Local Awareness and Early Diagnosis Baseline Assessments:

A Guide for Cancer Networks and Primary Care Trusts

This guide is a collaborative production between the National Cancer Intelligence Network (NCIN) and the National Cancer Action Team (NCAT)

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Introduction and context

The National Awareness and Early Diagnosis Initiative - NAEDI - was first announced in the Cancer Reform Strategy (CRS) and is being led by Mike Richards, National Cancer Director, and Harpal Kumar, Chief Executive of Cancer Research UK. The role of NAEDI is to co-ordinate and provide support to activities that promote the awareness and early diagnosis of cancer.

Cancer Networks are well placed to provide leadership for prevention, early diagnosis and inequalities. One important aspect of NAEDI is diagnosing cancer earlier; the CRS states that late diagnosis has been a major factor contributing to poor cancer survival rates in the UK. Cancer Networks, with Primary Care Trusts (PCTs), are expected to undertake a baseline assessment that will inform Network and PCT Strategic Commissioning Plans to ensure effective progress in this area, based on local health needs.

The Cancer Reform Strategy Advisory Board recently reviewed how they will assess the extent to which the actions in the Cancer Reform Strategy (CRS) are being implemented. This included the new work areas for 2010/11 commissioning intentions such as awareness and early diagnosis.

The Department of Health (DH) working with the National Cancer Action Team (NCAT) has made available £5m to Cancer Networks to progress local early detection initiatives. All Networks have been encouraged to make use of this resource and their proposals have included some or all of the following:

- Undertaking a baseline assessment (to feature in all initiatives)
- Undertaking the Cancer Awareness Measure (CAM) to assess population awareness of signs and symptoms of cancer
- Rolling out the Primary Care Audit
- Improving uptake for screening services and reducing variation in uptake that exists between GP practices
- Addressing inappropriate variation in urgent two weeks wait referrals between GP practices
- Healthy Community Collaborative (or similar initiatives) to tackle inequalities
- Setting local targets for reductions in cancer mortality

This document should be used as a guide to aid Cancer Networks and PCTs in the production of their baseline assessments. It covers the following areas:

- Useful data and information sources (pages 4-5)

- General issues to be considered when undertaking the baseline (page 6)

- Detailed information about each of the core indicators that should be included, with the rationale for the inclusion of each indicator

    o One year and five year survival rates, by PCT (page 7)
    o One year survival rates against international benchmarks (page 8)
    o Screening uptake and coverage, by PCT and General Practice (pages 9-10)
    o Referral rates, by PCT and General Practice (page 11)
    o Emergency admission, by PCT and General Practice (page 12)
    o Mortality by PCT, including local mortality targets (page 13)

- Detailed information about additional indicators that could be included   (page 14)

  - Cancer Awareness Measure
  - Primary Care Audit
  - Incidence
  - Stage at diagnosis

- Further information and support   (page 15)

The baseline assessment is for local use to help identify variation at Cancer Network, PCT and General Practice, and in one area international, level and therefore inform local strategy. NCAT will facilitate the sharing of plans to spread learning.

All Networks will be asked to develop sustainable plans to improve early diagnosis, building on their baseline assessment to feed into commissioning intentions for 2010/11.

National data sources are already available that provide comparable data for Cancer Networks and PCTs (these currently include the Cancer Commissioning Toolkit (CCT), the National Cancer Information Service (NCIS) and the National e-Atlas), however many national data sources do not publish data at General Practice level.

Cancer Networks and Cancer Network Information specialists may have historically focused on Acute Trust level data or may not have expertise in all of the areas outlined above; the area of PCT & GP Practice analysis as well as the local public health agenda may be unfamiliar. It is hoped that this specification will provide useful signposts where necessary.

This guide has been produced by Lucy Elliss-Brookes on behalf of the National Cancer Intelligence Network (NCIN), with support from NCIN colleagues (Di Riley and David Forman) and Kathy Elliott, National Lead for Prevention, Early Diagnosis and Inequalities (National Cancer Action Team, NCAT).

Comments and suggestions to further develop this guide are welcomed.

Useful data and information sources

There are key data sources available, both national and local, and key people and organisations who will be able to help you produce your baseline by providing the data or expert advice.

Suggested data sources are listed below, further information about the first three national ones is given at the end of this section including how to gain access to these data.

- Cancer Commissioning Toolkit
- National Cancer Information Service
- National e-Atlas
- National Cancer Waiting Times Database
- National Screening Service websites
- Hospital Episodes Statistics (HES)
- PCT Screening returns
- Healthcare Commission Annual Health Check
- Cancer Commissioning Guidance
- National Clinical Audit Support Programme Cancer Audit annual reports
- Monthly returns to UNIFY (Strategic Health Authority performance monitoring website)
- Vital Signs and Local Area Agreement monitoring
- Quality and Outcome Framework (QOF) targets & requirements
- Regional commissioning websites, e.g. London Health Observatory Practice Profiles

You may wish to make contact with some or all of the following people within your Cancer Network, who will be able to advise on data collection and submission routes in the Network PCTs, and will be able to advise on information being routinely published publicly or internally.

- Public health teams within PCTs
- Information teams within PCTs with knowledge of local GP and primary care information
- Commissioners within PCTs
- Regional Public Health Observatories (PHOs)
- Regional Cancer Registries
- Regional Quality Assurance Reference Centres (QARCS)
- Health Informatics Services (usually locality based)
- Information teams within Acute Trusts
- Cancer Services Teams within Acute Trusts

Who you approach may well be different for each locality.

Different data sources will give information at different levels (GP, Practice, Local Authority, Ward, PCT, Trust, Network, Cancer Registry, SHA, England) & it might be appropriate to draw comparisons and benchmarks at different levels for each of the indicators, depending on the data you have available to you, for example high level comparisons by PCT across a Network or across a Cancer Registry, or detailed comparisons by Practice for a PCT or for the whole Network. Cancer Networks should feel comfortable in identifying organisations within the baseline where appropriate or relevant.

About the Cancer Commissioning Toolkit (CCT), taken from NCIN website

The CCT is an online library of key cancer information and data which can be easily accessed by commissioners for use in the preparation of their commissioning plans. The CCT brings together information on cancer in an accessible and usable way to enable the benchmarking of services and to inform the commissioning process.

For more information go to http://www.ncin.org.uk/index_files/cct.htm

About the National Cancer Information Service (NCIS), taken from NCIN website

NCIS is a national web-based reporting tool, running across N3 (the NHS national network), providing users access to cancer information for their area. Through a configurable web interface, NCIS offers secure and timely information on cancer incidence, mortality and survival with control over drill-down to lower levels of data and data manipulation features, meaning that you can navigate to your area of interest with ease.

The applications in NCIS provide comparative views of the information held by the cancer registries of England and allow users to compare their own organisation or local geographies nationally data, and other GORs, LAs, SHAs, PCTs and Cancer Networks.

Access to the NCIS is only available through your regional cancer registry, for more information go to http://www.ncin.org.uk/index_files/ncis.htm

About the National Cancer e-Atlas, taken from NCIN website

A new interactive web-based resource, called 'Cancer e-Atlas', has been developed to improve access to cancer statistics across England. It aims to provide the public, health care professionals, commissioners and health service managers with basic information on incidence and mortality for the main types of cancers in men and women.

Using data from English cancer registries and the Office for National Statistics, cancer statistics (incidence and mortality) are shown for Local Authorities and Cancer Networks. Survival statistics are also shown but at Cancer Network level only. This is because any observed variations in survival rates across Local Authority areas are more likely to be caused by the natural variations that occur when dealing with smaller numbers of patients rather than showing real differences.

To access the e-Atlas go to http://www.ncin.org.uk/index_files/eatlas.htm

General issues to be considered when undertaking the baseline

- Understand who is going to use the information and their accountabilities for local commissioning, clinical leadership and service delivery

- What data periods are available for each indicator & how timely are the data – some data will only be available annually, other sources may publish on a monthly or quarterly basis

- The repeatability of the baseline assessment – organisations will wish to measure changes against the baseline over time, and for some indicators it will be appropriate to continue to monitor progress, for example on a quarterly basis

- Use of data at Acute Trust level – some data sources (e.g. for GP referral rates) will be available from Trusts but not from PCTs, consideration needs to be given as to whether uniform analyses using these data can be undertaken across the Network

- Presentation of data: tables, charts, graphs, text – a variety of presentation styles and formats will be appropriate & should be used accordingly

- There should be a clear link to the Network and PCT Strategic Commissioning Plans – the baseline assessment should feed the Cancer Network Local Awareness & Early Diagnosis strategy, it should be clear how the strategy has been informed by the baseline assessment

- Consider including the baseline assessment in the local Joint Strategic Needs Assessment and the Director of Public Health Annual Report

- Consider citation of all data sources used – not only is this good practice but it also allows data to be validated & compared over time & between organisations

- Reference any additional Local Awareness & Early Diagnosis Initiative (LAEDI) work that might be being undertaken locally, even if it is not consistent across the Network

One Year and Five Year Survival Rates
by PCT and Cancer Network, to include International Comparisons

Rationale: The overarching goal of NAEDI is to promote earlier diagnosis of cancer and thereby improve survival rates and reduce cancer mortality.

Specifically look at breast, lung, colorectal and prostate cancer. These four sites were nationally agreed due to numbers being large enough at PCT level to provide robust analyses. At PCT level, the number of cases for many cancers can be small. This leads to sensitive results that require careful interpretation.

NCIN and NCAT would advise that there is careful interpretation of survival rates grouped together for all cancers at PCT level, , as these are heavily influenced by the mix of cancers common within specific populations, for example lots of lung cancer reduces survival rates, lots of prostate cancer increases rates. A team led by Michel Coleman is working on methods to standardise for cancer type (like we do for age).

You may wish to also look at some of the less common tumours but should use a larger geographical area, for example Cancer Network or Strategic Health Authority (SHA), to provide more robust data.

Measures:

- Comparison of one year survival rate for different localities (Networks and PCTs)
- Year on Year improvement in % survival rates by tumour site

National data sources

- CCT: Yes - Cancer Network data on the toolkit (PCT data will be added in June 2009)

    o 1 year and 5 year cohort relative survival estimate for persons have been extracted from the NCIS database by rolling 5 year cohorts (1990-1994, 1991-1995 ... 1997-2001 (5 year estimates) ... 2001-2005(1 year estimates)) for Cancer Networks for selected major cancer sites. The survival estimates from NCIS relates to the June 2007 data submission by Registries to NCIS, which contains follow up on death information to the end of 2006.

- NCIS: Yes – PCT level survival data for breast, colorectal, lung and prostate cancer, with analysis possible by age (flexibility in age groupings), sex, etc. For 1 year relative survival estimates use details of cohorts of patients diagnosed up to 2005, for 5 year relative survival estimates, then it would be the cohort of patients diagnosed up to 2001.

- Other:

    o NCIN publication – by Cancer Network, including funnel plots
    o e-Atlas;

Local data would also be available from Cancer Registries

International Benchmarks

At the NAEDI launch event Mike Richards indicated that all PCTs and Networks should compare their one year survival figures against the best in Europe for the major cancers and, if found to be at a lower level, develop strategies and actions plans as appropriate. This suggestion has caused some Networks to ask NCIN and Cancer Registries for guidance as to what is the best in Europe. There is also some uncertainty as to which countries should be used for comparison against.

In order to help clarify this, for the purposes of this guide NCIN has provided a set of target figures for the best in Europe. The table below represents an extraction of figures from the latest EUROCARE data in which "best" is defined in a number of ways and then used these to propose a consensus target.

One-year, age-adjusted relative survival rates, adults diagnosed 1995-99 (EUROCARE-4 study) and range for Cancer Networks in England, diagnosed 1999-01 (NCHOD).

	Highest Eurocare		Highest Scandinavian		Highest with 100% coverage		Variation between English Cancer Networks	Consensus target
Breast	Iceland	97.4	Sweden	96.6	Iceland	97.4	90.0-95.8	97
Colon	Sweden	79.7	Sweden	79.7	Sweden	79.7	63.0-72.2	79
Lung	France	42.2	Sweden	36.8	Austria	37.4	21.5-29.7	37
Prostate	Switzerland	97.1	Sweden	96.0	Sweden	96.0	84.1-92.9	96

It is worth noting that the consensus target is based on 1995-9 EUROCARE data, so will almost certainly have improved since then.

It should be noted that the recorded survival for Prostate cancer is driven almost entirely by PSA uptake. It could be argued that a lower recorded survival indicates lower rates of over-treatment and therefore may indicate better population health outcomes; this is a very involved clinical and public health issue and as such the data should be interpreted with caution.

It should also be noted that the English data are not age standardised in quite the same way as the Eurocare data, it is hoped that this will make very little difference but this is something that needs to be addressed nationally.

In addition to the above, one of the national work streams of the Next Stage Review will also address international comparisons; a scoping exercise is currently underway.

Screening Uptake/ Coverage
by PCT and General Practice

Rationale: Variation in uptake/coverage of cervical, breast and bowel (as information becomes available) screening programmes may indicate service delivery issues that need to be addressed by commissioners, public health and providers. It may also raise questions about population groups or geographic areas where there is low public awareness and/or negative beliefs which would need to be investigated through other information (e.g. the Cancer Awareness Measure).

You should look at the three national screening programmes: breast, cervical and bowel (as information becomes available).

National data sources

- CCT: Yes, at PCT and Cancer Network level

- National screening websites: http://www.cancerscreening.nhs.uk/

    o Breast: http://www.ic.nhs.uk/statistics-and-data-collections/screening/breast-cancer
    o Cervical: http://www.ic.nhs.uk/statistics-and-data-collections/screening/cervical-cancer
    o Bowel: https://www.bcsp.nhs.uk/seclogon.aspx

- Breast Screening Programme, England 2007-08, report available on the NHS Information Centre (IC) website above, includes coverage by primary care organisation

- Cervical Screening Programme 2007/08 report available on NHS IC website above, includes coverage and time from screening to availability of result by Primary Care Organisation

- Data for bowel screening are available via the Bowel Cancer Screening Programme website above; reports broken down by PCT include uptake, attendances and waiting times

- Cancer Waiting Times (CWT): additional information on patients referred and diagnosed via national screening programmes will be being collected from 1st January 2009, the first national reports will be available in May 2009, although data quality & completeness is likely to be initially patchy

- Quality and Outcomes Framework (QOF): The QOF is a voluntary annual reward and incentive programme for all GP surgeries in England. It includes four cervical screening indicators (under the Additional Services Domain), one of which is the percentage of patients aged from 25 to 64 (in Scotland from 21 to 60) whose notes record that a cervical smear has been performed in the last five years. Practice level data for 2007/08 can be downloaded from the NHS IC website: http://www.qof.ic.nhs.uk/index.asp

Local data sources

- Data and reports at PCT and General Practice level will be available from Quality Assurance Reference centres (QARCS). Each Region has a QARC for breast screening and for cervical

screening, links to theses organisations are available on the national cancer screening website: http://www.cancerscreening.nhs.uk

- KC53 (cervical) and KC63 (breast) data submitted quarterly by PCTs to the SHA via Open Exeter, screening rates by PCT and General Practice

- Data and reports from Screening Centres

- Practice Profiles where available, e.g. London Health Observatory Practice Profiles: http://www.lho.org.uk/commissioning/PracticeProfiles.aspx

Indicators that can (or will) be measured through information available from the NHS Screening Programmes/QARC include those listed below. If the local priority is to reduce inequalities then local targets will be agreed and focused on areas or populations with low uptake or coverage.

- Breast screening: Percentage of women in specified age ranges offered screening for breast cancer

    o The number of women screened for breast cancer in the last three years/The number of women eligible for screening.
    o Coverage is defined as the proportion of women resident and eligible for screening who have had a screening mammogram at least once in the previous three years. Women who are ineligible (e.g. those who have had a bilateral mastectomy) are excluded.

- Breast screening: The percentage of eligible women whose first offered appointment is within 36 months of their previous screen

- Cervical screening: Percentage of eligible women screened

    o The effectiveness of the programme can also be judged by coverage (the percentage of women in the target age group who have been screened in the last five years)

- Cervical screening: Women to get results within 2 weeks

    o The cervical screening programme will ensure that all women receive the results of their screening tests within two weeks by 2010.

Labs will be working towards the 14-day turnaround time which needs to be in place by the end of 2010, further information about this is available on the NHS Cervical Screening Programme website (login required): https://www.csp.nhs.uk

- Bowel Screening: Access time to Screening Centre (waiting time for first offered nurse appointment and colonoscopy)

Referral Rates (cancer referrals and cancer diagnoses)
by PCT and General Practice

Rationale: We need to understand the different routes to diagnosis, less that 10% of cancers are diagnosed through screening and only 43% are diagnosed through the Two Week Wait (TWW) process, which leaves ≈50% of cancers diagnosed through other routes. It is possible that a significant amount of late diagnoses arise where patients have not gone through screening or the TWW route.

Variation in referral rates may indicate service delivery issues that need to be addressed by commissioners and primary care. It may also raise questions about population groups or geographic areas where there is low public awareness and/or negative beliefs which would need to be investigated through other information.

National data sources

- Cancer Waiting Times (CWT): PCT level data referral data are available, up to December 2008 the source of referral data are only broken down by TWW or other. More detailed information on source of referral will be being collected from 1st January 2009, the first national reports will be available in May 2009, although data quality & completeness is likely to be initially patchy

- Quality and Outcomes Framework (QOF): The QOF is a voluntary annual reward and incentive programme for all GP surgeries in England. It includes a cancer prevalence indicator (under the Clinical Domain), which could be linked to referral rates to provide an overall picture of activity and potentially identify disparities. Practice level data for 2007/08 can be downloaded from the NHS IC website: http://www.qof.ic.nhs.uk/index.asp

Local data sources

- Referral rates at General Practice level would need to be calculated from data gathered by the Acute Trusts – data also may be available from local Health Informatics Services.

Referral rates by PCT would be readily available to Cancer Networks via downloads & analysis from the National CWT-Db, either via crude analysis (looking at total numbers of patients referred & comparing to cancer diagnoses) or by more sophisticated methods (downloading the patient level data & analysing the data through from referral to diagnosis for each episode). Networks should look at the following aspects:

- the volume of Two Week Wait (TWW) referrals compared to practice size/population
- all newly diagnosed cancers assessing the route of referral, i.e. the numbers that were referred in via TWW or other (your local data sources may break down 'other' into more useful categories, this additional breakdown should be pursued if possible)
- all TWW referrals assessing the 'hit rate', i.e. the numbers that were positively diagnosed with cancer versus no cancer diagnosed
- performance against the 24 hour rule for TWW referrals (as an indication of how quickly referrals are making their way in to secondary care)

**Emergency Admissions (for patients with cancer)
by PCT and General Practice**

Rationale: This is a reflection that patients may not be getting diagnosed or treated at an early stage of their cancer, thus it may be an indicator of late presentation, late diagnosis and entry to treatment not through primary care.

Networks should use the overall emergency admission rate for patient with cancer as a gross indicator to identify where there is variation at General Practice level and thus where additional scrutiny or investment (e.g. use of the Primary Care Audit tool) should be explored.

National data sources:

- CCT: Yes - Cancer Emergency Bed Days per 100k weighted population and Total Cancer Bed Days per 100k weighted population (provided by NatCanSAT from HES. Latest data is 2005/6)

    - Cancer Emergency Bed Days per 100k weighted population: Over the past eight years, although elective day case episodes (usually for chemotherapy) have risen, inpatient admissions for cancer have also risen by 25%. Most of this increase relates to emergency cancer inpatient episodes and emergency bed days are rising by 2.5% each year. This indicator, which measures the number of emergency bed days for cancer per head of unified weighted population, is an indicator for local action in the Vital Signs. Many emergency admissions are due to the side effects of treatment, for example chemotherapy, or radiotherapy, or due to progressive disease.

    - Total Cancer Bed Days per 100k weighted population: An appropriate level of bed usage by patients with a cancer diagnosis, when accompanied by appropriate lengths of stay, is an indication of efficient hospital based cancer services. This metric is influenced by many factors; the availability of day case treatment, the implementation of patient pathways, early discharge planning and the availability of local hospice services.

- Hospital Episode Statistics (HES), available direct from HES (http://www.canceruk.net) or through Cancer Registries

General emergency admissions data by PCT would be available to Cancer Networks via HES data.

Local data sources

- Emergency admissions at General Practice level would need to be calculated from data gathered by the Acute Trusts – data also may be available from local Health Informatics Services.

Data on total emergency admissions by General Practice is available via the QOF, however these data are not cancer specific.

Mortality
by Cancer Network and PCT

Rationale: The overarching goal of NAEDI is to promote earlier diagnosis of cancer and thereby improve survival rates and reduce cancer mortality. The mortality rate represents the number of people dying from cancer in a given year.

National target - Reduction in death rates from cancer by 20% by 2010 in people under 75 (from the 1995-97 baseline)

Local targets – PCTs and Cancer Networks, particularly Spearhead areas, may have set local cancer mortality targets as part of their Local Area Agreements, Operating Plans (Vital Signs), and World Class Commissioning. The CRS stated that The Department of Health will work PCTs to agree challenging goals for reducing cancer mortality in every Cancer Network area by 2012. These goals will pay particular attention to tackling different forms of inequality as a means to reducing overall mortality. Cancer mortality may be a specific local target or it may be expected to make a significant contribution to another target such as life expectancy.

National data sources:

- CCT: Mortality rates per 100,00 population (age <75) and Percentage change in mortality rate since 1997

    o Mortality rates per 100,00 population (age <75): Count data for 1996-2005 have been extracted from the NCIS by ICD10 3 digit site, single year and quinary age group for Cancer Networks, 2002 PCTs and 2002 SHAs.

    o Percentage change in mortality rate since 1997: Count data for 1996-2005 have been extracted from the NCIS by ICD10 3 digit site, single year and quinary age group for Cancer Networks, 2002 PCTs and 2002 SHAs.

- NCIS: Yes, analysis by age, sex, ICD code, lower super output areas

- e-Atlas – based on NCIS by Local Authority

A joint project between the National Health Inequalities Support Team and NCAT, on local cancer mortality targets, is being considered for 2009/10.

Key additional indicators

- **Cancer Awareness Measure (CAM)**

  o As part of NAEDI, Cancer Research UK has commissioned the development of a new tool, the Cancer Awareness Measure (CAM), to provide a validated measure of public awareness of cancer and cancer symptoms. The CAM tool is now being tested at a local level by a number of 'Early Implementer PCTs.

  o National data being analysed, to be released in 2009; Local data being collected through an 'Early Implementer Group'. (7 PCTs in 4 Cancer Networks); Data archive being investigated, with plans to establish in 2009.

  o A Getting Started Group for the next group of PCTs and Cancer Networks using the CAM, is being formed, with a national event planned for 1st June 2009

  o You should include local data and any information available on local progress if applicable

- **Primary Care Audit**

  o NAEDI, working closely with the Royal College of General Practitioners, is in May 2009 launching the Primary Care Audit templates to measure the incidence or extent of delays in primary care amongst patients subsequently diagnosed with cancer. Plans are being developed to support GPs, PCTs and Cancer Networks to use the national templates which have been developed and tested by GP cancer leads over the past years.

  o The national primary care audit templates are part of a national project has been initiated, with plans to: interrogate an existing research database; and establish a centre to support local and national analysis.

  o You should include local data and any information on local progress if applicable

- **Stage at Diagnosis**

  o For many cancer types patients who have a more advanced stage of disease at the time of diagnosis have a worse prognosis than those with an earlier stage of disease

  o National Clinical Audit Support Programme Cancer (NCASP) annual reports, available for five tumour groups (Lung, Colorectal, Head & Neck, Breast and Oesophago-Gastric Cancer), will provide some data at Cancer Network level

  o Local data will be available from Cancer Registries - Cancer Registries should be working in collaboration with Cancer Networks to improve the quality of staging data, as outlined in the National Contract.

- **Cancer Incidence**

  o Widely available nationally (CCT, NCIS, NCIN publications) and regionally

Further support for the baseline assessments

- Support for the baseline assessments and all other NAEDI related queries is available from Kathy Elliott, National Lead for Prevention, Early Diagnosis and Inequalities, National Cancer Action Team:

    o   Blackberry and Mobile - kathy.elliott@gstt.nhs.uk – 07799 095779

    o   Office - kathy.elliott@dh.gsi.gov.uk – 020 7972 4816

- General information about NAEDI, including the NAEDI newsletters, is available on the Cancer Research UK website: http://www.naedi.org.uk

- Informatics support regarding this guide is available from the National Cancer Intelligence Network (NCIN):

    o   Until 30th June 2009 – Lucy Elliss-Brookes, NCIN Information Project Manager (on secondment to the NCIN) – lucy.elliss-brookes@ncin.org.uk

    o   From 1st July 2009 - enquiries@ncin.org.uk - 020 7061 8137

- Two supporting workshops entitled "A guide to NAEDI baseline assessments" are planned for the June 2009 Network Development Programme event.

- It is intended that future national support for the baseline assessments will include examples of good pieces of work that have been undertaken by Cancer Networks. Suggestions and offers of work to include in this portfolio would be welcomed by Kathy Elliott.