

The future of cancer networks

Policy recommendations as a result of
a joint seminar held at the Kings Fund

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Introduction

Originally proposed by the Calman-Hine report in 1995 and formally implemented by the NHS Cancer Plan in 2000, cancer networks have survived multiple reorganisations of the NHS. In May 2011, Health Secretary Andrew Lansley announced that funding for cancer networks would be maintained until April 2013 and that the Government intended to ensure that they had a long term future.

Following a recommendation from the NHS Future Forum that networks become embedded throughout the proposed new NHS structure, in June 2011 the Government's response to the Future Forum report made clear that networks will be retained and strengthened (Department of Health, 2011).

The Government also said, however, that further work is needed to define networks, and review their range and function. Informed by a seminar held at The King's Fund, this paper is intended as a contribution to that further work, specifically looking at the role of cancer networks. It makes a number of recommendations for an overall approach to the functions, accountability and form of cancer networks after April 2013, when Clinical commissioning groups will begin to operate.

Implementing these recommendations would help to ensure that cancer networks have a secure, valuable and important role in ensuring high quality cancer care in England.

Background

Cancer networks have made a significant contribution to cancer services over the last 15 years. They have been a valued channel for communication and an important route for engagement and coordination across the healthcare system, including at the level of multidisciplinary clinical teams. They have led efforts to ensure the implementation of clinical guidance (the Improving Outcomes Guidance), have supported the translation of national policy into local action in areas such as cancer waiting times, and have helped commissioners to identify population needs and set service specifications for providers.

However, they have also had weaknesses. Their success in catalysing local action has varied considerably, and they have not always been able to get all local PCTs or all local providers to work together successfully to coordinate essential improvements such as centralising specialist services. Looking to the future of cancer networks, therefore, it will be important to find ways to capitalise on and support what works well and address what could be improved.

Recommendations for the future of cancer networks

Function – should cancer networks provide support to commissioners, or to providers, or both?

In a complex disease area like cancer, where the delivery of well-specified high quality clinical pathways, spans prevention to diagnosis, treatment, support and end-of-life care, effective commissioning is both important and challenging. Commissioning high quality clinical pathways requires the comprehensive identification of the needs of the local population, the definition of outcomes that meet those needs and the ongoing monitoring of performance against those outcomes. The achievement of these objectives require strong commissioning, spanning a wide range of specialist knowledge and competencies, which the cancer network can provide.

While clinical commissioning groups will have statutory commissioning authority, it is recognised that they might not all have the required expertise to act as strong commissioners in cancer care (Primary Healthcare Professionals Monitor, 2010; Cancer Campaigning Group, 2011). Beyond issues of expertise, the commissioning of many services for cancer treatment (eg radiotherapy) typically requires coordination at a larger geographical area than Clinical commissioning groups will cover, generally felt to be populations of 1–1.5 million. Cancer networks have been and will be in the best position in the new NHS structures to provide this broader coordination.

Overall, therefore, cancer networks represent an effective and necessary vehicle to fill the potential expertise gap in commissioning cancer care in the new NHS structures, and should provide support to clinical commissioning groups, including coordination between them.

In addition to the commissioning support function of networks, historically and in some cases more recently, cancer networks have also had a role working directly with providers to support care delivery, particularly in terms of implementing national initiatives such as waiting times standards. The line between providing support to commissioners and providing support to providers is not an entirely clear one – effective commissioning involves close working relationships with and alongside providers. Cancer networks could therefore choose to operate in some form as support to providers as well as support to commissioners. After all, the delivery of high quality clinical pathways also requires integration among providers offering different levels of care and across various settings and therefore strong management and careful coordination. This provider coordination has not always been achieved effectively, with, for example, issues in transitioning patients across settings, and defining responsibility and ownership of the pathways. Thus, depending on the local circumstances, there might be a need to support providers in strengthening shared governance to achieve integration more successfully. Cancer networks could offer this kind of support.

However, there are potential risks with a single network organisation combining the key role of delivering support to commissioners with that of supporting providers to coordinate the management of care pathways. As indicated above, providing commissioning support implies working alongside providers to ensure effective clinical pathways. However dealing with the practicalities of supporting the management and coordination of clinical pathways might result in a dilution of focus on broader issues that are key to strong commissioning, such as the actual effectiveness of those pathways in meeting population needs. Support to providers in achieving integration should be provided through the creation of a separate shared governance vehicle.

The two functions of commissioning support and provider support can be integrated, however, at the clinical level, through the operation of tumour boards. Because tumour boards are clinically led and specialist groups, they could have two separate functions as clinical advisors to commissioners and as clinically-led delivery groups. Thus, they can be a platform for shared governance and integration of commissioning and provision support.

Key recommendations

- Cancer networks should operate primarily through providing support to commissioners, while ultimately concerned with ensuring the delivery of high quality clinical pathways for cancer care locally.
- The commissioning support function of networks is essential as Clinical commissioning groups lack the required expertise in cancer to act as strong commissioners.
- Depending on local circumstances, cancer networks might offer support to providers in strengthening integration and coordination of care across pathways. However, commissioning and provider support should not be provided by a single network organisation but through separate structures. However, local circumstances should ultimately determine the structures that cancer networks take in different regions.
- At the clinical level, tumour boards (multiprofessional clinical groups) can act as advisory to commissioners and clinically led delivery team thus bringing together the commissioning and provider support functions.

Accountability – how can cancer networks best fit into the broader accountability structures in the NHS?

The revised Health and Social Care Bill – although still subject to parliamentary debate – sets out a sweeping set of reforms which will significantly reshape formal accountability relationships within the NHS. Under these plans, clinical commissioning groups will have responsibility for the majority of commissioning. The new NHS Commissioning Board will provide ‘national leadership’ on commissioning and will hold clinical commissioning groups accountable against a ‘Commissioning Outcomes Framework’.

Historically cancer networks have not been subject to any formal accountability relationship towards the centre. While in practice cancer networks have tended to work well with the national teams in implementing national policy, there has been considerable variation in networks’ successes locally, and there are very few mechanisms by which networks can be held to account for the performance within their locality. There is also little scrutiny of how the money allocated to cancer networks is spent, and for what outcome. Thus, it is crucial that a new accountability relationship between the networks and the centre is created and transparent to all involved. Given the networks’ central role in supporting commissioners, and the key role that will be played by the Commissioning Board in government plans, it seems logical for this formal line of accountability to be up to the Commissioning Board. The Government’s response to the Future Forum report recognises this, saying that networks are to be hosted by the Commissioning Board (Department of Health, 2011).

There is a need to accurately and clearly define the nature of this new accountability relationship, what the network will be accountable for and how, and what sanctioning powers the Commissioning Board will have if the network is failing to discharge its defined function. While the responsibility for delivering the Commissioning Outcomes Framework will be with the clinical commissioning groups and networks should not be held to account for outcomes, it is envisaged that the network should be accountable for delivering the necessary support to enable local action plans and achieve those outcomes. For example, one key aspect of delivering this support is to ensure transparency across the local patch. Thus networks should have a duty to report to the Commissioning Board on issues that might be of impediment or concern in the implementation of action plans. However, networks will need to carefully balance this duty with the need to avoid acting as ‘whistle blowers’, as this might destabilise local relationships and the network ability to engage commissioners and providers locally.

If networks are held to account by the Commissioning Board, there should be in place the resultant mechanisms and ultimately sanctions if the network fails to perform its functions. For instance, the chair of the network board should be the accountable officer, and the Commissioning Board could have the power to remove and replace this officer in particularly serious instances.

While it is clear that a new line of accountability should be created between the centre and the networks, at the local level, there is obviously a tension between formal powers and authority and the ability to foster softer relationships. On the one hand, because cancer networks have not previously had any form of authority towards commissioners and providers some have suggested this has weakened their ability to effect positive change. On the other hand, softer engagement with local organisations has been a key lever of networks to develop the necessary goodwill among providers and commissioners in the past and it might be endangered by the design/creation/establishment of formal powers. Therefore it is envisaged that there should not be a formal accountability relationship between the network and clinical commissioning groups and providers. This means that, for example, networks should not have formal powers and authorities to performance manage commissioners and providers, nor powers to reward or sanction.

Rather, the clinical commissioning groups, responsibility to engage with and listen to networks in developing local action plans should be part of the formal accountability relationship between them and the Commissioning Board. Clinical commissioning groups, as part of their authorisation process, should be required to show that specific arrangements are in place to engage with networks and be subsequently held to account for taking into consideration and effectively putting into practice those arrangements when developing local plans. It is also important to ensure that cancer networks link up effectively with clinical senates.

Key recommendations

- Networks should have a direct line of accountability towards the NHS Commissioning Board, with a duty to ensure transparency locally
- No formal accountability relationship should be formed between networks and clinical commissioning groups and providers. Rather the responsibility of clinical commissioning groups to engage with networks should be part of their formal accountability relationship with the Commissioning Board.

Form – who should be involved in cancer networks and what benefits might there be in cancer networks merging with other clinical networks?

Traditionally, cancer networks have largely involved acute care professionals. However, while cancer is treated within the acute care setting, it is also increasingly a long term condition, which requires a broader range of expertise and support. Thus networks should be strengthened by expanding and diversifying the mix of professionals, ranging from primary care to community services, public health and social care. In addition, given the centrality of designing care around the patient needs and preferences, patient involvement and engagement is needed at all levels through the creation of patient involvement structures that are internal to the network.

The network model adopted in cancer care has also been developed in other disease areas. There are currently 28 cancer networks and a similar number cover other areas such as cardiac and stroke care. However, the viability of these networks is being challenged by the current financial climate and the need to achieve efficiency savings within the system. The creation of a single network covering multiple clinical areas becomes an appealing option to meet these challenges.

Disease areas like cardiac and stroke share many of the same issues, such as the delivery of high quality clinical pathways requiring complex commissioning and careful coordination and integration among providers of different level of care and across different settings. A single clinical network model presents a number of features that can help achieve these objectives more efficiently and effectively. Firstly, common services (like administration, data, end of life care, patient engagement, and workforce and training) can be shared. Secondly, common work streams, such as prevention and rehabilitation, can be identified. Thirdly, learning and sharing of good practices across services as well as the development of new practices such as better integration with social care, are facilitated. Finally, consistent financial and business processes can be designed. In addition, efficiency can be improved while protecting the operation of smaller networks.

However, the dilution of intelligence at the local level and the loss of cancer expertise is a concern in combining different clinical areas in one model. One plausible option to address this concern is to create a single network that unifies strategic direction across disease areas at the top of the network structure but preserve disease-specific clinical boards. This approach would achieve the benefits of unification in terms of sharing of common services, learning and consistency of business processes across the disease areas but retain differentiation at the clinical level and maintain clinical engagement and expertise.

However, it is clear that the suitability of a single clinical network needs to be weighed against local circumstances, as transaction costs of setting up a single network can be considerable. So for example, a network might be facing specific pressing issues and becoming part of a single clinical network might lead to a lack of focus on those issues and ultimately a reduced ability to address them. Equally, different networks (and individuals within them) come with a cultural and relational history; so where there are patterns of poor relationships, these might be hard to alter and could have a strong influence on the success of a single network.

Key recommendations

- Networks need to be strengthened by expanding and diversifying the mix of professionals involved, including primary care, community services, public health and social care
- Patients need to be involved through the creation of structures that are internal to the network
- A single clinical network (ie covering multiple clinical areas) is an appealing option to meet the challenges posed by the current financial climate as it can generate efficiencies from sharing services and learning, and consistency of business processes and financial accounts
- In order to maintain local intelligence and knowledge, unification should happen at the strategic level and differentiation should be preserved at the clinical level.
- The suitability of a single clinical network needs to be weighed against local circumstances as transaction costs can be considerable

Acknowledgements

Many thanks to the participants of our seminar on the future of cancer networks, held at The King's Fund on 23 May 2011. These were:

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