

# The role of cancer networks in the new NHS

October 2012

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# Foreword

The Government has set an ambition of saving 5,000 lives from cancer by 2015. The outcomes-based approach of the new NHS is a welcome step towards putting the patient at its heart. Macmillan Cancer Support wants everyone with cancer to receive the highest quality care and support that meets all of their needs, be they medical, financial, practical or emotional.

Cancer networks have played a key role in reconfiguring cancer services since they were established in 2000, following the first cancer plan, with the result that survival figures and patient experience have both improved. Macmillan wants people to receive the best care and support possible from the NHS and we believe that cancer networks have a vital role to play in delivering that. Indeed, their expertise will be crucial in ensuring that Clinical Commissioning Groups are able to deliver improved outcomes for people with cancer.

Macmillan undertook this research in July 2012 because we were concerned about threats to networks' functions. However, since then, there have been a number of developments that have alarmed us even more. We believe there is real danger that the progress that cancer networks have made over the last 12 years in improving outcomes will be lost in the transition to the new system.

Initial proposals regarding new support teams suggest a significant reduction in the number of network staff. It is hard to see how such large reductions will not have a detrimental impact on their work. This is not just a concern for Macmillan, but for colleagues working to support people with other conditions such as heart disease and stroke. There is also a lack of plans in place to ensure retention of experienced staff, whose knowledge and relationships ensure the success of networks.

There is still a lack of clarity about funding - how it will be allocated and responsibility for spending it. The exact remit of clinical networks also remains to be clarified.

These developments mean there is now a great urgency to implement the recommendations of this report and we are pleased that progress is already being made in some of these areas. Our recommendations include the need for networks to have a remit that covers all five domains of the outcomes framework and for plans to be put in place to ensure the retention of experienced staff and continuation of key projects. We are keen to give our support and expertise to the NHS Commissioning Board to implement these recommendations, and embed cancer networks at the heart of the reformed NHS. It is not too late to ensure the future and strengthening of cancer networks but the time to act is now.



**Mike Hobday**  
**Director of Policy and Research**

# Executive Summary

Macmillan believes that cancer networks have a key role to play in the reformed NHS. Since being established 12 years ago they have worked with clinicians, commissioners and providers to drive up standards of care and improve outcomes for cancer patients.

The Government announced in May 2011 that cancer networks would be retained in the NHS, but draft proposals published in February 2012 suggested that there will be significant changes to their structure and function. In July 2012 the NHS Commissioning Board Special Health Authority published new proposals on clinical networks, providing more detail on these changes. In order to assess the impact of the proposed changes on cancer networks, Macmillan interviewed cancer network Directors.

Directors of cancer networks raised significant concerns about the proposals, including the change in focus of networks' activities, and changes to their structure and funding. They also highlighted the impact that uncertainty about the future of networks has already had on their work and ability to retain staff. One network Director gave the example of having to abandon work around survivorship - providing care and support to those living with and beyond cancer - due to a lack of resource.

The Government's proposals suggest that the main focus of cancer networks will be on preventing people from dying prematurely. We are concerned that this proposed remit is too narrow. Currently cancer networks also work to improve recovery after treatment and ensure people have the information and support they need both during and after treatment. These are all areas that matter hugely to people with cancer. We cannot risk a decline in the support available, and ultimately outcomes for people with cancer, because many areas have been deprioritised.

The majority of Directors interviewed (19 out of 23) indicated that suggested structural changes to cancer networks would negatively impact on their ability to deliver their functions to improve cancer outcomes. A major concern for cancer network Directors was the suggestion that they will lose their dedicated staff teams, in favour of getting support from centralised teams supporting a number of networks. A number of Directors highlighted how the expertise of dedicated teams and relationships with local healthcare providers were integral to ensuring the networks' effectiveness.

Macmillan believes that the NHS Commissioning Board should take steps to address these concerns to ensure that cancer networks can effectively support commissioners to improve outcomes in the reformed NHS. As such, this report includes the following recommendations:

## Recommendation 1

The NHS Commissioning Board should ensure that cancer networks are given a remit which includes all five domains of the NHS Outcomes Framework. This remit

should support work across the whole cancer pathway, including early diagnosis, treatment, redesigning services, cancer patient experience, and survivorship.

## **Recommendation 2**

The NHS Commissioning Board should clearly define the functions of cancer networks to ensure that they deliver the most effective support to commissioners. We recommend that these functions should closely mirror those set out by Macmillan and the Cancer Campaigning Group.

## **Recommendation 3**

The NHS Commissioning Board should ensure that sufficient staff, including experienced Directors, are retained to support cancer networks to deliver their functions effectively in the new structure.

## **Recommendation 4**

The NHS Commissioning Board should ensure that the cancer specific expertise, including that of patients, that exists in the current network structures is not lost in the transition to the new system.

## **Recommendation 5**

The NHS Commissioning Board should commit that sufficient funding will be available for individual cancer networks to be able to deliver their functions effectively after April 2013.

# Introduction

## What are cancer networks?

Cancer networks were established in 2000. Each network consists of a number of NHS organisations working together to deliver high quality, integrated cancer services for their local populations.

There are 28 cancer networks in England. The former Minister of State for Care Services, Paul Burstow described them as '*a place where clinicians from different sectors come together to improve the quality of care across integrated pathways*' and are '*a clear example of how this way of working delivers better quality care*'.<sup>1</sup>

Cancer networks work in local areas with clinicians, patients and managers to deliver the national cancer strategy, to improve performance of cancer services and to facilitate communication and engagement around cancer issues. Cancer networks receive both central government funding and funding from local NHS bodies. However, historically they have had no statutory functions and have not been accountable to the Government for delivering improvements in cancer services.

## What do we know about their future?

In 2011, the former Secretary of State for Health, Andrew Lansley, committed to fund cancer networks until 2013. After that time, responsibility for supporting 'strengthened' cancer networks will transfer to the NHS Commissioning Board.

The NHS Commissioning Board Special Health Authority published proposals setting out their future role in the NHS in July 2012.

### Key proposals:

- Clinical networks, including cancer networks, will be established as Strategic Clinical Networks (SCNs) from 2013 onwards.<sup>2</sup> The functions of SCNs will be to advise commissioners, support change projects and improve outcomes.
- SCNs will be supported administratively by centralised support teams in 12 geographical areas. These central teams will replace the dedicated staff teams currently attached to individual networks.
- Each SCN will have a particular focus linked to the Domains of the NHS Outcomes Framework.<sup>3</sup> Cancer networks will focus on Domain 1: Preventing

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<sup>1</sup> Hansard HC Debate, 30 April 2012, Col 1288 W.

<sup>2</sup> NHS Commissioning Board, *The Way Forward, Strategic Clinical Networks*, July 2012.

<sup>3</sup> The NHS Outcomes Framework is a set of indicators on which the NHS is measured. The Framework includes indicators such as 'Under 75 mortality rate for cancer'. The Framework is split

people from dying prematurely. However, the proposals suggest that improvements to patient experience and patient safety underpin all NHS care and will be embedded in the work of all SCNs.

- Clinical Commissioning Groups will be able to demonstrate ‘excellence in commissioning at their annual assessment through active engagement with the SCNs’.<sup>4</sup>
- SCNs will be hosted by the NHS Commissioning Board and will have clear terms of reference. They will also have an annual accountability agreement with the NHS Commissioning Board for the programmes of work they carry out on quality and improvement.

## Methodology

From May to July 2012, Macmillan interviewed 23 of the 28 cancer network Directors. At the time the interviews were conducted, network Directors had seen draft proposals for strategic clinical networks, which proved to be similar to the final proposals published by the NHS Commissioning Board in July 2012.

Interviews were conducted over the telephone. The content of the interviews focused on the current structure of the network, recruitment and retention of staff, notable achievements and the role of the network support team in delivering key functions. The aim of the interviews was to get insight on what the impact of the current proposals could be.

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into 5 Domains, each of which focuses on a certain set of outcomes. For example, the indicator above comes under Domain 1: preventing people from dying prematurely.

<sup>4</sup> NHS Commissioning Board, *The Way Forward, Strategic Clinical Networks*, July 2012. Frequently asked questions.

# Focus and Function

## Focus of cancer networks' activities

The proposals published in July 2012 for SCNs suggested that cancer networks would focus on Domain 1 of the NHS Outcomes Framework – the aim of this domain being to incentivise the NHS to prevent people from dying prematurely. In cancer, a number of factors prevent people from dying prematurely, but 'diagnosis of cancer at a later stage is generally agreed to be the single most important reason for the lower survival rates in England', which suggests there could be strong incentives to focus on early diagnosis.<sup>5</sup>

Interviews with network Directors revealed that the current remit of networks is much wider than early diagnosis. Directors explained that whilst many cancer networks work with primary care clinicians to improve early diagnosis, they are also involved in many other elements of the cancer pathway, including improving the use of existing treatments and uptake of new treatments, redesigning services, improving patient experience and supporting integration. This work covers all five domains of the NHS Outcomes Framework.<sup>6</sup> Their responses raise the concern that limiting the focus of cancer networks to reducing mortality may therefore result in other valuable work streams being under-resourced and de-prioritised.

The current remit of cancer networks across the whole pathway has led to improved outcomes for patients. These outcomes have included increased survival, better patient experience, improved treatment and recovery, and improved support and information throughout their cancer journey. The table below highlights some specific examples from network Directors on improved patient outcomes, which correlate to each of the domains in the Outcomes Framework.

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<sup>5</sup> Department of Health, *Improving outcomes a strategy for cancer*, 12 January 2011.

<sup>6</sup> Domain 2 is about 'enhancing quality of life for people with long term conditions'. Domain 3 is about 'helping people to recover from episodes of ill health or following injury'. Domain 4 is about 'ensuring that people have a positive experience of care'. Domain 5 is about 'treating and caring for people in a safe environment and protecting them from avoidable harm'.

	Domain	Improved outcomes for patients
1	<i>Preventing people from dying prematurely</i>	One Director cited how their network had achieved increases in breast cancer survival through analysing local cancer data. Their analysis showed that the reason behind poor survival rates was deprivation and stage of diagnosis, not screening uptake as previously thought. This evidence led to action which has improved one year survival rates.
2	<i>Enhancing quality of life for people with long term conditions</i>	Cancer networks are involved in activities to help people recover from the effects of cancer. One network developed a model of follow up after the end of treatment for breast cancer. Low risk patients were supported to be more independent at the end of treatment by offering intense support. This required a new commissioning model, which has since been rolled out to cover bowel and endometrial cancer.
3	<i>Helping people to recover from episodes of ill health or following injury</i>	Many networks had supported 'enhanced recovery' programmes. One network in particular delivered a '23 hour breast cancer pathway pilot' which reduced unnecessary lengths of stay for people in hospital.
4	<i>Ensuring that people have a positive experience of care</i>	We know that patients place a high value on having access to good quality information. Many networks have played a key role in improving this through supporting the roll out of information prescriptions. Information prescriptions are a tool that enables people to have information specifically tailored to their cancer type and circumstances.
5	<i>Treating and caring for people in a safe environment and protecting them from avoidable harm</i>	Many network Directors cited examples of improving the use of cancer drugs. One Director cited the specific success of ensuring the appropriate use of Herceptin throughout their network.

## Delivery of key functions

Alongside ensuring that the remit of cancer networks is broad enough, it will be vital that there is clarity as to their specific functions to ensure that they can be held accountable on delivering them. The current proposals on strategic clinical networks provide very little detail as to what their exact functions will be.



Previous work undertaken by Macmillan has identified what we think the key functions of cancer networks should be to improve outcomes for people with cancer, and these are detailed below. These functions closely mirror those recommended by the Cancer Campaigning Group, a coalition of national cancer related charities, following a series of interviews with a variety of staff from ten networks.<sup>7</sup>

### **Driving forward local cancer strategy**

Cancer networks are instrumental in ensuring that the national cancer strategy 'Improving Outcomes: A strategy for cancer' is delivered. Cancer networks analyse local circumstances to determine what needs to be done to ensure that the outcomes set out in the strategy are delivered at a local level. One network Director set out how they do this practically - by assigning each member of their team responsibility for delivering an aspect of the strategy, which they deliver by working with local stakeholders.

### **Driving service redesign to ensure integration**

Cancer networks have a key role to play in ensuring the integration of cancer services across an area, through designing what the cancer journey should look like for patients. Seventeen of the Directors highlighted that cancer networks are involved in the cancer pathway from the beginning to the end. Network Directors described themselves as having a role as an 'honest broker' in bringing together different providers to help design and implement these cancer pathways, to ensure they deliver the outcomes that are actually important to patients.

### **Providing vital expertise on cancer**

Cancer networks have awareness of local population needs gained through collection and analysis of data, and awareness of gaps in cancer service provision. This expertise will be vital in ensuring effective commissioning of cancer by Clinical Commissioning Groups. One way that this expertise has been used is to ensure better use of cancer drugs. Directors cited examples of how they had helped commissioners to save significant amounts of money in this area by advising how cancer drugs could be more effectively used, without a reduction in quality of care.

### **Monitoring performance of providers to highlight poor outcomes**

Cancer networks monitor performance of providers, identifying poor performance and improving outcomes. Reducing waiting times is a practical example of this. One Director gave the example of how they had worked with primary and secondary care providers at one hospital to reduce chest x-ray waiting times from an average of 15 days to 3 days.

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<sup>7</sup> Cancer Campaigning Group, *Developing excellence in cancer networks*, February 2012.

## **Recommendation 1**

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## **Recommendation 2**

The NHS Commissioning Board should clearly define the functions of cancer networks to ensure that they deliver the most effective support to commissioners. We recommend that these functions should closely mirror those set out by Macmillan and the Cancer Campaigning Group.

# Structure

The vast majority of network Directors that we interviewed (19 out of 23) expressed concerns about the impact of structural changes on their ability to deliver their functions in the reformed NHS. These are functions that, as set out in the last chapter, improve outcomes for people with cancer. However it should be noted that six network Directors stated that in principle, change could be good for the networks.

## Current structure of cancer networks

The work of cancer networks is currently co-ordinated and driven by a dedicated network staff team. Although the structure and size of the dedicated teams vary from network to network, our research shows that they all have a team that includes a Director, and most have a nurse and/or medical Director. Many networks also employ a pharmacist, an allied health professional lead<sup>8</sup> and a patient and public involvement lead. Most networks also employ project managers and/or service re-design facilitators, and staff to analyse and collect data.

## Changes to network structure

The proposals for clinical networks suggest there will be significant changes to the network staff teams. Under the new proposals, the dedicated staff teams that cancer networks have at present will be replaced by geographical support teams who will support all the clinical networks in that area.

Each geographical support team will be led by a part-time clinical Director and an overall network Director. It is unclear in which field the clinical Director will be a clinical specialist given that these support teams will be supporting a number of conditions. These Directors will appoint a core team that could include both generalist and specialist expertise staff.

Although the NHS Commissioning Board Special Health Authority has stated that there will continue to be professional expertise for cancer networks, there was significant concern among Directors that a loss of dedicated teams may undermine the networks functions.

All network Directors interviewed stressed the fundamental role that the dedicated teams play in the delivery of functions of cancer networks, viewing them as being '*absolutely critical*', '*vital*', '*essential*' and '*crucial*'. Referring to the new proposals on clinical networks, one Director stated that, '*removing [network teams] would render the network virtually useless*'.

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<sup>8</sup> Both of which are commonly funded by Macmillan grants.

## Potential loss of organisational memory

There is currently no detail on how the organisational memory, in terms of knowledge of local circumstances, stakeholders and projects, will be retained in the new system and carried forward to shared teams in the different geographical areas.

Almost half of cancer network Directors (11 out of 23) raised concerns about the potential loss of organisational memory in the new system. They cited specific concerns that if network teams were required to work over larger geographical areas, the valuable relationships they had already formed locally to drive improvement across the cancer pathway would suffer. More than a third (9 out of 23) stated that widening the geographic area covered by networks would have a detrimental impact on their work streams, as the success of the network was dependent on strong knowledge of the local area.

## Involvement of people affected by cancer

Cancer network Directors highlighted the value of involving people in their work who have experienced cancer, such as redesigning pathways of care. This involvement is crucial to ensure that networks deliver the outcomes that really matter to patients. Several networks include patient representatives in their clinical groups, and many also ensure that patients are involved in commissioning and in working with providers to make improvements. Concern was expressed from Directors that the changes in structure would lead to user involvement in cancer services suffering, with one Director stating that 'user involvement looks unlikely following the reforms'.

## Impact of uncertainty on staffing

Almost all network Directors (17 out of 23) reported recent difficulties in recruiting and retaining staff, with over half (13 out of 23) suggesting that the current uncertainty about the future of cancer networks was the principal reason for this. Only two network Directors stated that they had not seen a significant impact, although one of these reported being aware that other networks were having difficulties.

Over half of networks (13 out of 23) had reduced teams as a result of the current uncertainty over the future of cancer networks. Some (9 out of 23) were struggling to recruit new staff, as they were unable to offer permanent contracts or advertise permanent posts outside the NHS, or were simply not allowed to recruit at all. As a consequence, some network teams had to prioritise certain projects over others, whilst another team had been forced to abandon several existing projects altogether, representing a significant waste of resource.

### **Recommendation 3**

The NHS Commissioning Board should ensure that sufficient staff, including experienced Directors, are retained to support Cancer Networks to deliver their functions effectively in the new structure.

### **Recommendation 4**

The NHS Commissioning Board should ensure that the cancer specific expertise, including that of patients, that exists in the current network structures is not lost in the transition to the new system.

# Funding

The uncertainty about funding has the potential to impact negatively on cancer networks' ability to deliver key functions.

## Current funding of cancer networks

The current funding for cancer networks included in the Strategic Health Authority (SHA) bundle for cancer networks for 2012-13 is £18.5 million.<sup>9</sup> The same figure was identified for 2010-11 and 2011-12.

## Impact of funding reductions on networks

If funding is not maintained at its current level, cancer networks may have to significantly reduce the range and ambition of the projects they are working on. Several of the network Directors interviewed (8 out of 23) specifically stated that reductions in funding for their network would reduce the range of projects they are able to work on, with some (7 out of 23) stating that the current uncertainty had already led to certain projects being prioritised over others. One Director reported that they had already had to abandon work around survivorship, providing care and support to those living with and beyond cancer, due to lack of resource.

Several interviews (7 out of 23) highlighted wider concerns amongst the Directors that a reduction in the size of cancer network teams, which would result from loss of funding, would almost certainly lead to important work to drive up cancer outcomes not happening at all. Directors highlighted that acute trusts and clinicians simply do not have the capacity to take it on themselves.

## Future funding of cancer networks

The NHS Commissioning Board will take over the responsibility of funding cancer networks after 2013. The NHSCB Special Authority outlined that £10 million will be allocated to strategic clinical networks from their own running costs, with additional funding coming from the NHS main programme budget. It is suggested that this figure will be divided equally among 12 geographical support teams as core funding.

Macmillan has received assurances from the Department of Health that £32 million will be assigned to clinical networks from the main budget, which will be allocated according to population size, taking inequalities into account. Therefore, overall strategic clinical networks will be allocated £42 million pounds per year in total. This funding, however, will be shared across all clinical networks and senates. This fact leaves considerable uncertainty about the specific level of funding that cancer networks will receive in the new system, and whether those funds will be sufficient to ensure they can continue to drive improvements in outcomes for people with cancer.

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Hansard HC Debate, 21 May 2012, Col 458 W.

## **Recommendation 5**

The NHS Commissioning Board should commit that sufficient funding will be available for individual cancer networks to be able to deliver their functions effectively after April 2013.

# Conclusion

The report shows that the overall view of current cancer network Directors is that considerable work needs to be done to ensure that cancer networks can play an effective role in improving cancer outcomes in the NHS. It highlights very significant concerns about whether they will be able to continue to drive changes in cancer care if some of the issues identified with the current proposals for SCNs, around their proposed remit, structure and funding, are not addressed.

The NHS Commissioning Board should consider implementing the following recommendations to ensure that vital work that has been undertaken by cancer networks is built on and not lost.

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The NHS Commissioning Board should ensure that cancer networks are given a remit which includes all five domains of the NHS Outcomes Framework. This remit should support work across the whole cancer pathway, including early diagnosis, treatment, redesigning services, cancer patient experience, and survivorship.

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