



---

## Multi Disciplinary Team Coordinators Conference Hilton Birmingham Metropole NEC, West Midlands



## Wednesday, 2nd March 2011

To register for the event please go to: [www.eventprouk.com](http://www.eventprouk.com)  
Click on **EVENT REGISTRATION** then input

User Name: **EP1384**

Password: **MDT**

(Please ensure you use Capital letters)

If you are not able to register online and require a registration form or any assistance please email me on the address [marie@eventprouk.com](mailto:marie@eventprouk.com)

A chance to attend the FREE NHS conference aimed solely at MDT & pathway coordinators, Data Managers and those involved in MDTs

**M – Meet new and existing colleagues**

**D – Discuss current challenges**

**T – Targets – you are not alone!**

**C – Come and share your ideas**

**C – Come and make a difference!**

Meets the members of your National MDT Coordinators Taskforce

*Agenda attached – subject to change*

## DRAFT AGENDA

09:00	Registration and Refreshments	
10:00	Welcome Plenary	Angela Heer, NC MDTC Forum Member
10:10	Refresh Cancer Reform Strategy	Stephen Parsons, Director, National Cancer Action Team
10:40	Data Capture, Northern Ireland	Dr Lisa Ranaghan, Cancer Information, Northern Ireland Cancer Registry
11:00	Move to Workshops	
11:20	<b>Workshops</b> <ol style="list-style-type: none"> <li>1. Peer Review</li> <li>2. Tumour Site Specific – Lung – Dr Mick Peake National Clinical Lead, Lung Cancer</li> <li>3. Tumour Site Specific – Colorectal – Mr Mark Chapman, Lead Colorectal Cancer Clinician</li> </ol>	
12:20	Move to Workshops	
12:30	<b>Workshops</b> <ol style="list-style-type: none"> <li>1. Peer Review</li> <li>2. Tumour Site Specific – Lung – Dr Mick Peake National Clinical Lead, Lung Cancer</li> <li>3. Tumour Site Specific – Colorectal – Mr Mark Chapman, Lead Colorectal Cancer Clinician</li> </ol>	
13:30	Lunch	
14:15	National Cancer Waiting Times	Greg Martin, Performance and Operations Manager (Cancer Services), University Hospital Bristol NHS Foundation Trust
15:00	MDT Development Update + DVD	<p>Professor Amanda J Ramirez, Director King's College, London, Promoting Early Presentation Group &amp; National Clinical Lead for Cancer Patient Information and MDT Development</p> <p>Cath Taylor, Cancer Research UK London Psychosocial Group, Institute of Psychiatry, Kings College, London.</p>
16:00	Closing Plenary <ul style="list-style-type: none"> <li>• Update on UKACR Improving Outcomes training package</li> <li>• Comments on each presentation</li> <li>• Importance of completing evaluation forms</li> <li>• Focus on the future</li> </ul>	Serena Hodges, NC MDTC Forum Vice Chair  Tina Ball, Cancer Registry Manager South West Public Health Observatory
16:20	Close and Finish	

# Workshops

## Peer Review

National Cancer Peer Review (NCPR) is a national quality assurance programme for NHS cancer services. The programme involves both self-assessments by cancer service teams and external reviews of teams conducted by professional peers, against nationally agreed “quality measures”. NCPR is managed by the National Cancer Action Team and is an integral part of the NHS Cancer Reform Strategy (2007) and the overall NHS Cancer Programme, led by the National Cancer Director.

## Tumour Site Specific - Lung

This session will cover anatomy, presentation, investigation used and the treatment options for lung cancers. The session will conclude with a question and answer session.

## Tumour Site Specific – Colorectal

This session will cover anatomy, presentation, investigation used and the treatment options for colorectal cancers. The session will conclude with a question and answer session.

**A sharing table will be available at the Conference should you wish to “share” documents, protocols, ideas etc with colleagues**

## EVENTS & CANCER DIARY 2011/2012

### National MDT Forum Meetings 2011

*Last meeting held: Friday 21<sup>st</sup> January 2011*

#### Future meetings:

- Tuesday 17<sup>th</sup> May 2011 - 10am – 4pm
- Tuesday 28<sup>th</sup> June 2011, 10am – 4pm
- Friday 4<sup>th</sup> November 2011, 10am – 4pm
- Friday 27<sup>th</sup> January 2012, 10am – 4pm

# MDT STEERING GROUP UPDATE - November 2010

The MDT Development Steering Group, have been overseeing a project, which has aimed to; identify domains/themes that are essential for a good/high performing MDT; agree how best to measure an MDT against each domain/theme and provide support/tools to help MDTs to reach and maintain high level of performance in each domain/theme.

We have been involved with all members of the multi-disciplinary team, to get all your views and what you want, need and expect from your colleagues and meeting. Some of you would have been directly involved by filling out the survey, and attending the workshops held to discuss and analyse its results and get advice and potential ways forward. All this has been used to produce the following;

- **Characteristics of an effective MDT**

- **Peer Review**

- evolved from the Improving Outcomes Guidance (IOGs) which are largely evidence-based with a degree of clinical consensus;
- had changed over time and is now taken as mandatory by the NHS;
- measured structure and process and is objective;
- has a commitment to openness and transparency - main clients are the public and commissioners;
- is moving towards a more judgmental approach.

It was also noted that action has been and continues to be taken to ensure the peer review process is not over burdensome to the NHS. The 2009/10 round is now complete.

- **Outcome data**

- NCIN have been working to bring together cancer information to feedback at MDT and other levels. This would support the peer review process by highlighting questions as part of clinical lines of enquiry.

- **Self Assessment & Feedback (SAAF)**

- this would be a means for MDTs to assess themselves in areas that don't lend themselves so well to peer review including relationships, leadership and clinical decision making;
- the key was for the SAAF to allow teams to evaluate themselves in a safe and helpful way;
- it would be based on what teams thought were important (via 2009 survey);
- it would involve their perceptions and be developmental not judgmental;
- participation would be voluntary (at least initially);
- the results would not be in the public domain.

- **MDT Development Showcase DVD**

- produced based around the characteristics document to highlight the impact of different working practices/behaviors on MDT working. It had been based on footage from real MDT meetings and interviews with real MDT members but had been re-created by actors.

The MDT Development DVD and further information on the Self Assessment & Feedback tools will be presented at next years National MDT Coordinators Conference, taking place at the Birmingham Metropole, March 2<sup>nd</sup> 2011. Look forward to seeing you.

**Juanita Asumda**  
**Network Cancer Services Coordinator,**  
**National MDT Coordinators Forum Chair**  
**Royal Surrey Hospital Foundation Trust**

**WELCOME** - Mr Lindsay Campbell - Managed Clinical Network National Manager for Sarcoma, HPB and Neuro Cancers. Lindsay will be the NC MDT representative for the time being until a permanent replacement is nominated.

In NHS Scotland the cancer MDTs are organised at Board, regional or national level depending on the cancer. For example; breast patients are managed through a weekly NHS Board-wide MDT, Gynae patients are managed through a weekly region-wide MDT, and sarcoma patients are managed through a weekly Scotland-wide MDT.

There are 14 Boards in Scotland who are responsible for the MDTs and each Board chooses how to organise tracking, coordination and audit of cancer patients who reside in that NHS Board. For example, Greater Glasgow and Clyde have a separate Tracker, Coordinator and Auditor, while Forth Valley has a combined Tracker and Coordinator and a separate Auditor. The 14 Boards are split between 3 regional cancer networks;

North of Scotland Cancer Network (NoSCAN) = Grampian, Highland, Orkney, Tayside, Shetland, Western Isles. **South East** of Scotland Cancer Network (SCAN) = Borders, Dumfries & Galloway, Fife, Lothian. **West of Scotland** Cancer Network (WoSCAN) = Ayrshire & Arran, Forth Valley, Greater Glasgow & Clyde, Lanarkshire

There are 9 Managed Clinical Networks operating regionally;

Breast  
Colorectal  
Gynae  
Haemato-Oncology  
Head and Neck  
Lung  
Oesophageal-Gastric  
Skin  
Urology

and 4 Managed Clinical Networks operating nationally;

Sarcoma  
Liver/Pancreas/Gallbladder/Biliary Tree  
Brain/Central Nervous System  
Children, Teenagers and Young People

MDT Coordinators typically arrange the weekly MDTs, including video conferencing, patient list, outcome communication and minutes. Some MDT Coordinators are responsible for multiple cancers. For example, Colorectal and Oesophageal-Gastric. This depends on the size of the board and numbers of patients involved. Some MDTs manage patients with different primary cancers. For example, Highland MDT for Colorectal, Oesophageal-Gastric or Liver/Pancreas/Gallbladder/Biliary Tree cancers. MDT Coordinators are part-time or full-time. MDT Coordinators are members of the Scottish and UK MDT Coordinators Forum.

Lindsay Campbell  
Managed Clinical Network National Manager for Sarcoma, HPB and Neuro Cancers. c/o West of Scotland Cancer Network  
1st Floor, St. Mungo Building  
Glasgow Royal Infirmary  
84 Castle Street  
Glasgow

## UKACR Improving Outcome Groups - A training programme for Cancer DT Co-ordinators

Over the past 2 years a body of work has been administered by the UKACR Improving Outcomes Group in an endeavour to orchestrate a training/accreditation programme for Cancer MDT Co-ordinators across the United Kingdom. The first positive step in this difficult and complex undertaking was made when the company Tribal were commissioned to undertake a scoping exercise of what would be required. A comprehensive report was issued by Tribal in September 2009 outlining the stages of development necessary to take the training programme forward. The work continued and advice was sought from educational bodies regarding a qualification/accreditation process and a successful application was made to the DoH for the programme to become part of the E-LFH project. The UKACR Group continues to meet regularly and is currently looking at the training package itself, how the package will look, together with the accreditation process and how this can be achieved for those who want it. Selected Group members have been tasked with individual roles with some members working on the content aspect of the modules and others on the delivery of the training perspective of the package.

The overall message following the 7<sup>th</sup> Annual MDT Co-ordinator conference in London in March 2010 demonstrated an overwhelming consensus that MDT Co-ordinators feel that training is fundamental and necessary if the MDT Co-ordinator role is to continue to develop.

The good news is that despite set backs and financial constraints the work of the UKACR Group is set to continue on this project.

Sue Hughes  
Cancer MDT/Information Manager  
National Cancer MDT Co-ordinating Forum Group.

# SERVICE IMPROVEMENT - Stockport NHS Foundation Trust

## 'Clinical Pathway Awareness Sessions.' "Clinical Pathway Awareness Sessions"

### What was the Problem?

Stockport NHS Foundation Trust has a high volume of referrals with approx 750 patients per week on the Cancer PTL. Up to April this year, the trackers and coordinator role was a dual role which often led to staff feeling overwhelmed with the workload, constantly fire fighting and having an overall negative effect on staff morale. With the new standards for cancer and the increased demand on services a team re-structure had taken place, the outcome being that we would have designated trackers and designated MDT coordinator role with their own set of responsibilities.

We now have 6 cancer pathway trackers with one only being full time and the rest working a range of part time hours. They track all tumour groups which are Lung, Lower GI, 2WW Suspected Breast, 2WW Non Cancer Breast, Skin, Urology, Upper GI, Head & Neck, Sarcoma, Haematology, Paediatrics, Brain and Central Nervous System. The Cancer Trackers have now been in their new roles for approx. 6 months and a recent review through appraisals has shown that generally the staff are happier and have a more positive approach to work as they have more time to dedicate solely to the tracking processes and ensuring patients are navigated through their pathways in a more streamlined and manageable way. An area that was highlighted through the reviews was that although each tracker was an "expert" within their particular tumour group they had only limited knowledge of clinical pathways of other tumour groups when cover was required for sickness and annual leave which could potentially delay patients on their pathways. This could result in inaccurate information being recorded and ultimately patients breaching their pathways due to administrative errors. We recognised that it was a priority and essential for all cancer trackers to understand all clinical pathways to improve the efficiency of the tracking processes so Clinical Pathway Awareness Sessions were arranged in collaboration with the Cancer Nurse Specialist from each of the specialties.

### What We Did

Dedicated clinical pathway awareness sessions were set up with the engagement of the clinical nurse specialists. The sessions lasted a maximum of 1.5 hours and concentrated on the patient experience at assessment, diagnostic tests and treatment stages of their journeys and why certain investigations/treatments were necessary. The specialist nurses provided information on patient pathways, answered questions and made the whole process easy to understand to a non-clinical person which was easily absorbed and not too intense. Feedback from the specialist nurses was that they found the sessions beneficial to them as they were more able to understand the tracker role which was ultimately to know their patients, where they are at and where they should be along the pathway at any given time with the added responsibility of ensuring patients are tracked within national targets.

### What has been learnt?

Although not all sessions have taken place, the feedback from those that have, have been enthusiastic and positive. The comments received back are:

- The sessions have acted as refresher courses, updating on new treatments and techniques.
- Knowing what the protocols are have aided and improved the tracking processes and will eliminate administrative delays.
- Covering other colleagues work will be easier to understand and track.
- The sessions have given time and the opportunity to ask questions (from both sides) either on clarifying pathways or interpretation of national targets.
- The sessions are provided by clinical professionals so up to date knowledge is at hand.
- Improved clinical knowledge.

**Author: Angela Heer**

## Initial Report of the MDT Coordinators' Survey 2010

Lamb B<sup>1,2</sup>, Sevdalis N<sup>1</sup>, Green JSA<sup>2</sup>

<sup>1</sup> Centre for Patient Safety and Service Quality, Department of Surgery and Cancer, Imperial College London. <sup>2</sup> Department of Urology, Whipps Cross University Hospital, London

Correspondence: Mr Benjamin Lamb, Department of Surgery and Cancer, Imperial College London, 5<sup>th</sup> Floor Medical School Building, St. Mary's Hospital, London W2 1PG

Email: [benjamin.lamb@imperial.ac.uk](mailto:benjamin.lamb@imperial.ac.uk); Tel: +44 20 7594 9727; Fax: +44 20 7594 3137

**Introduction** Multidisciplinary teams (MDTs) are becoming the model of care for patients with cancer worldwide. Research into the specific effects of MDTs on patient outcomes has led to inconclusive results, since other factors including novel treatments, technology and service changes have evolved in parallel [1]. However, MDTs are widely felt to improve communication, coordination and decision-making between healthcare professionals when weighing up treatment options with cancer patients [2].

The role of the MDT Coordinator is relatively new, and as such it is developing all the time. What is clear though, is that the work of the MDT coordinator is pivotal to the effectiveness of an MDT [3]. This view has been reflected in the establishment of the National MDT Coordinators' Taskforce, Forum, and the Annual Conference, along with development of national job descriptions and training programmes [4].

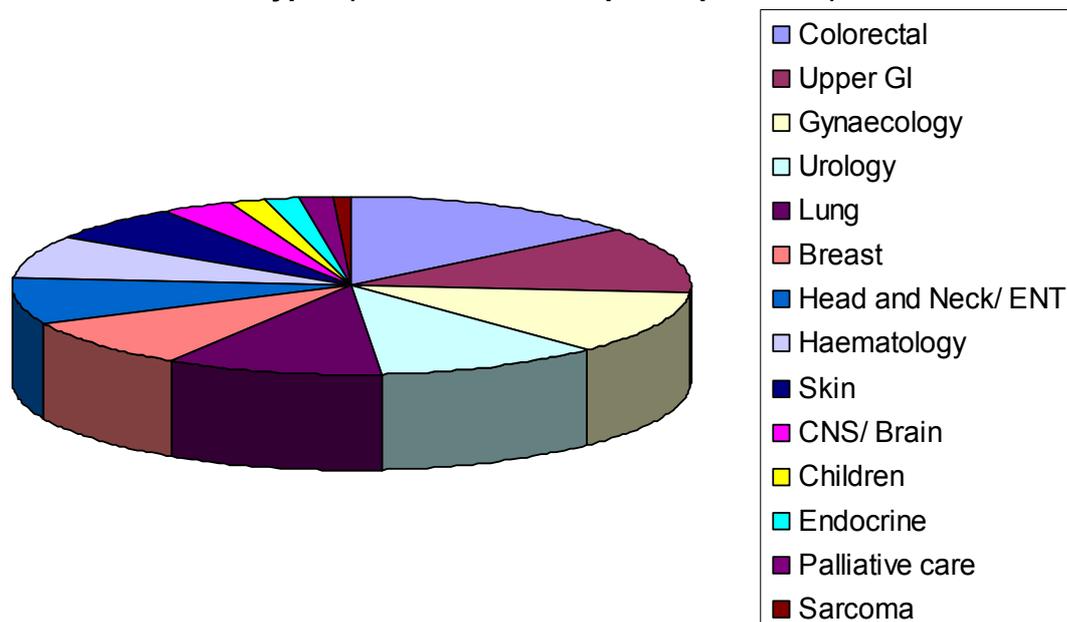
The survey that many of you kindly completed is part of a program of research- building on existing research in team performance in healthcare- to improve the quality and performance of MDTs in a scientific and systematic manner. Our research so far has demonstrated that clinical decision-making by cancer MDTs is influenced by many factors including the attendance of team members, the process of case discussion and the information available when making decisions, team leadership, preparation for meetings, as well as facilities and equipment, and the administrative process of actioning outcomes from meetings [5]. Many, if not all of these factors come into the work of an MDT coordinator. It is important for us to know your experiences and opinions on these matters so that we can understand what improves, or impairs the effectiveness of an MDT.

**Results** Our survey covered the organisation of the MDTs in which you work, case discussions, decision making, leadership, the administration of MDT meetings and your experience of and attitudes towards training for MDT coordinators. Overall we had 265 responses (83% MDT Coordinators, 8% administrators, 3% managers and 3% nurses). 71% of respondents had the title of MDT coordinator, whilst the remaining 29% had additional or alternative titles, which may explain why 38% felt that your job plan does not reflect what you actually do. Respondents had most commonly entered the position of MDT coordinator from other administrative positions in the NHS, but 16% had come from non-NHS jobs.

Table 1 shows the percentage of respondents who coordinate for each tumour type, some respondents coordinate for more than one. Our results suggest that coordination and administration of the local MDT is easier than that of the specialist, and of the supra-specialist. The majority of respondents had undergone some kind of induction course and received training in Data systems and IT, data protection and sharing. Approximately half had received training in general oncology, anatomy/physiology, medical terminology, videoconferencing, communication skills and patient pathways. The majority of respondents wanted further training in general oncology, specialist oncology, audit and research, recording of complex minutes, and peer review. Approximately half of respondents wanted further training in anatomy/physiology, medical terminology, videoconferencing, coding, leadership, negotiation skills, and patient pathways.

Table 1: Percentage of respondents who coordinate for each tumour types (more than one response permitted)			
Tumour type	%	Tumour type	%
Colorectal	17	Haematology	9
Upper GI	14	Skin	8
Gynaecology	14	CNS/ Brain	4
Urology	13	Children	2
Lung	12	Endocrine	2
Breast	11	Palliative care	2
Head and Neck/ ENT	10	Sarcoma	1

**Table 1: Percentage of respondents who coordinate for each tumour types (more than one response permitted) %**



Respondents felt that it was nearly always possible to make decisions on cases at the first presentation, and that when it was not possible barriers are most commonly lack of radiological or pathological information, or non-attendance of key personnel. Respondents felt that medical members of the MDT always contribute to case discussions, whilst nurses nearly always contribute, and MDT Coordinators do not often contribute. Regarding the weight that the opinions of different MDT members have in deciding treatment decisions, surgeons and physicians' opinions always carry weight, those of oncologists nearly always, radiologists usually, pathologists, and nurses sometimes, and MDT coordinators never carry weight. Respondents felt that disagreements do not happen very often. For the position of chair of the MDT, 81% of respondents have surgeons, 21% oncologists, 52% physicians, 11% radiologists, 8% pathologists and 3% MDT coordinators. 24% have a chair that rotated between members, though 68% thought that the position of chair could rotate. Asked how the meeting goes when the usual chair is away, 3% said better, 84% the same, and 13% worse.

Over 90% of respondents had patient tracking software at a local level, with this falling to 60% at specialist level and to less than 40% at supra specialist level. Just under half of respondents were able to input data from MDT meetings in real time during the meetings, and fewer than 30% transpose data onto national databases. Regarding communication of the outcome of the MDT meeting, email was the most frequent means of communication to administrators and clinicians. Respondents tended to communicate to GPs by letter. Approximately three quarters of respondents are able to send out decision or minutes from MDT meetings on the same day as the meeting, and over 90% within 48 hours, at a local level. 85% of respondents felt that their venue was fit for purpose.

**Discussion** Our results suggest that the role of the MDT coordinator is essential to the smooth running of an MDT, and equally as important to the consistent care of patients along the cancer pathway. Respondents appear to have received some relevant training and have access to equipment and facilities appropriate for the job. Although MDT coordinators appear not have a direct role in clinical decision-making, it seems that their work supports the decision-making of the clinical members of the MDT, and without it, decisions could not be made. These findings support our own previous research, as well as work carried out by others, including the National Cancer Action Team, and the Intercollegiate Cancer Committee of the Royal Colleges that recognises the role of the MDT coordinator, as well as the need to strengthen the position by improving resources and training available to MDT coordinators nationally [4,6,7]. The results presented here are a first, brief analysis of the survey data. A more in depth assessment of the results will be undertaken by our research team in the near future, with the production of a more comprehensive report.

In conclusion, the MDT meeting should not be seen in isolation, but rather as a pivotal point in the patient care pathway, linking information about patients and their disease to the decision making process, and then to the ongoing care of the patient thereafter. The role of the MDT coordinator is therefore central to the care of cancer patients, both locally, and also through the coordination and sharing of data on a wider level.

## References

1. Hong NJ, Wright FC, Gagliardi AR, Paszat LF. Examining the potential relationship between multidisciplinary cancer care and patient survival: an international literature review. *J Surg Oncol*. 2010 Aug 1;102(2):125-34. Review.
2. Fleissig AJ, Jenkins V, Catt S, Fallowfield L. Multidisciplinary teams in cancer care: are they effective in the UK? *Lancet Oncol* 2006 Nov;7(11):Nov.
3. The Characteristics of an effective MDT. London, NHS National Cancer Action Team, 2009.
4. Educational initiatives to improve the effectiveness of cancer multidisciplinary teams. London, Academy Of Medical Royal Colleges, 2009.
5. Lamb BW, Green JSA, Vincent C et al. (2010) Decision-making in surgical oncology. *Surgical Oncology*, doi:10.1016/j.suronc.2010.07.007
6. Multidisciplinary team members views about MDT working: Results from a survey commissioned by the National Cancer Action Team. London, NHS National Cancer Action Team, 2009.
7. Soukop M, Robinson A, Soukop D, Ingham-Clark CL, Kelly MJ. Results of a survey of the role of multidisciplinary team coordinators for colorectal cancer in England and Wales. *Colorectal Dis* 2007 Feb;9(2):146-150.

## 4. MISSION STATEMENT

As the National Cancer MDT Co-ordinators Forum, we provide a national voice to inform, support and motivate fellow co-ordinators, to bring professional recognition to the role and contribute to improving the patient pathway.

### Current Work streams:-

- MDT Co-ordinators Conference – 2010
- Recruit new members to the National MDT Forum Group **on-going**
- MDT Co-ordinator / Cancer Registries Qualification/training qualification - **ongoing**
- Identify and establish further regional MDT co-ordinator meetings – **on-going**
- Address and expand communication links through out the UK – **on-going**
- Regular articles in the Cancer Action Team Magazine – **continually on-going**
- Developing the 'MDTC Forum Group website **Is now set up and running.....NCIN.org.iuk** – Type MDT co-ordinators in search box.
- To further develop and maintain links with Networks which will ultimately aid the support of MDT Co-ordinators Nationally - **On-going**

**Please forward any articles or projects that you are involved in and are proud to share to:**

[Diane.wilkes@rwh-tr.nhs.uk](mailto:Diane.wilkes@rwh-tr.nhs.uk)

***YOU could be just the person we are looking for:***

1. **Do you enjoy being an MDT Cancer Co-ordinator?**
2. **Would you like to make a difference to the role?**
3. **Can you see yourself working with other Co-ordinators to promote the role nationally?**
4. **Are you someone who enjoys a challenge?**

**If you have answered 'Yes' to the questions above the MDT Taskforce Group has vacancies in the following regions and would love to hear from you:**

- **Yorkshire and the Humber – covering the Yorkshire and Humber and Yorkshire Coast CNs**
- **East of England – covering Anglia, Essex and Mount Vernon CNs**
- **East Midlands – covering East Midlands and North Trent CNs**
- **North East – covering North of England CN**
- **London – covering North London, NE London, SE London and West London CNs**

The National Cancer MDT Coordinators Forum Team

<p><b>Juanita Asumda – Chair</b>          Network Cancer Services Coordinator          Royal Surrey County Hospital NHS Foundation Trust  <a href="mailto:Juanita.Asumda@rnhs.net">Juanita.Asumda@rnhs.net</a>          Region Covered: South East Coast; Surrey, West Sussex &amp; Hampshire CNs</p>	<p><b>Serena Hodges – Vice Chair</b>          Upper GI Services Coordinator          University Hospitals Bristol NHS Foundation Trust  <a href="mailto:Serena.Hodges@UH Bristol.nhs.uk">Serena.Hodges@UH Bristol.nhs.uk</a>          Region Covered: South West; Peninsula, Dorset, Avon Somerset &amp; Wiltshire CNs</p>		<p><b>Diane Wilkes – Newsletter Editor</b>          MDT Coordinator          The Royal Wolverhampton Hospital NHS Trust  <a href="mailto:Diane.Wilkes@rwh-tr.nhs.uk">Diane.Wilkes@rwh-tr.nhs.uk</a>          Region Covered: West Midlands; Greater Midlands, pan Birmingham, Arden, 3 Counties CNs</p>	
<p><b>Sue Hughes</b>          Cancer MDT/ Information Manager          Betsi Cadwalder University Local Health Board  <a href="mailto:Sue.Hughes2@wales.nhs.uk">Sue.Hughes2@wales.nhs.uk</a>          Region Covered: Wales; North Wales, South East Wales and South West Wales CNs</p>	 <p><b>“As the National Cancer MDT Coordinators Forum, we provide a national voice to inform, support and motivate fellow coordinators, to bring professional recognition to the role and contribute to improving the patient pathway.”</b>  <b>Making a Difference Together</b></p>		<p><b>Lindsay Campbell</b>          MCN National Manager for Sarcoma, HPB and Neuro Cancers          Glasgow Royal Infirmary  <a href="mailto:Lindsay.Campbell@ggc.scot.nhs.uk">Lindsay.Campbell@ggc.scot.nhs.uk</a>          Region Covered: Scotland; Board 1, Board 2 and Board 3 CNs</p>	
<p><b>Margaret Fleming</b>          Cancer Services Administrative Coordinator          The Western Trust  <a href="mailto:Maragaret.Fleming@westerntrust.hscni.net">Maragaret.Fleming@westerntrust.hscni.net</a>          Region Covered: Northern Ireland</p>			<p><b>Angela Heer</b>          Cancer Services Manager (MDT)          Stockport NHS Foundation Trust  <a href="mailto:Angela.Heer@stockport.nhs.uk">Angela.Heer@stockport.nhs.uk</a>          Region Covered: North West; North of England, Merseyside &amp; Cheshire and Greater Manchester &amp; Cheshire CNs</p>	
<p><b>Anna Peart</b>          MDT Coordinator Team Leader          Heatherwood &amp; Wexham Park NHS Hospitals Foundation Trust  <a href="mailto:Anna.Peart@hwph-tr.nhs.uk">Anna.Peart@hwph-tr.nhs.uk</a>          Region Covered: South Central; Central South Coast, Thames Valley CNs</p>	<p><b>Di Riley</b>          Associate Director, Clinical Outcomes Programme          National Cancer Intelligence Network          &amp;          National Cancer Action Team  <a href="mailto:Driley@nhs.net">Driley@nhs.net</a></p>		<p><b>Lynn Faulds Wood</b>          British Television Presenter          President, National Cancer MDT Coordinators Forum          President, European Patients' Coalition          Lynn's Bowel Cancer Campaign – <a href="http://www.bowelcancertv">www.bowelcancertv</a></p>	
<p>VACANCY          YOU          Region Covered: North East; North of England CN</p>	<p>VACANCY          YOU          Region Covered: East of England; Anglia, Essex, Mount Vernon CNs</p>	<p>VACANCY          YOU          Region Covered: East Midlands; East Midlands and North Trent CNs</p>	<p>VACANCY          YOU          Region Covered: London; North London, North East London, South East London, South West London and West London CNs</p>	<p>VACANCY          YOU          Region Covered: Yorkshire &amp; The Humber; Yorkshire, Humber &amp; Yorkshire Coast CNs</p>