** – Karen Clifford Skin Cancer Charity (SKCIN), Cancer Research UK, Teenage Cancer Trust (TCT), and British Dermatology Association (BDAA) skin cancer awareness initiatives
- **Macmillan Therapy Team** – cancer rehabilitation
- **Telephone** - various telephone follow up services
- **User involvement** - involving patients/users in service improvement initiatives (eg Breakthrough Breast Cancer Service Pledge)
- **Enhanced Recovery Programme**
- **Telephone** - assessment pre- and post chemotherapy
- **Bristol Royal Children's Hospital** - oncology 'daybed centre' with access for children and adults

Question 6 - What developments in prevention, screening, diagnosis, treatment or after care can be expected which will impact upon the way in which cancer services need to be commissioned or delivered?

Prevention

- **Local authority responsibility for public health** - should enable more joined up prevention between health and social care
- **Anti-smoking investment** - action should continue to be expanded
- **Prevention messages** - should focus on disadvantaged groups
- **Information prescriptions for primary care** - to include prevention and signs and symptoms information

Screening

- **FS** - roll out
- **Digital mammography** - roll out
- **Higher risk people** - should be targeted for screening
- **Text/e-mail** - should be used for screening appointments management
- **Ovarian and lung screening** - should be developed

Diagnosis

- **NAEDI** - expansion and roll out
- **Use of QOF** - incentivise NAEDI
- **Risk assessment tools** - for GPs need developing and rolling out
- **Diagnostic centres** - to improve experience and drive efficiencies
- **Molecular diagnostic** - laboratories to be rolled out

Treatment

- **Genetic and molecular service** - expansion
- **IMRT (Intensity-Modulated Radiotherapy)** - roll out
- **Laparoscopic surgery** - roll out
- **Proton Beam Therapy** - roll out
- **Drug pricing** - structures review and change

Aftercare

- **Self management** - rolled out for end of treatment
- **Different staffing roles/more flexible approach** - for delivery of follow up
- **Enhanced recovery programme** - further roll out
- **Post treatment assessment/care plans** - for all

Question 7 - Looking at the plans set out in the White Paper and associated consultation documents (some to be published shortly) what are the issues and opportunities for delivering cancer services and improved outcomes ?

Opportunities

- Cancer Network and other non cancer network collaboration
- National decision making by NHS Commissioning Board
- National commissioning of radiotherapy (specialist services)
- Incentives for quality improvement via QOF, CQUINS and CQC
- Interim development of cancer Quality Standards
- Re-focus of networks to support commissioning
- Accelerate momentum of NAEDI and impact of screening via Public Health England
- More patient choice
- National commissioning of specialist services for rarer cancers
- Development of PROMS for different tumour types

Issues / Risks

- Losing the cancer network expertise during the process of restructuring
- Further variation of services if too many GP Consortia
- Cancer pathways could be further fragmented unless commissioning joined up
- Quality of professional training could be compromised if no national provision of this.

Question 8 - As we develop work to improve cancer outcomes, how can we make sure that we continue to try and tackle inequalities in cancer care?

- **Better data** – to better understand inequalities and develop key performance indicators to measure improvements (better data on rarer cancers highlighted)
- **Social deprivation** – more use of social marketing techniques to better target people with prevention and symptom awareness messages
- **Under treatment of older people** – more needs to be done to understand this issue and better equip the professionals on decision making in this area
- **Accessible information and choice** – roll out of information prescriptions and targeted information for different groups
- **General support for work of National Cancer Equality Initiative (NCEI) and the priorities identified.**

REVIEW OF THE CANCER REFORM STRATEGY

BACKGROUND

Significant progress has been made on cancer services and outcomes since the publication of the Calman-Hine report in 1995, with the NHS Cancer Plan (2000) and the Cancer Reform Strategy (CRS - 2007) contributing to this progress. Cancer mortality has fallen, survival rates are improving for many cancers and patients' experience of their care has improved.

Despite the considerable progress, survival rates in England for many cancers are currently lower than in many comparable countries. The Coalition Government wants to tackle this, and to focus on improvement in quality and outcomes for cancer patients.

AIMS OF THE REVIEW

The aims of the review of the CRS are to:

- align cancer strategy with the White Paper, *Equity and excellence: Liberating the NHS*
- set the direction for the next 5 years, taking account of progress since the CRS was published in December 2007
- show how outcomes can be improved despite the difficult financial position

The review will concentrate on the key issues in the White Paper: putting patients and the public first (“No decision about me, without me”); improving quality and healthcare outcomes; autonomy, accountability and democratic legitimacy; and cutting bureaucracy and increasing efficiency. The review will also focus on the key challenges on cancer:

- rising incidence
- achieving better survival rates (primarily through earlier diagnosis)
- lowering mortality rates, especially in older people
- rising prevalence (3% per year)
- suboptimal care for survivors
- inequalities, both in terms of experience of care and in outcomes
- slow diffusion of new technologies
- managing the costs of cancer

The review will look at potential service developments for cancer up to 2015, along with potential areas for savings and levers for improvement in the new NHS.

CONSULTATION DOCUMENTS FOLLOWING THE WHITE PAPER

The White Paper has been accompanied by a series of consultation documents which are open for comment until 11 October 2010. These include:

- the NHS outcomes framework.
- commissioning for patients
- freeing providers and economic regulation
- local democratic legitimacy in health

There will be further consultation documents, eg on the information strategy, workforce planning and the cancer drug fund which are expected in the Autumn.

The CRS review will be influenced by all these policy consultations.

For example, the NHS Outcomes Framework, *Transparency in outcomes – a framework for the NHS*, is designed to support improved health outcomes for the all patients. The proposed NHS Outcomes Framework is structured around five high level outcome domains. These are intended to cover everything the NHS is there to do. These five outcome domains are:

- | | | |
|--|---|---------------------------|
| <ul style="list-style-type: none"> • Preventing people from dying prematurely • Enhancing the quality of life for people with long-term conditions | } | EFFECTIVENESS |
| <ul style="list-style-type: none"> • Helping people to recover from episodes of ill health or following injury | | |
| <ul style="list-style-type: none"> • Ensuring people have a positive experience of care | } | PATIENT EXPERIENCE |
| <ul style="list-style-type: none"> • Treating and caring for people in a safe environment and protecting them from avoidable harm | | |
| | } | SAFETY |
| | | |

All these domains are relevant to cancer patients and so the new Outcomes Framework will be important for driving improved outcomes.

PROCESS FOR REVIEWING THE CRS

The Department of Health is keen to involve as many people as possible in the review of the CRS and in thinking through how the direction set by the White Paper and the associated consultation documents can be applied for the benefit of cancer patients.

The CRS Advisory Board will oversee the review. We will be consulting and utilising the experience of various CRS initiatives, existing advisory groups, cancer charities, industry and professional groups. In addition to being involved in face to face discussions, you can also send in your comments to the CRS Review Team by e-mailing: crsreview2010@dh.gsi.gov.uk. The Department is particularly interested in hearing the views of the cancer community on the following issues:

- Are there particular priority areas for action which need to be addressed if cancer outcomes are to be improved?
- What opportunities are there for delivering efficiencies or saving money in cancer care?
- How best can quality and outcomes in cancer care be measured?

- What further action is required to improve patients' experience of treatment and care?
- Are you aware of examples of good practice in cancer service delivery which could be replicated?
- What developments in prevention, screening, diagnosis, treatment or after care can be expected which will impact upon the way in which cancer services need to be commissioned or delivered?
- Looking at the plans set out in the White Paper and associated consultation documents (to be published shortly), what are the issues and opportunities for delivering cancer services and improved outcomes?
- As we develop work to improve cancer outcomes, how can we make sure that we continue to try and tackle inequalities in cancer care?

Please contribute to the wider consultations as well as to the CRS Review discussion. If you are making comments on the White Paper or one of the consultation documents which are relevant to cancer patients, please could you copy your comments to the CRS Review mailbox.

The White Paper and the consultation documents can be found at:
<http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm>

CONCLUSION

The White Paper and the consultation documents offer us a significant opportunity to be at the centre of redesigning the services the NHS delivers and to reshape cancer care around the needs of the individual. It is an opportunity we cannot afford to miss: to put NHS cancer services on the path to deliver outcomes among the best. We very much hope that you will help us in this task and ensure that we update the current CRS to the best possible effect.

We intend to publish an updated strategy, informed by the review, in the winter.

Membership of the CRS Advisory Board

Adrian Newland	President, Royal College of Pathologists and Cancer Network Medical Director
Alan Hall	Director of Performance, DH
Alex Markham	Professor of Medicine, University of Leeds, Chair, Office for Strategic Coordination of Health Research (OSCHR) Translational Medicine Board
Bruce Keogh (Chair)	Director General, NHS Medical Directorate, DH
Cally Palmer	CE, Royal Marsden Hospital
Caroline Huff	Cancer Network Nurse Director
Chris Carrigan	Director, National Cancer Intelligence Network (NCIN)
Chris Welsh	Medical Director, Yorkshire and Humber SHA
Ciaran Devane	CE Macmillan Cancer Support
Duncan Selbie	CE, Brighton and Sussex University Hospitals
Frank Chinegwundoh	Department of Urology, St Bartholomew's Hospital
Gail Richards	CE, NHS Oldham (Oldham PCT)
Gareth Brewerton	Patient representative
Gerard Hetherington	Director Clinical Programmes, DH
Graeme Betts	Director of Adults, Community and Leisure, Newham
Harpal Kumar (Deputy Chair)	CE, Cancer Research UK
Ian Carruthers	CE, South West SHA
Jane Allberry	Deputy Director, Cancer Services, DH
Jane Barrett	Royal College of Radiologists
Janet Williamson	National Director for NHS Improvement
Jeremy Hughes	CE, Breakthrough Breast Cancer
Joanne Rule	National Cancer Equalities Initiative
John Black	President Royal College of Surgeons
Julietta Patnick	Director, NHS Cancer Screening Programmes
Mary Barnes	Cancer Network Director, Avon, Somerset and Wiltshire
Michael Williams	Oncology Centre, Addenbrooke's NHS Trust Directors Group
Mick Peake	National Clinical Lead for Lung Cancer
Mike Richards	National Clinical Director, Cancer and End of Life Care
Nigel Marchbank	Chair, National Cancer Networks Medical Directors Forum
Nikki Morris	Patient Representative
Peter Clark	Medical Oncologist, Clatterbridge Centre for Oncology
Robert Naylor	CE, University College London Hospital
Roger Wilson	Patient Advocate
Russell Hamilton	Research & Development Directorate, DH
Ruth Hussey	Regional Director of Public Health, NHS North West
Kathryn Tyson	Director of International Health and Public Health Delivery
Stephen Cannon	Royal College of Surgeons
Steve Field	Royal College of General Practitioners

Stephen Parsons
Stephen Jones

Director, National Cancer Action Team (NCAT)
Joint CE, Coventry Teaching PCT