

Regional Cancer Networks Evaluation Report

September 2010

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CANCER CONTROL NEW ZEALAND

Mana Whakahaere Matepukupuku Aotearoa

Cancer Control New Zealand

Cancer Control New Zealand was established in 2005 to provide independent and expert advice to the Minister of Health and to report on New Zealand's performance in providing cancer care.

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Foreword



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Establishment of regional cancer networks was a key component of the New Zealand Cancer Control Strategy Action Plan 2005-2010. Over the period 2006 – 2008, four regional cancer networks were established – three in the North Island and one in the South Island. In early 2007, the Cancer Control Council undertook a review of the initial development of the networks. The Council noted concerns regarding the increasingly disparate nature and effectiveness of these networks, and recommended that a formative evaluation be undertaken as soon as possible to assist in their further development. This recommendation was accepted by the Minister of Health, but not acted upon.

Over the three years 2007-2009, CCNZ continued to monitor their development. In 2009, it recommended to the Minister of Health that a process evaluation needed to be commissioned to assess whether the regional cancer networks had achieved their initial aims and objectives and if they had had a positive impact on cancer control within their regions.

In early 2010, the Minister of Health asked CCNZ to commission a process evaluation, which was carried out between March and August 2010. The evaluation focuses on describing and assessing what has occurred in the development of the networks to date, with consideration of outcomes. The evaluation included many formative components, such as the development of a programme logic and a focus on learning what could be improved in the future. Key informant interviews were undertaken and a comprehensive on-line survey of cancer sector stakeholders allowed collection of information from a large group of individuals and stakeholders.

Key findings arising from the evaluation are:

- all four regional cancer networks are achieving well against the implementation criteria agreed for this evaluation and making good progress towards achieving their immediate and intermediate outcomes
- There has been increased momentum in the last year as networks have become more firmly established and there appears to be a convergence of activity across the four networks in recent times
- there is an almost unanimous view from all quarters that the value of the networks will increase over time
- cancer stakeholders have a sense of commitment to the networks and all regional cancer networks have made extensive and commendable efforts to engage with their wide variety of stakeholders
- networks have made excellent progress in establishing clear governance structures

Areas where we found that there was room for improvement include:

- the engagement of the primary care sector into the activity of the networks
- the development of distributed leadership amongst network stakeholders, thereby facilitating share ownership of the network and its work programme
- having clear prioritisation criteria that stakeholders collectively own and are committed to
- rationalisation of work programmes, such that they are within the capacity of the number of staff available to undertake the work.

CCNZ would like to thank the many individuals and organisations who have contributed to the successful establishment of regional cancer networks in New Zealand and who have taken part in this evaluation. We welcome any feedback on this report and look forward to continuing to work closely with the regional cancer networks through our role in the monitoring and evaluation of cancer control.

CCNZ has made the following recommendations to the Minister of Health:

That the Minister:

1. Notes the findings of the evaluation, and that the majority of stakeholders and clinicians believe the regional cancer networks are already returning value to the sector and that this value will increase over time.
2. Agrees for CCNZ to circulate the evaluation report to all DHB CEOs, the four regional cancer networks, and stakeholder collaborative groups, encouraging them to review the report, and to address those matters relevant to them.
3. Agrees for CCNZ to commission an in-depth evaluation of the lung cancer tumour stream project in order to determine the impact and effectiveness of regional cancer networks in addressing high needs populations, to be completed within 18 months.
4. Agrees that the Ministry should work alongside the regional cancer networks to ensure inclusion and integration with primary care and secondary/tertiary services in a whole of systems approach to cancer services.
5. Suggests that a national strategic plan for cancer should be developed. This plan should inform and align all regional cancer networks' annual work plans, provide a more cohesive focus on cancer control and assist the networks with the spread of innovation and best practice.

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Executive Summary

In 2006 the Ministry of Health asked District Health Boards (DHBs) to form themselves into regional groupings and establish regional cancer networks. Regional cancer networks were identified as key to the implementation of many of the 112 actions contained in the Cancer Control Action Plan 2005 – 2010 (the Action Plan).

The challenge facing the DHBs in establishing the regional cancer networks was to take 21 autonomous DHBs and find a way for them to work collaboratively with non DHB stakeholders including consumers, NGOs, palliative care providers, Maori, and primary care providers to enhance service planning and delivery of cancer care.

This evaluation was commissioned by Cancer Control New Zealand on request of the Minister of Health. The purpose of the evaluation was to assess the implementation of the four regional cancer networks since their inception, to learn about how the regional cancer networks can be improved and developed to add further value into the future and to inform the development of other health networks.

A programme logic model was developed as part of this evaluation in consultation with the network managers and clinical directors. The logic model is based on information about the way in which regional cancer networks operate included in the Cancer Control Strategy and Action Plan, the Cancer Programme Plan, the CFA variation, and the individual networks' strategic plans as well as some key literature and assessment tools pertaining to evaluating networks. The evaluation methodology used criteria derived from this programme logic model in a mixed method approach allowing a triangulation of qualitative and quantitative data from different sources to build up a comprehensive picture of the functioning and immediate outcomes of the regional cancer networks.

The focus of the evaluation was on assessing the regional cancer network initiative in New Zealand as a whole, rather than an individual assessment of each network. Unless otherwise stated, results have been collated and reported collectively.

We congratulate the regional cancer networks on their efforts to date and urge them to address areas for improvement identified in this executive summary and throughout the report.

How well have the networks been implemented?

The regional cancer networks are making good progress against the implementation criteria agreed for this evaluation (see traffic light report at the end of this executive summary).

Network stakeholders see communication as the most important criterion for successful network functioning. All networks would benefit from adopting some new communication strategies to ensure stakeholders are well informed about network functioning and activities and to enable stakeholders to more easily determine which written or electronic material is relevant to them.

The six clinical directors and four network managers are commended for their leadership and all indications are that the regional cancer network staff are doing an excellent job. There are

opportunities to develop distributed leadership amongst network stakeholders, thereby facilitating shared ownership of the network and its work programme. The roles and responsibilities of stakeholder representatives are currently not well articulated or understood and need to be clarified to enable them to more effectively communicate, advocate and take more of a leadership role in their sector.

Cancer stakeholders generally accept the benefits of working collaboratively via the regional cancer networks and hence have a sense of commitment to the networks. All the regional cancer networks have made excellent progress in establishing clear governance structures and all networks have well defined collaborative structures to guide and manage the network's work programme. The ultimate aim however is to achieve stakeholder ownership of the network - when they are all acting as one. We only found isolated examples of stakeholders feeling the sense of 'we' that signals collective ownership and hence this is an area where there is opportunity for measurable improvements over the next two to three years. We also found areas for improvement in some of the regional stakeholder collaborative groups that would enhance the sense of independence from any particular agency and facilitate the spirit of collaboration and collective ownership.

All regional cancer networks have made extensive and commendable efforts to engage with their wide variety of stakeholders (including consumers, Māori, NGOs, clinicians, DHBs) and stakeholders are generally satisfied with these arrangements. The area of stakeholder engagement that requires the most attention is the engagement of the primary care sector. This was found to be one of the most significant barriers to progress for the networks and likewise one of the greatest opportunities for improvement. Linkages between the networks and DHB funding and planning teams also appear to be weak points and all four regions need to improve in this area.

The Northern Cancer Network appears to have made the greatest gains in Māori engagement and Māori leadership and all regional cancer networks are urged to collaborate on the development of a consistent Māori framework across all networks. Establishing mechanisms for engagement of other ethnic groups is also an area for future attention.

Specific funding appears to have forced a focus on reducing inequalities and all four networks have mechanisms in place to pass an 'inequalities lens' over potential initiatives to determine which are most likely to have a positive impact on reducing inequalities. Different networks have taken different approaches to reducing inequalities but it was beyond the scope of this evaluation to determine the likely effectiveness of these initiatives. If specific reducing inequalities funding is going to continue beyond 2010/11, consideration could be given to undertaking a more focused evaluation of the value and outcomes of the reducing inequalities activities each regional cancer network has undertaken, given that it is nearly 50% of the annual vote health budget for each network.

All regional cancer networks have a clearly written statement of purpose but they have broadened their purpose beyond facilitating regional collaboration of service planning and delivery to also focus on improving patient information and experiences. All networks have ongoing processes for strategic and annual planning and most respondents felt the mechanisms to feed their ideas and suggestions into the network operate reasonably well. However, a disappointingly high number of survey respondents and interviewees don't have a clear understanding about how decisions are

made, and don't believe the network's prioritisation and decision making processes result in defined, clear or realistic activities.

All networks appear to have work programmes that are considerably more ambitious than the number of staff available to undertake the work. Competing priorities coupled with limitations on resources have the potential to create tensions between stakeholders and may jeopardise stakeholder's commitment to and ownership of the network. Stakeholders need to have collective ownership of and commitment to the network's mechanisms for planning, prioritisation and decision making.

The regional cancer networks have established a wide variety of network groups and are engaged in a dispersed range of activities that differs between the four regions. There has been increased momentum in the last year as the networks have become more firmly established and there appears to be a convergence of activity across the four networks, reflecting both the requirements of the National Cancer Control Programme for lung and colorectal tumour streams and the increased sharing of information across the networks about what is working.

There has been little or no monitoring and evaluation of either the performance of regional cancer networks themselves or of their various work streams, although KPIs for intermediate outcomes are being developed. There is significant room for improvement in this area.

What outcomes have the networks achieved and how valuable are these to the cancer sector?

The majority of survey respondents (who felt able to comment on this point) and interviewees (including all four lead CEOs and network chairpersons) believe the regional cancer networks are already returning value for money and there is an almost unanimous view from all quarters that the value will increase over time. This result should provide strong evidence for continuing to fund the regional cancer networks and send a clear signal to stakeholders of the value of their collective and collaborative participation. A more focused evaluation of the impact of one of the activities all regional cancer networks are doing, for example the lung tumour stream work, would be required to determine the value of specific network initiatives.

All regional cancer networks appear to be making good progress towards achieving the immediate and intermediate outcomes from the programme logic model (see traffic light report at the end of this executive summary).

Raising awareness of cancer inequalities was seen as the area the regional cancer networks have had the greatest impact on, with over a quarter saying the network had significantly impacted on this outcome. Māori representatives from each network were particularly unified in their view that the focus on inequalities wouldn't have occurred without the networks.

Other outcomes respondents believe the networks have had noticeable impact on are:

- Bringing people together and developing relationships
- Increased opportunities for sharing information
- Increased opportunities to identify and prioritise initiatives
- Enhanced service planning by bringing together stakeholders

- Cancer stakeholders being better informed about cancer control and cancer inequalities
- Improved co-ordination between service providers
- Service development initiatives and removing service blockages arising from the tumour stream work
- Improved multidisciplinary approaches
- Bridging the gap between national policy and local implementation.

The networks' focus on improved patient experiences appears to be a particular success and many interviewees see this as a significant point of difference between the regional cancer networks and the DHBs.

Stakeholders also believe the networks will lead to a reduction in the impact of cancer. However, there is only a tenuous link between the regional cancer network model and the ultimate outcome of reducing the incidence of cancer. The networks and the Ministry may wish to consider removing the ultimate outcome of reducing the incidence of cancer and formally adding the outcome of improved patient experience.

What are the enablers and barriers that have made the difference between successful and disappointing implementation and outcomes?

A range of barriers and areas for improvement are articulated throughout the report. Networks are urged to focus on removing all possible barriers in their efforts to become more successful over time.

Specific barriers to implementation and outcomes identified by interviewees are:

- The model and the environment
- Lack of national oversight, national direction or national guiding documents
- Lack of mandate, the lack of authority
- Getting service providers to implement changes arising from the regional cancer network activities without any mandate or any discretionary funding to 'require' them to take action
- Multiple stakeholders and multiple competing priorities
- Difficulties in engaging with the primary care sector
- The paucity of evidence, data and technology at national, regional and local level.

Almost all interviewees mentioned the skills, competencies and attitudes of network personnel (particularly clinical leaders, network managers, network staff members, and regional stakeholder collaborative group chairpersons) as key enablers of success. The Minister of Health's focus on collaborative arrangements throughout the health sector is seen as giving the networks a good mandate to get the parties to the table. The network structure is also seen as an enabler: its ability to bring people together collectively; the independence of the networks; the independent thinking the network can bring to an issue; their ability to connect stakeholders together.

Networks could all do more with increased revenue, with more staff. The dedicated funding of the networks is seen as an enabler but limitations of resources were also seen as a barrier. There are inequities between the four networks when revenue is apportioned against the number of DHB districts they each cover and this will inevitably lead to barriers to those networks with more DHBs

or larger geographic regions. There would be merit in introducing a variable funding model to enable all four networks to operate on more of a level playing field.

What can we learn about how the networks can be improved and developed to add further value into the future?

The regional cancer networks have been allowed to develop differently, and they have. Over time they have become more aligned and national linkages with other agencies and between networks and the Ministry, particularly the New Zealand Regional Cancer Network Forum, are operating well. Despite this, establishing a mechanism to more formally link networks together – nationally and between regions - was the most commonly mentioned opportunity for improving and developing the regional cancer network model to add further value. Interviewees were not suggesting replacing the regional level or creating a top down hierarchy but rather strengthening and further developing existing arrangements. Their suggestions ranged from creating a virtual national network to a national network with regional offices. They felt this would provide greater alignment, connectivity, consistency, cooperation and collaboration between the networks and have the potential to reduce duplication of effort.

The greatest opportunities for improving and developing network activities are seen to be continuing to develop and expand the tumour stream work, further development of MDMs, and improving the interface between primary and secondary cancer services. Indications are that focusing more on the front end of the tumour pathways provides the greatest opportunities for reducing inequalities. Whilst it was outside the scope of this evaluation there appears to be an opportunity for the networks to lead the regional planning process for cancer control. Numerous other opportunities for further development are identified throughout this report.

What can we learn that will inform the development and implementation of other networks in the health sector?

Key factors identified by interviewees for building successful networks are:

- Allow sufficient time for the network to have a positive influence on outcomes
- Relationships, trust and a sense of collective identity
- Vision, passion and determination
- Inspire, lead and facilitate collaboration
- Communication is a critical mechanism for achieving collaboration
- Identify champions and bring people with you
- Good management and clinical leadership
- Representative governance structures and effective linkages
- Reduce duplication of effort
- Have a clear framework that identifies the network's goals, purpose, decision making processes and mandate
- Focus on a small number of goals
- Trust your stakeholders and empower them to add value
- Explore opportunities for a consistent model for Māori, consumer and primary care stakeholders to input into different networks.

There is considerable consistency between the advice our interviewees gave to those developing other health networks and the criteria for operating a successful network used in this evaluation. Hence we trust that many of the findings discussed throughout this report will be relevant to other networks.

Further evaluation work

Each of the regional cancer networks has received \$875,000 over the past four financial years to 'investigate and address systemic causes of cancer inequalities'. If such funding is going to continue beyond 2010/11 consideration could be given to undertaking a more focused evaluation of the impact of the reducing inequalities activities each regional cancer network has undertaken.

In order to more fully assess the impact of the regional cancer networks' activities, a more focused evaluation could be conducted of one of the activities all regional cancer networks are doing, for example the lung tumour stream work.

Further development to be done nationally or by the networks collectively

The issues and options for strengthening and further developing mechanisms for linking networks together nationally and between regions will need to be explored in more detail before decisions can be made.

A variable funding model needs to be developed to enable all four networks to operate more equitably and achieve the same outcomes. This should include a funding formula to target reducing inequalities funding to areas of greatest need if this funding is to continue beyond 2010/10.

Further development work for the networks to do individually or collectively

All four regional cancer networks need to develop:

- Monitoring and evaluation activities against the programme logic framework (incorporating the KPIs currently being developed by the regional cancer networks)
- Communication strategies to ensure stakeholders are well informed about network functioning and activities and to enable stakeholders to more easily determine which written or electronic material is relevant to them.

Traffic light report

Table 1 summarises the findings of the evaluation against each of the inputs, activities and the immediate, intermediate and ultimate outcomes of the work of the regional cancer networks as contained in the programme logic (Table 6).

As this evaluation pertained to the regional cancer networks collectively the status assigned to each of these criteria is a collective finding. Within each area one network may be doing better or worse than the others. Where this is the case it is noted in the detail of this report. The networks may choose to work on any of the red or orange areas individually or collectively.

Table 1 – Traffic light report

Evaluation criteria against logic model	Rating
Inputs	
Sufficient understanding of network purpose	
Sufficient commitment to and ownership of network from network stakeholders	
Good leadership	
Appropriately skilled and connected staff	
Sufficient funding	
Sufficient access to data/information	
Activities	
Communication – information dissemination and knowledge sharing	
Evidence based strategic and business planning	
Develop patient pathways	
Reducing inequalities focus in activities	
Monitoring and evaluation processes	
Develop and maintain governance structure	
Develop and maintain region-wide network groups and workstreams	
Ensure clarity of linkages and decision making processes within network	
Links with funding and planning	
National linkages	
Active involvement of cancer stakeholders in network groups / activities	
Primary care	
Māori	
Other ethnic groups	
NGOs and palliative care providers	
Consumers	
DHB clinicians	
Network members communicate, advocate, lead on network activities within their sector	
Appropriate quality improvement and service development opportunities identified and prioritised	

Immediate outcomes	
Stakeholders are better informed about cancer control	
Cancer stakeholders are more aware of cancer inequalities	
Increased use of quality improvement tools and methodologies	
Increased focus on the patient experience	
Increased access to information about cancer services for cancer providers	
Agencies and organisations providing cancer care have increased opportunities for information sharing	
Cancer stakeholders have more opportunities to identify and prioritise initiatives across the region	
Enhanced collaborative service planning across the region occurs	
Intermediate outcomes	
Improvements to patient flows – more streamlined and efficient referral processes	
Improved multidisciplinary approaches	
Improved co-ordination of service delivery between service providers	
Improved consistency of practice / services across the region	
Long-term (ultimate) outcomes	
Reduced incidence of cancer	
Reduced impact of cancer	
Reduced inequalities	
Improved patient experience	

Key

Excellent progress made	
Good progress made – opportunities for improvement	
Limited progress made – significant opportunities for improvement or change	

Introduction

This evaluation of the four regional cancer networks in New Zealand was commissioned by Cancer Control New Zealand (CCNZ). The Minister of Health directed CCNZ to undertake this evaluation in order to assess the implementation of the networks since their inception, to learn about how the regional cancer networks can be improved and developed to add further value into the future and to inform the development of other health networks.

CCNZ undertook an open tender process to choose an evaluator and Trio Consulting was selected to be the independent evaluator. A sub-committee of CCNZ committee members managed the evaluation.

This report is Trio Consulting's main output from the evaluation. The primary audience for this evaluation report is the Minister of Health, the Ministry of Health (the Ministry), CCNZ, regional cancer network managers, clinical directors and network group members.

The evaluation took place between April and August 2010, with the main data gathering phase occurring in June and early July 2010.

Cancer Control New Zealand wanted to have the following objectives addressed as part of the evaluation.

1. Describe the development and implementation of the networks and how these have changed over time, including
 - describing the forms and functions (structures developed and activities undertaken) and resources involved (eg budgets, staffing) for each network
 - linkages with other parts of the cancer control sector
 - similarities and differences between each network
2. Assess whether these forms and functions reflect the expectations for the networks over time, including
 - those listed in the Cancer Control Action Plan
 - the Ministry's objectives for all networks (eg Crown Funding Agreement (CFA), National Cancer Control Programme work plan)
 - the objectives stated for each network
3. Describe the factors that have influenced, both positively and negatively, the development and operation of the networks over time, including
 - assessing what roles key groups (including the Ministry, National Cancer Control Steering group, regional cancer networks' governance structures, DHBs, others) have played
 - assessing the influence of different network structures and processes
 - the impact of a changing environment (e.g. change of government, re-prioritisation, health sector structural reforms)

4. Ascertain whether the networks have actively involved key cancer sector stakeholders in their region including: the NGO sector, Māori, Pacific, clinicians, consumers, Primary Health Organisations and assess the value this has added.
5. Identify successes, failures and opportunities for improvement and further development (as they relate to each region and the cancer sector as a whole).
6. Determine the impact the networks have had, including:
 - whether they are having a positive effect on processes, on patient flows, on more efficient services
 - whether they are likely to reduce inequalities and to reduce the incidence and impact of cancer in the longer term.

The six objectives were translated into four overarching evaluation questions:

1. How well have the networks been implemented?
2. What outcomes have the networks achieved and how valuable are these to the cancer sector?
3. What are the enablers and barriers that have made the difference between successful and disappointing implementation and outcomes?
4. What can we learn:
 - a) about how the networks can be improved and developed to add further value into the future and
 - b) that will inform the development and implementation of other networks in the health sector?

These four overarching questions have guided the methodology and form the basis for the structure of this report. The report is in ten sections grouped together into four parts:

PART A	<ol style="list-style-type: none"> 1. Background and Context 2. Methodology 3. Describing the Networks
PART B	<ol style="list-style-type: none"> 4. Network Implementation 5. Stakeholder Engagement 6. Network Activities
PART C	<ol style="list-style-type: none"> 7. Network Outcomes 8. Network Value
PART D	<ol style="list-style-type: none"> 9. Enablers and Barriers 10. Learnings

PART A

1 Background and context

This first section of the report provides some background and context to the development of the regional cancer networks in New Zealand, outlines the key linkages with the rest of the cancer control sector and places the regional cancer networks in the context of the wider health sector.

1.1 Initial regional cancer network implementation activity

Cancer is a complex group of diseases and cancer control covers a broad continuum from primary prevention, screening, diagnosis and treatment to palliative care. In addition, effective planning, coordination, integration of resources and activities, monitoring and evaluation and research and surveillance are all key components of cancer control. There are a wide range of organisations and individuals involved in cancer control including: the Ministry, District Health Board (DHB) staff including funding and planning, operational management and hospital specialists and other clinical staff, primary care providers, public health specialists, non-government and Māori and Pacific organisations, hospices, private providers, researchers and consumers and carers. An integrated approach to cancer control requires all these organisations and individuals to work closely together and to develop a shared vision of how they can effect change in cancer control.

New Zealand's first Cancer Control Strategy, the 'New Zealand Cancer Control Strategy' (the Cancer Control Strategy) was published in 2003. In 2005 the Ministry released the Cancer Control Action Plan 2005 – 2010 (the Action Plan). The Action Plan listed 112 actions for implementation over the 5 year period 2005 – 2010 to meet the Strategy's objectives. It also identified 12 specific priorities for implementation in Phase 1 (the first one to two years). The first priority of the Action Plan was to: '*Establish regional cancer networks*'. Regional cancer networks were also identified as key stakeholders for many of the 112 actions in the Action Plan; however there was little detail in the Action Plan about the role and functioning of regional cancer networks.

In 2006, the first implementation activities were undertaken to develop four regional cancer networks: Northern, Midland, Central and Southern. These activities are outlined in an independent review undertaken by Trio Consulting for the Cancer Control Council (now known as CCNZ) in early 2007.¹

The review found:

- The Ministry had taken a support and facilitatory role in the development of regional cancer networks, leaving it to DHBs to decide the number, form and role of regional cancer networks in their region

¹ Regional Cancer Networks, Phase One Review

- The Ministry had released a number of documents relating to regional networks between early 2006 and early 2007 that appeared to be discussion documents reflecting thinking at a particular point in time, with changing definitions, terminology, objectives and suggested roles
- No overarching nationally agreed framework to guide implementation of the networks had been developed as this was considered to be too prescriptive and inappropriate
- The 21 (at the time) autonomous DHBs had successfully formed themselves into four regional cancer networks and were in the early stages of appointing clinical directors and network managers, and setting up network governance and other structures
- There were similarities and many differences in the way the regional cancer networks were being developed
- Regional cancer networks are complex structures, and were venturing into largely uncharted territory in terms of the degree of co-operation between DHBs and within the wider cancer control sector and they would require time and considerable skill and commitment to develop
- There was potential for confusion around the roles and responsibilities of the various groups involved in cancer control including the Ministry, regional cancer networks, the Cancer Control Council and DHBs.

A number of recommendations were made relating to regional cancer networks including: processes to clarify roles, responsibilities, linkages, communication flows and monitoring and review functions of the various parties in the cancer control sector; the development of a national framework; the establishment of a national collective of regional cancer networks; the undertaking of an on-going formative evaluation process.

Since that time the regional cancer networks have continued to develop and evolve as has the wider cancer control sector.

1.2 Regional cancer networks as part of wider cancer control

The Ministry provides specific funding for the regional cancer networks (via a CFA with four lead DHBs) and also advises the regional cancer networks on agreed priorities and monitors the regional cancer networks via quarterly reports (now six monthly) as well as its role in funding and monitoring District Health Boards (DHBs).

Since 2008, the Ministry has also led the development of a Cancer Control Programme. The Cancer Control Programme is a national programme that covers Ministry, DHB, and regional cancer network activity to implement the Government's priorities for cancer and the New Zealand Cancer Control Strategy. The Cancer Control Programme is governed by the Cancer Control Steering Group (CCSG), a joint Ministry and DHB group and receives advice on priority setting from a variety of advisory groups including the Cancer Treatment Advisory Group (CTAG) and the Palliative Care Advisory Group.

The governance and key responsibilities of stakeholders of the Cancer Control Programme are outlined in the following graphics.

Figure 1 – Governance for Cancer Control Programme

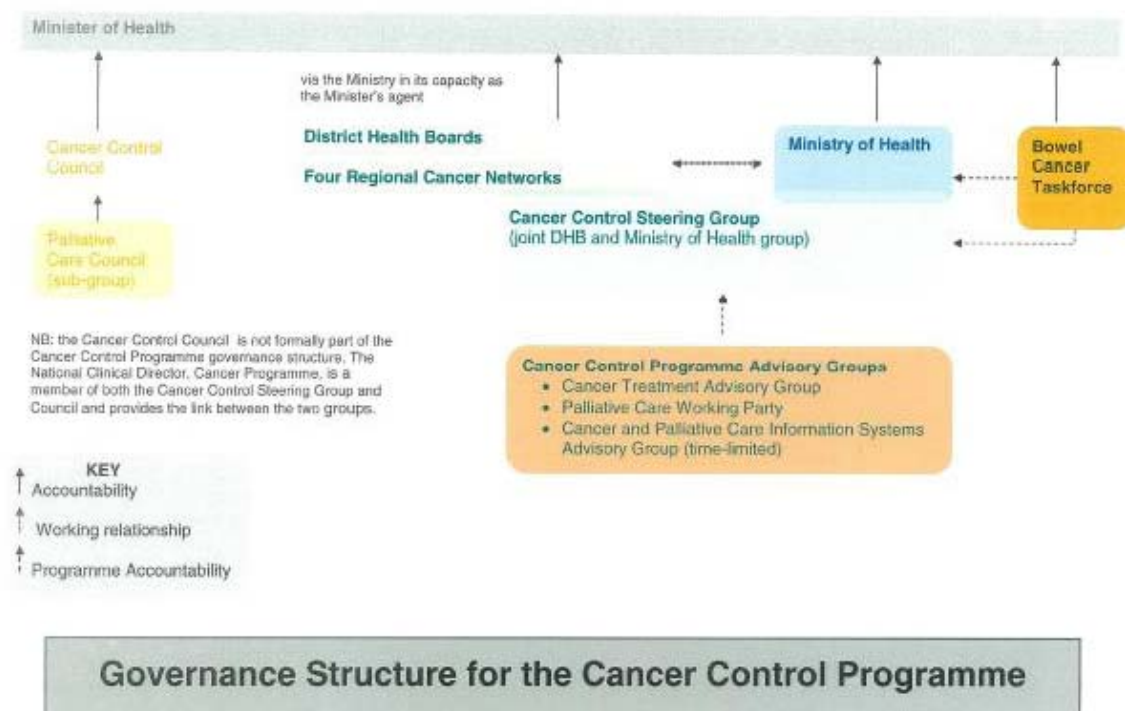
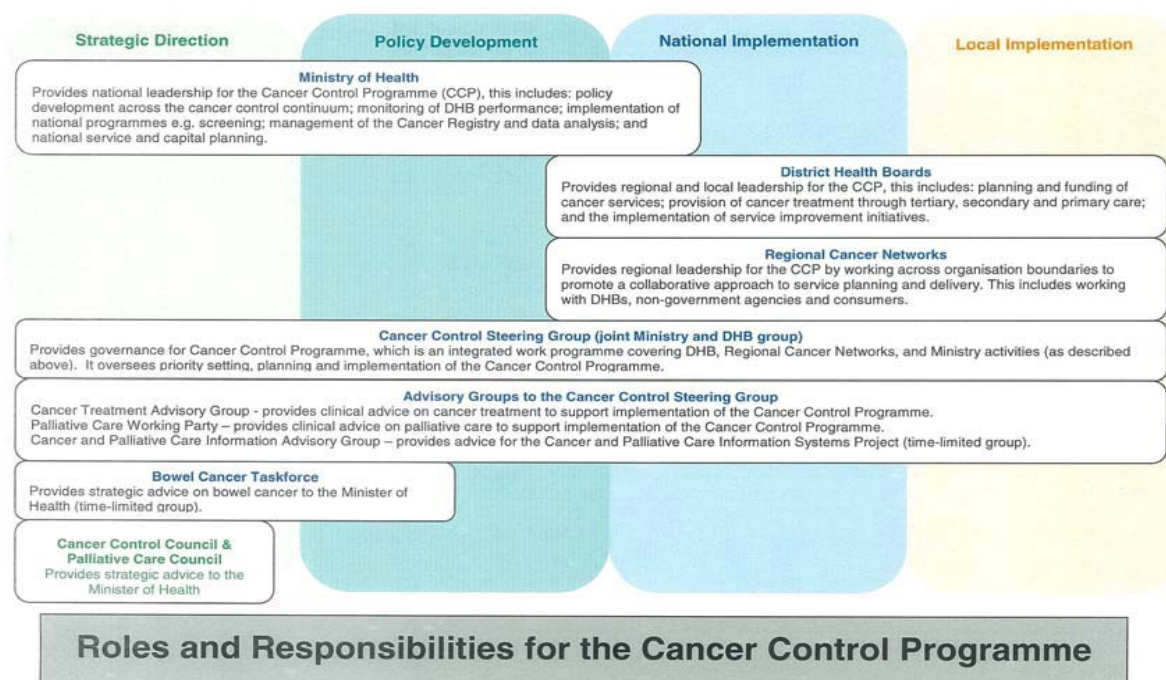


Figure 2 – Roles and responsibilities of Cancer Control Programme



In 2009, a 2009/10 Cancer Control Programme Work Plan was developed that covers the whole cancer continuum with a priority focus on lung and colorectal (bowel) cancer with the objective of improving treatment of priority cancers. The regional cancer networks have specific lead responsibilities within the “improve treatment of priority cancers” objective of this plan. A recently finalised 2010/11 work plan states a similar set of responsibilities for regional cancer networks. This work plan has superseded the Action Plan as the key national implementation document driving priorities in the cancer control sector.

Cancer Control New Zealand (CCNZ) formed as the Cancer Control Council in 2005 and changed to its current form in February 2010. CCNZ is a Ministerial Advisory Committee providing an independent and sustainable focus on cancer control through strategic advice to the Minister of Health.

Individual DHBs have a key role to play in the cancer control sector as funders and providers of local cancer services. DHBs are responsible for assessing the health and disability needs of their community and managing resources and service delivery to best meet those needs for their population, and are accountable to the Ministry via a District Annual Plan (DAP). As such, all service funding and planning decisions relating to cancer rest with each of the individual 20 DHBs. Over the last several years as the regional cancer networks have been developing, the DHBs have been operating in a fiscally constrained environment.

NGOs, hospices, Māori and Pacific providers and primary care providers / PHOs also play a key role in cancer control in New Zealand and one of the key reasons for setting up regional cancer networks was to more closely involve this wider sector in a co-ordinated way.

1.3 Regional cancer networks as part of the wider health sector

The regional cancer networks were set up and continue to operate within a health sector that is primarily localised via the DHB structure.

There are few other regional infrastructures operating in the current health sector. All regions have regional shared service agencies, although the boundaries of these do not line up exactly with the regional cancer network boundaries. These regional agencies have taken on varied roles and responsibilities across the country, including audit, service planning and analysis functions in some clinical areas.

In January 2009 the Minister of Health commissioned a review of the health and disability system. The Ministerial Review Group made a number of recommendations focusing on the following themes:

- Stronger clinical leadership in decision-making
- Accelerating improvements in quality and safety
- Higher system performance and secure future sustainability
- Improved national and regional service planning and decision-making
- Minimising administrative costs and reducing bureaucracy and waste².

² <http://www.moh.govt.nz/moh.nsf/indexmh/aboutmoh-changes2009>

According to the Ministry's website these decisions have already resulted in a number of changes in the way the health and disability system is organised including the establishment of the National Health Board as a business unit within the Ministry.

The Ministerial Review Group saw clinical networks as one of the key avenues for making changes to models of care. The Horn report states:

Clinical networks, which often also include managers and consumers, have been successful in some specialty areas in improving the coordination of care to deliver a more seamless experience for patients. For example, the regional cancer networks are important in bringing together all of the key people involved in caring for cancer patients in a way that can help address the problems created by fragmented care. More should be done to develop the influence of existing networks and develop new networks.

The regional cancer networks are the first comprehensive regional network of this type to operate in New Zealand and are a new way of working, bringing together as they do a range of organisations and roles from funding and planning to providers across the DHB, primary care and NGO sectors with consumers to collaborate regionally.

There is increasing interest in clinical networks as a mechanism to improve service planning and clinical governance within the New Zealand health sector. Policy development work is underway within the Ministry to develop national clinical networks and in the future more regional clinical networks.

2 Methodology

This section of the report summarises the methodology chosen for this evaluation. Further detail can be found in Appendix A.

2.1 Evaluation context

The following factors influenced the scope of the evaluation and dictated the methodology chosen.

Firstly, the evaluation needed to build on and not duplicate evaluative activity that was already progressing. Several of the regional cancer networks had developed outcomes frameworks as part of their strategic planning and the regional cancer networks and the Ministry have been collectively working on the development of key performance indicators that include wait-times, intervention rates, and patient experience survey results. In addition, the regional cancer networks have been charged with reporting on priority tumour (lung and colorectal) wait times and proportion of patients discussed at multi-disciplinary meetings as part of the Cancer Control Programme Work Plan. The initial baseline data for this was first collected in late 2009. Further work was occurring in 2010 to ensure consistent data definitions and collection could occur in the future and hence this was not available for this evaluation. In addition, the Ministry's monitoring of regional cancer network performance did not provide any additional data that could be used to evaluate network activity over and above what could be found in network quarterly reports.

Despite the recommendations of the 2007 review by CCNZ, no single overarching framework has been developed for the regional cancer networks and no formative evaluation had been undertaken prior to the commissioning of this evaluation. Because of this there was no consistent programme logic or evaluation framework that the regional cancer networks were all working within that clearly described how the activities of the network linked to the immediate, intermediate and ultimate outcomes and what indicators could be used to assess the achievement of these outcomes. Therefore no baseline data (other than the very recent intermediate outcome data) had been collected against which to assess the regional cancer networks' progress on these outcomes.

Secondly, the nature of the cancer control sector meant that there were a large variety and number of stakeholders to involve, including Ministry staff, DHB funding and planning, operational management and clinical staff, as well as NGOs, consumers, primary care providers, Māori, Pacific and hospice stakeholders. These stakeholders needed to be involved in each of the four network regions.

Thirdly, initial interviews with key network staff and a high level review of documentation found a wide range of activity being undertaken by each network, much of which had only commenced in the last 12 months, and significant differences in the types of activities being undertaken across the four networks.

And finally, this evaluation was required to be undertaken in a short time frame and therefore there was no opportunity to measure change over time within this particular evaluation.

2.2 Evaluation scope and focus

Given the evaluation context and the objectives to be addressed, the methodology required:

- The development of a framework whereby the regional cancer networks could be appropriately rated against a set of common criteria relevant to all networks regardless of the specific activity undertaken in each
- Gathering key stakeholder opinion about the functioning and outcomes of the networks given that there was no time for a longitudinal approach that collected and measured more objective indicators over time
- An inclusive approach, allowing those who wanted to have a say an opportunity to do so
- A comprehensive look at the functioning and immediate outcomes of the networks, given that data was already being collected that would inform an understanding of the intermediate outcomes that the regional cancer networks were working towards.

The focus of the evaluation was on assessing the success (or otherwise) of the implementation of the regional cancer network initiative in New Zealand as a whole, rather than an individual assessment of each cancer network separately.

The evaluation was primarily a process evaluation focusing on describing and assessing what has occurred in the development of the regional cancer networks implementation to date, with some consideration of outcomes. It was acknowledged by the CCNZ subcommittee that this evaluation was occurring still relatively early on in the development of regional cancer networks and hence it was not expected that there would be significant outcomes achieved to date, particularly seeing as many initiatives had only recently been initiated and were just beginning to gain momentum. The evaluation included many formative components, such as the development of a programme logic with the regional cancer networks, and a focus on learning what could be improved in the future development of the networks. In fact many respondents commented that they found the process of participating in the evaluation very helpful in their own thinking about network functioning.

It was beyond the scope of the evaluation to undertake a full literature review, although some key literature was reviewed³ in the development of the key criteria against which to assess the network's implementation.

³ Government Policy on the Development of Clinical Networks. Health Report 20100236. Ministry of Health. 2010
Innes J, Hughes H (2009). Health Networks Literature Review. Stratum Ltd for Central TAS
Siggins Millar (2008) Literature Review of Managed Clinical Networks. Developed for Cancer Australia.
Goodwin N, Peck E, Freeman T, Posaner R (2004) Managing Across Diverse Networks of Care: Lessons from Other Sectors. Final report to the NHS SDO R&D Programme, Health Services Management Centre, University of Birmingham
Williams B (2003) A review of collaborative relationships between government agencies and community organisations. Networks, Collaborations, Coalitions and Partnerships.
Cancer Service Networks National Demonstration Program (CanNET) Evaluation Tool. Siggins Miller. Australia
Partnership Self Assessment Tool. Centre for the Advancement of Collaborative Strategies in Health.
Assessing Strategic Partnerships. Partnership Assessment Tool. Nuffield Institute for Health. UK
Collaboration Factors Inventory. Wilder Research. Amherst Wilder Foundation. US

It was also beyond the scope of the evaluation to describe and evaluate each individual project that each network had undertaken. Rather the focus was on the contribution the networks make as a system to achieving their own immediate outcomes and the wider sector's intermediate outcomes. Case studies were recommended by the evaluators to be included as part of the evaluation to look more closely at specific activities all networks had undertaken (specifically of the lung cancer work groups and the reducing inequalities activities) but it was decided by the CCNZ evaluation subcommittee that this was outside the scope of the current evaluation.

2.3 Evaluation overview

The evaluation process included the following key activities, designed to fit the context, timeframe and budget for the evaluation. The aim was to use a mixed method approach, allowing a triangulation of data from different sources to build up a comprehensive picture of the functioning and immediate outcomes of the regional cancer networks. The evaluation methodology drew from international examples of evaluations of network functioning and included:

1. Key informant interviews and high level documentation review to understand the scope of regional cancer networks' role and functioning
2. Agreement of the evaluation methodology with CCNZ sub-committee
3. Development of an overarching programme logic and set of key criteria to assess regional cancer network functioning and outcomes against at a national level
4. Data collection including:
 - a) Qualitative face to face or telephone interviews and email questionnaire with key stakeholders from each network including the lead CEO, chairperson of the regional stakeholder collaborative group, Network Manager and Clinical Director(s) as well as a clinical, NGO, Māori, consumer and primary care representative and interviews with Ministry staff and CTAG chairperson
 - b) Email questionnaire to a representative from each of the 20 DHB funding and planning and operational staff and local cancer network representatives as well as others on the regional stakeholder collaborative group of each network not already interviewed
 - c) An on-line survey sent to all cancer sector stakeholders on each of the network's databases
5. Analysis of documentation, interviews, and survey results
6. Reporting of findings.

Both qualitative and quantitative approaches were undertaken, although the focus was on the rich source of information able to be collected via qualitative interviews with key network stakeholders as these were the people best able to provide feedback on network implementation and articulate key learnings for the future. Consistent quantitative questions were asked of all qualitative interviewees as well as being included in the email questionnaire and on-line survey as an efficient way to collect data from large groups of people and these are presented in charts in this report. It was beyond the scope of this evaluation to undertake any statistical analysis of these quantitative questions.

In summary, the evaluation included responses from five methodologies across the four networks, as shown in Table 2:

Table 2 – Method in which responses were obtained

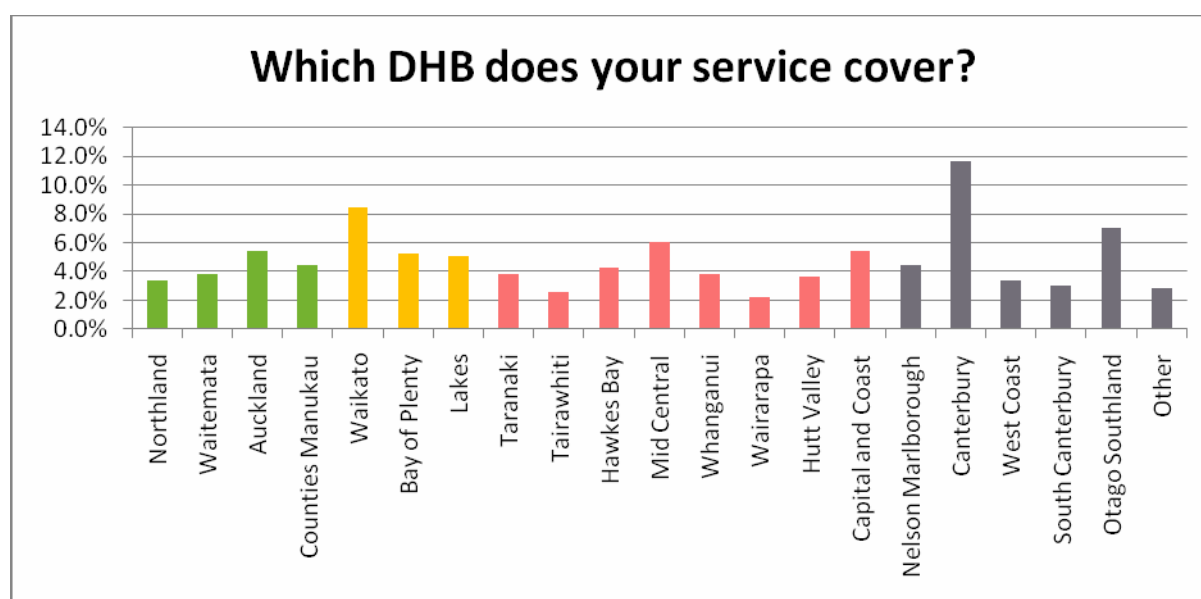
	Northern	Midland	Central	Southern	Other	Total
Key informant interviews	2	1	1	2	1	7
Qualitative interviews (face to face or telephone)	8	9	9	9	2	37
Questionnaires completed by qualitative sample group	5	8	8	7		28
Email questionnaire	10	7	12	13		42
On-line survey	42	63	96	92		293

Further details of the methodology, sample size, response rates, and question types can be found in Appendix A.

2.4 Summary of evaluation participants

Across all the stakeholder interviews (qualitative, email and on-line), representation was achieved across all DHB regions, as outlined in Figure 3.

Figure 3 – Representation of sample across DHB area



The sample also included representation from the various stakeholder groups within the regional cancer networks and from the various roles in the sector as outlined in the following two summary charts of those who completed the quantitative questions (excluding lead CEO of each network, Ministry staff and chairperson of CTAG).

Table 3 – Stakeholder representation of respondents

	Total		Northern		Midland		Central		Southern	
NGO	43	11.6%	8	14.5%	5	6.8%	17	15.2%	13	11.9%
Consumer	25	6.8%	7	12.7%	3	4.1%	11	9.8%	4	3.7%
Māori provider	10	2.7%	1	1.8%	0	0.0%	8	7.1%	1	0.9%
Pacific provider	1	0.3%	0	0.0%	0	0.0%	1	0.9%	0	0.0%
PHO / primary care provider / GP	25	6.8%	2	3.6%	6	8.1%	6	5.4%	11	10.1%
DHB operational management	33	8.9%	3	5.5%	9	12.2%	13	11.6%	8	7.3%
DHB funding and planning	38	10.3%	9	16.4%	6	8.1%	15	13.4%	8	7.3%
DHB clinician	82	22.2%	13	23.6%	20	27.0%	18	16.1%	31	28.4%
DHB other staff member	57	15.4%	8	14.5%	16	21.6%	10	8.9%	23	21.1%
Shared service agency	3	0.8%	0	0.0%	0	0.0%	1	0.9%	2	1.8%
Network staff member	11	3.0%	2	3.6%	2	2.7%	4	3.6%	3	2.8%
Hospice	22	5.9%	2	3.6%	7	9.5%	8	7.1%	5	4.6%
Other	20	5.4%	2		6		6		6	

Table 4 – Role on network (multiple responses allowed)

	Total		Northern		Midland		Central		Southern	
I am on the network's governance/executive/steering group	53	12.2%	11	20.4%	14	18.4%	14	12.3%	14	12.8%
I am a member of one of the regional cancer network's other regional groups	89	20.6%	23	42.6%	25	32.9%	27	23.7%	14	12.8%
I am a member of a local cancer network group (at DHB level)	130	30.0%	18	33.3%	23	30.3%	44	38.6%	45	41.3%
I am actively involved in a cancer network project but not on any group	31	7.2%	7	13.0%	4	5.3%	15	13.2%	5	4.6%
None of the above	130	30.0%	14	25.9%	25	32.9%	37	32.5%	54	49.5%

2.5 Limitations of the method

The methodology attempted to capture the views of the most important network stakeholders while also providing the opportunity for the wider sector to have input. The evaluation method managed to achieve good representation and should therefore be able to be relied upon as being a fair reflection of the regional cancer networks.

While it was possible to ensure a representative sample of the most important stakeholders via the qualitative interviews, response bias from the email questionnaire and the on-line survey was not able to be controlled in the method used. While multiple attempts were used to follow up the email questionnaire recipients (which were very similar for each network) there did not end up being identical representation from each network responding. And in the on-line survey there was no way of controlling who responded.

There are therefore some differences both in the total number of responses and the representation across the sector for each network. For this reason we have used an average response across all four networks in representing the answers to the quantitative questions and have not provided responses by network as the underlying samples are not the same. The only place where network specific quantitative results are displayed graphically is in the network activities section of the report and caution should be taken in comparing network results due to this underlying difference in samples. As with any survey we also do not know the opinion of those who didn't respond and how it may be similar or different to those who did.

The quantitative results presented in this report should be viewed as supporting the rich source of information provided by the qualitative conversations with the key stakeholders for each network.

3 Describing the regional networks

This section of the report provides a high level overview of the regional cancer networks in New Zealand. More detail about the structure and activities of the networks can be found in Part B of the report.

3.1 Geography

The four regional cancer networks in New Zealand are divided as shown in the following diagram.

Figure 4 – Map of regional cancer network boundaries



In the developing stages of the regional cancer networks it was left up to DHBs to determine the number and geographical composition of the regional cancer networks. As a consequence there are disparities between the geographical spread and the number of DHBs within each regional network.

Table 5 summarises the geographical spread of the four networks and their relationship to the publicly funded regional cancer centres and regional shared service agencies.

Table 5 – Geographical spread of regional cancer networks

	Northern	Midland	Central	Southern
Number of DHBs	Four	Three	Eight	Five
Which DHBs	Northland Auckland Waitemata Counties Manukau	Waikato Lakes Bay of Plenty	Taranaki Tairāwhiti Hawkes Bay Whanganui Midcentral Wairarapa Hutt Valley Capital and Coast	Nelson Marlborough Canterbury West Coast South Canterbury Southern
Area covered	Smallest	Third largest	Second largest	Largest
Population coverage	Covering 1.54 million people, representing 37% of NZ population ⁴	Covering 632,000 people, representing 16% of NZ population ⁵	Covering 983,000 people, representing 24% of NZ population ⁶	Covering 985,000 people, representing 24% of the NZ population ⁷
Public regional cancer centres	One regional cancer centre (Auckland Hospital)	One regional cancer centre (Waikato Hospital) BOP cancer centre established Sept 2008 (Tauranga Hospital)	Two regional cancer centres (Palmerston North and Wellington Hospitals)	Two regional cancer centres (Christchurch and Dunedin Hospitals)
DHB shared service agencies	NDSA Same DHBs involved	HealthShare Owned by five Midland DHBs	TAS TAS does not include Tairāwhiti and Taranaki DHBs	SISSAL Same DHBs involved
Cross boundary issues	No cross boundary issues	Taranaki and Tairāwhiti (part of Central network) have an open invitation to link into the Midland network for specific patient flows	Taranaki and Tairāwhiti link into the Midland network for specific patient flows Nelson Marlborough also links with Central network activity for specific patient flows into the Central region ⁸	Nelson Marlborough DHB has open invitation to participate as required in the Central network due to specific patient flows.

⁴ Northern Health Needs Assessment August 2009

⁵ Midland Cancer Network Health Needs Assessment. 2009

⁶ Central Cancer Network Health Needs Assessment 2009

⁷ Southern Cancer Network Strategic Plan – October 2009

⁸ An MOU exists to manage this overlap

3.2 Purpose and objectives

There is no single consistent overarching purpose stated for the regional cancer networks. The Action Plan, Cancer Control Programme Work Plan, the CFA and each individual regional cancer network's strategic plan each have slightly different ways of describing the regional cancer networks' purpose. Hence the following description has been developed by the evaluators and draws from all these sources and is outlined here to introduce the role of the networks to readers not overly familiar with the regional cancer networks.

The overall objective of the regional cancer networks is to work across organisational, service and professional boundaries to promote a collaborative approach to service planning and delivery across the region with the aim of reducing the incidence and impact of cancer, reducing inequalities with respect to cancer and improving the patient experience.

Further detail about the purpose of the networks is included in section 4.2.

3.3 Programme logic model

The following programme logic (also often known as an outcomes framework) was developed as part of this evaluation to describe the inputs, activities and the immediate, intermediate and ultimate outcomes of the work of the regional cancer networks. It is a working model that can be developed further by the regional cancer networks to reflect understanding and practice over time. Further detail about how the model was developed can be found in Appendix A.

It is important to note that actual implementation of initiatives is the role of the constituent members of the network (eg DHBs, primary care providers, NGOs etc) and as such the intermediate and ultimate outcomes are those of the sector, not solely of the regional cancer networks. Other activity of DHBs, primary care providers and NGOs, independent of network initiated activity may also be contributing to these outcomes.

The network's role can be seen as leading and facilitating the change management process required to implement initiatives in the sector that the network has identified, and prioritised initiatives that lead to these intermediate and ultimate outcomes.

Table 6 – Programme logic model for regional cancer networks

	Inputs	Activities of the network	Immediate Outcomes ⁹	Activities of the sector	Intermediate Outcomes ¹⁰		Ultimate Outcomes
Network management team (employed staff)	Sufficient funding	Communication – information dissemination and knowledge sharing ¹¹	Stakeholders are better informed about cancer control Cancer stakeholders are more aware of cancer inequalities	Appropriate quality improvement and service development initiatives are implemented	Improvements to patient flows – more streamlined and efficient referral processes	Reduced risk factors**	Reduced incidence of cancer
	Sufficient access to data / information	Evidence based strategic and business planning ¹²			Improved multidisciplinary approaches	Improved early detection* *	
Network structure (cancer stakeholders)	Good leadership	Develop patient pathways	Increased use of quality improvement tools and methodologies Increased focus on the patient experience		Improved co-ordination of service delivery between service providers	Improved cancer treatment (for priority cancers)**	Reduced impact of cancer
	Appropriately skilled and connected staff	Promote quality improvement methodologies and tools Reducing inequalities focus in activities ¹³ Monitoring and evaluation processes			Improved consistency of practice / services across the region	More timely access to services (improved wait times)**	
	Sufficient understanding of network purpose	Develop and maintain governance structure	Increased access to information about cancer / cancer services for cancer patients* Increased access to information about cancer services for cancer providers		Reduced duplication of services*	Improved supportive care	Improved patient experience
	Sufficient commitment to and ownership of network from cancer stakeholders	Ensure clarity of linkages and decision making processes within network Active involvement of cancer stakeholders in network groups / activities			Development of cancer workforce*	Improved research and surveillance	
	Well functioning network management team	Network members communicate, advocate, lead on network activities within their sector	Cancer stakeholders have more opportunities to identify and prioritise initiatives across the region Enhanced collaborative service planning across the region occurs				
	Sufficient funding	Appropriate quality improvement and service development opportunities identified and prioritised					

⁹ Those identified with an * not included in evaluation as not started yet

¹⁰ Intermediate Outcomes Column One includes outcomes derived from the CFA (note those identified with an * are not included in this evaluation upon advice from the network managers and clinical directors as these are areas that the networks have not been active in since their inception). Column Two includes outcomes from the Cancer Control Programme Work Plan (**) and also those from the Cancer Control Strategy.

¹¹ Including cancer control information, service data, service directories, patient educational material etc

¹² Including evidence based data, information and advice provided to guide prioritisation within network and for use by cancer sector stakeholders and identification of gaps and barriers to performance across existing services

¹³ These are outlined in Section 3 of the CFA – Appendix C'

3.4 Network structure and activities

In the three years since the 2007 review, each network has developed the following infrastructure to enable it to meet its overall objectives and achieve its outcomes:

- A network structure, including:
 - A regional collaborative / governance / steering / executive group with linkages through a lead CEO to the DHB CEOs group for the region (known throughout this report as the regional stakeholder collaborative group)
 - Local cancer networks
 - Tumour work stream groups focusing on quality improvements for specific cancers
 - Other network groups that meet on a regular basis (either project based or on-going), including for example consumer and Māori leadership groups, service development groups
 - Linkages with existing groups in the region (e.g. funding and planning managers group)
 - A website for sharing information
 - A database of people that the network communicates with
- A network management team who facilitates the work of the network groups and undertakes additional activities

Appendix B outlines the overall structure diagram of each network, and further detail about the structure of each network can be found in sections 0 and 5 of the report.

The networks did not all start at the same time and did not all develop this infrastructure at the same rate. Midland Cancer Network evolved from an existing non-surgical treatment service group in 2006 whereas the other networks developed entirely new infrastructure, with Southern only fully forming in 2009.

The network groups have undertaken a wide range of activity, facilitated by the network management team. In addition, the network management team has itself undertaken a range of activities. A summary of these activities can be found in section 0 of the report.

3.5 Resources available to the regional cancer networks

The regional cancer networks are funded to operate primarily via a Crown Funding Agreement variation (CFA) with the Ministry (see Appendix C: Crown funding agreement for the detail of this). Prior to 1 July 2007, each DHB received implementation funding for the development of regional cancer networks and aggregated this together to fund network development in each region. From 1 July 2007, one DHB in each region was designated as the Lead DHB and this DHB receives the funding for the operation of the regional cancer network. This core funding of \$250K per annum is used to pay staff, run the network structure (including the facilitation and secretariat of groups and other network infrastructure such as the website and communications) and undertake project activities.

In 2008, specific funding was added to allow the networks to focus on reducing inequalities (\$250K per annum) and to source data analysis capacity (\$50K per annum) and this will continue until the current CFA expires in June 2011.

In 2009, the Ministry funded specific cancer initiatives via a Cancer Development Fund. Some regional cancer networks applied for and received funding for specific projects from this fund. In addition, some regional cancer networks have sourced funding from other sources. Table 7 outlines the high level income and expenses of the regional cancer networks over the last four years, and has been provided by network managers.

Table 7 – Summary of budgets for each regional cancer network

		Northern	Midland ¹⁴¹⁵	Central	Southern
2006/7					
Income	Core revenue	250,000	250,000	250,000	250,000
Expenditure	Salaries	0	164,729		0
	Other costs	0	52,344		0
	Total expenditure		217,073	70,000	
Net surplus (deficit)		250,000	32,927	180,000	250,000
2007/08					
Income	Unspent rollover	162,574		180,000	250,000
	Core revenue	250,000	250,000	250,000	250,000
	Reducing inequalities	125,000	125,000	0 ¹⁶	125,000
	Data projects	25,000	25,000	0	25,000
	Other income		90,000 ¹⁷		
	Total income	650,000	490,000	430,000	650,000
Expenditure	Salaries	162,574	379,796	277,000	99,242
	Other costs	49,499	100,848	22,000	54,498
	Total expenditure	212,073	480,644	299,000	153,740
Net surplus (deficit)		437,927	9,356	131,000	496,260

¹⁴ Note this budget does not include funding for facilitation of the Waikato Palliative Care Network that the regional cancer network manager is also responsible for

¹⁵ Accounting internal recharge and outsourced rule changes over the 4 years, overhead charges not included in accounts therefore an estimation has been made

¹⁶ Agreement between MDHB and MoH to defer new reducing inequalities and data funding to 08/09

¹⁷ Waikato AYA CFA one off fund for establishing regional service

		Northern	Midland ¹⁸¹⁹	Central	Southern
2008/09					
Income	Unspent rollover	437,927		131,000	496,260
	Core revenue	250,000	250,000	250,000	250,000
	Reducing inequalities	250,000	250,000	250,000	250,000
	Data projects	50,000	50,000	50,000	50,000
	Other	100,000 ²⁰	7,959 ²¹	163,000 ²²	
	Total income	1,087,927	557,959	844,000	1,046,260
Expenditure	Salaries	485,503	441,912	491,000	361,408
	Other costs	162,316	153,133 ²³	82,000	106,056
	Total expenditure	647,819	595,045	573,000	467,464
Net surplus (deficit)		440,108	(37,086)	271,000	578,796
2009/10					
Income	Unspent rollover	440,108		271,000	578,796
	Core revenue	250,000	250,000	250,000	250,000
	Reducing inequalities	250,000	250,000	250,000	250,000
	Data projects	50,000	50,000	50,000	50,000
	Other	494,952 ²⁴	176,193 ²⁵	83,000 ²⁶	1,938 ²⁷
	Total income	1,485,060	726,193	904,000	1,130,734
Expenditure	Salaries	758,870	395,982	450,000	429,046
	Other costs	389,555	258,020	328,000	197,226
	Total expenditure	1,148,425	654,002	778,000	626,272
Net surplus (deficit)		336,635	72,191	126,000	504,462
2010/11 budget					
Income	Unspent rollover	336,635		126,000	504,462
	Core revenue	250,000	250,000	250,000	250,000
	Reducing inequalities	250,000	250,000	250,000	250,000
	Data projects	50,000	50,000	50,000	50,000
	Other	392,263	38,498 ²⁸		86,200 ²⁹
	Total income	1,278,898	588,498	676,000	1,140,662
Expenditure	Salaries	672,852	469,632	498,000	493,131
	Other costs	621,896	100,336	172,000	498,720 ³⁰
	Total expenditure	1,294,748	569,968	670,000	991,851
Net surplus (deficit)		(15,580) ³¹	18,530	6,000	148,811

¹⁸ Note this budget does not include funding for facilitation of the Waikato Palliative Care Network that the regional cancer network manager is also responsible for

¹⁹ Accounting internal recharge and outsourced rule changes over the 4 years, overhead charges not included in accounts therefore an estimation has been made

²⁰ APRHS funding for Public health registrar

²¹ \$7818 subcontracted project manager to MidCentral DHB for establishing AYA service, \$141 other

²² Deferred funding from 2007/08 \$150,000 plus \$13,000 from Genesis oncology trust for prostate project

²³ Does not include one off capital set up costs over 2007-2009 of \$82,117

²⁴ \$70,000 MoH funding for early presentation of lung cancer project, \$424,952 for HRC research project

²⁵ \$174,500 MoH Cancer Service Development Fund, \$1693 other

²⁶ MoH Cancer Service Development Fund

²⁷ MoH Cancer Service Development Fund

²⁸ \$37,160 MoH Cancer Service Development Fund, \$1,338 other

²⁹ MoH Cancer Service Development Fund

³⁰ Includes SICR and addressing inequalities pilot funding from 2010/11

³¹ Note deficit relates to HRC funded research project, costs will be recovered from the 2011/12 HRC revenue

Part B

4 Network implementation

How well have the regional cancer networks been implemented?

This section of the report outlines how the regional cancer networks rate on key criteria associated with successful network functioning.

4.1 Evaluation criteria

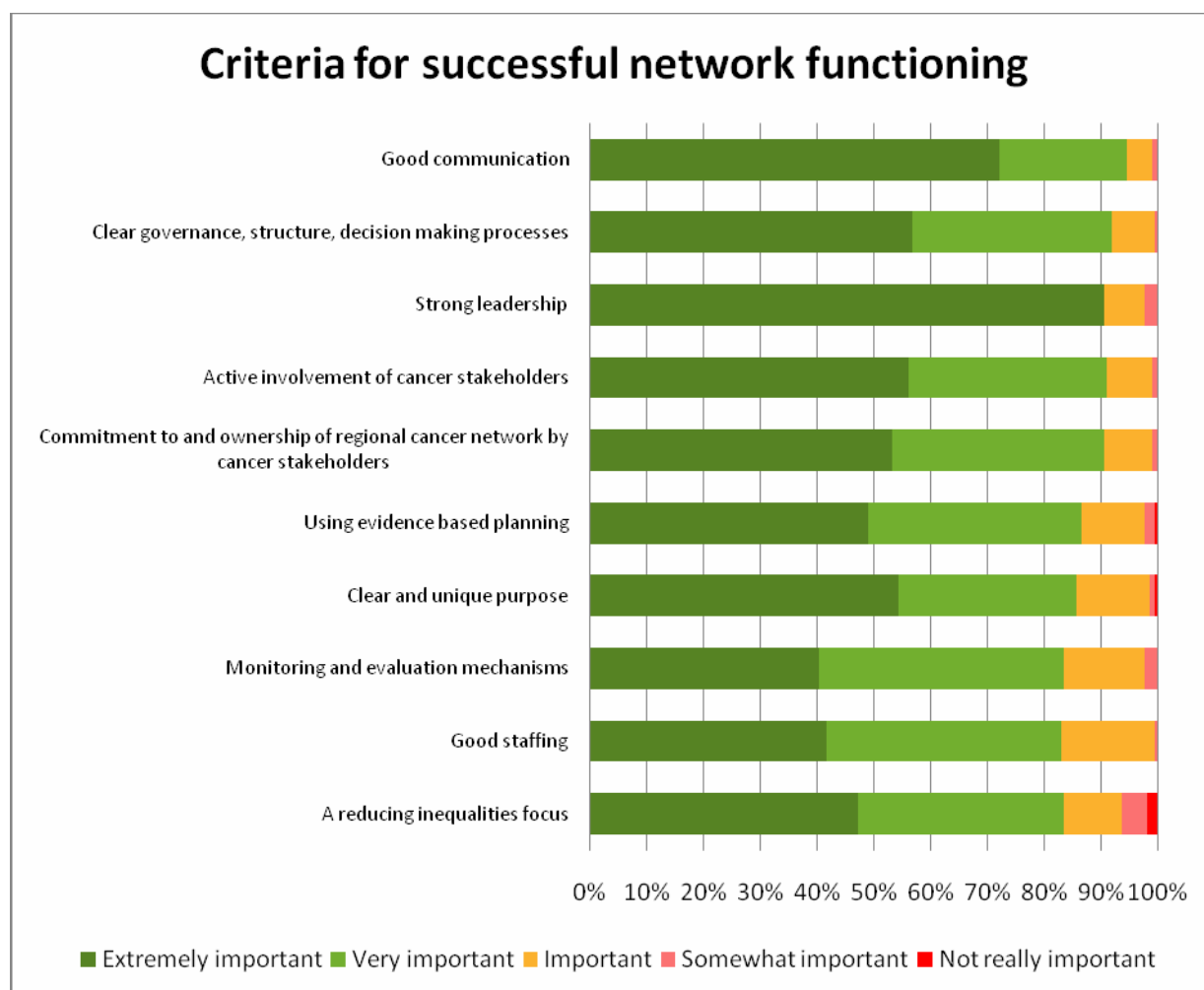
The criteria chosen to assess how well the networks have been implemented have been drawn from the programme logic model (Table 6), confirmed as important in the literature and agreed to by network managers and clinical directors. They include:

- Clear and unique network purpose
- Commitment to network from cancer stakeholders
- Clear governance, structure and decision-making processes
- Active involvement of cancer stakeholders
- Leadership
- Staffing
- Communication
- Evidence-based planning, prioritisation and decision making
- Reducing inequalities focus in activities
- Monitoring and evaluation processes.

To further validate the use of these criteria, all those who responded to the survey who were part of a regional or local cancer network group or project were asked to assess the importance of these criteria to successful network functioning.

The following chart (Figure 5) illustrates the responses from the 224 people who answered this question, confirming that all the criteria used to assess network functioning are considered important to the sector.

Figure 5 – Criteria for successful network functioning (in order of extremely and very important)



Specific questions were developed relating to these criteria, drawn in part from a variety of international tools used to assess networks, collaboratives and partnerships.³² The combined results of these questions for all networks (presented as an average of results for each of the four networks) are outlined in graphic form in sections 0 and 5. In addition, qualitative discussion (from either the open ended questions in the survey or face to face or telephone discussions) and the review of regional cancer network documentation also informed the analysis of the regional cancer networks on these criteria.

³² Including:

- Cancer Service Networks National Demonstration Program (CanNET) Evaluation Tool. Siggins Miller. Australia
- Partnership Self Assessment Tool. Centre for the Advancement of Collaborative Strategies in Health.
- Assessing Strategic Partnerships. Partnership Assessment Tool. Nuffield Institute for Health. UK
- Collaboration Factors Inventory. Wilder Research. Amherst Wilder Foundation. US

4.2 Clear and unique purpose

4.2.1 Introduction

It is important in a network when people are coming together, that they are clear about what it is they are trying to achieve collectively and how this is different to what they or other parts of the sector are responsible for achieving alone.

The key questions here are:

1. Do the regional cancer networks have a clear and unique purpose?
2. Do stakeholders understand what that purpose is?
3. Are the networks doing work that is unique to them?

4.2.2 Conclusions

All regional cancer networks have a clearly written statement of purpose but there is no single consistent wording across the different networks and national documentation, although they do appear to follow consistent themes.

The networks have broadened their purpose beyond facilitating regional collaboration of service planning and delivery to also focus on improving patient information and experiences.

There appears to be some belief that regional cancer networks are doing work that fits more with the purpose of other stakeholders and therefore there is work to be done to ensure the networks are focusing on work that is unique to them.

In general cancer stakeholders have a reasonable understanding of the broad purpose of the regional cancer networks and this aligns with the objectives outlined for each network.

There is however room to better communicate the networks' unique purpose to network stakeholders and having a consistent statement would aid this.

4.2.3 Evidence and discussion

The first indications of the intended purpose of the regional cancer networks are contained in the Action Plan in statements such as:

- *Enhance cooperation and collaboration for cancer control*
- *Formally recognise the current informal collaboration between cancer control agencies*
- *Facilitate the coordination of services across the health providers at the primary, secondary and tertiary levels*
- *Bringing the various providers and consumer organisations together to ensure effective cooperation and the integration of services, where appropriate*
- *Provide a mechanism for organisations and people to work with each other to plan and coordinate services in line with clearly defined national standards of treatment*
- *Provide a forum to look at issues that are of particular concern to patients, such as referral patterns, access and service provision.*

The Ministry website has the following statements of purpose. The first three of these are almost word for word from the Action Plan:

The New Zealand Cancer Control Strategy Action Plan identified the need to develop formal regional structures that would enhance cooperation and collaboration for cancer control.

The regional cancer networks facilitate and coordinate services across health providers at all levels and bring various providers and consumer organisations together to ensure co-operation and integration of services, where appropriate.

In addition they provide a mechanism where all can work with each other to plan and coordinate services in line with national standards of treatment.

There are four regional cancer networks in New Zealand who work across organisational boundaries to promote a collaborative approach to service planning and delivery.

These statements of purpose are not universally reflected in the CFA or in any of the current regional cancer network documentation, as refinements to the understanding of the role and purpose of the regional cancer networks have been made as they have developed. The CFA provides an outline of the purpose of the regional cancer networks. The initial 2007 CFA stated that:

Regional networks are complex organisational and service delivery structures that work across organisational boundaries. Regional networks bring together key stakeholders to plan and deliver a set of comprehensive and integrated cancer services, that are co-ordinated across patient care pathways through a multi-disciplinary team approach, for a given population (region). Regional networks can increase access to comprehensive cancer services by promoting a collaborative approach to care planning and delivery.

The current CFA that became operational in May 2008 states that:

Networks have a leadership, facilitation and co-ordination role in implementing the Cancer Control Strategy, improving cancer outcomes and reducing inequalities. Networks work across organisational boundaries and promote a collaborative approach to service planning and delivery.

The Cancer Control Programme describes the role and responsibilities of the regional cancer networks as follows:

Provide regional leadership for the CCP (Cancer Control Programme) by working across organisational boundaries to promote a collaborative approach to service planning and delivery. This includes working with DHBs, non-government agencies and consumers.

Each of the regional cancer networks has a slightly different statement of purpose in their strategic plans as outlined in Table 8. They all also state their ultimate goal as being that stated in the Cancer Control Strategy: to reduce the incidence and impact of cancer and to reduce cancer inequalities. The full wording of the networks' objectives and principles can be found in

Appendix D – Objectives and principles of each network.

Table 8 – Network purpose statements from network strategic plans

Northern	Midland	Central	Southern
<p>The Network's vision is to improve cancer control through increased regional collaboration.</p> <p>The Network's objectives are to support the local delivery of effective, efficient and equitable cancer control services by:</p> <ul style="list-style-type: none"> • Facilitating Cancer Control Strategy and Action Plan planning and implementation • Facilitating regional collaboration to improve patient experiences and outcomes • Supporting quality improvement initiatives designed to achieve the vision • Supporting regional integration across traditional silos. 	<p>The Network's vision is improved cancer control through increased regional collaboration not constrained by organisational, service or professional boundaries.</p> <p>The Network has a leadership, facilitation and coordination role in bringing together and working with stakeholders to:</p> <ul style="list-style-type: none"> • Reduce the incidence and impact of cancer • Reduce inequalities with respect to cancer; and • Improve the experience and outcomes for people with cancer and their family / whānau through the complex pathway of care. 	<p><i>Vision</i></p> <p>The Network's vision is improved cancer prevention and control through increased regional collaboration not constrained by organisational, service or professional boundaries.</p> <p><i>Purpose</i></p> <p>The purpose of the Network is to take a proactive leadership, facilitation, collaborative and coordinated approach across organisational and service boundaries to ensure all providers of cancer prevention and care in the network area work together with the community to:</p> <ul style="list-style-type: none"> • Manage the implementation of the Strategy and Action Plan • Improve the journey of cancer patients and their family/whānau through the complex pathway of care, ensuring equitable, high quality, patient centred, evidence based and multidisciplinary care. 	<p>The Southern regional cancer network, by providing a framework to improve collaboration and co-ordination across cancer control groups and services, is expected to achieve the key objectives as set out in the CFA.</p>

The objectives for each of the networks have changed over time as the networks have become clearer about what their purpose and role is. Given the lack of a national framework, it is not surprising that it has taken time to be clear about what the networks' role and purpose is. Although they are not identical, all the statements of purpose are similar and have converged over time and centre on facilitating and leading regional collaboration.

Improving the patient journey through the pathway is a core focus of the regional cancer networks as articulated in their strategic plans. This focus on improving the patient experience is not yet reflected in national documentation relating to regional cancer networks.

The regional cancer networks all have similar strategic directions outlined in their strategic plans relating to:

- Sharing knowledge and information to enable informed decision making (for patients, health professionals, and the public)

- Facilitating regional service quality improvement to enable better, sooner, more convenient services
- Infrastructure improvement / development.

These strategic directions appear to be broader than that detailed in national documentation relating to regional cancer networks which focuses on collaboration related to “service planning and delivery”.

Respondents were asked what they understood the purpose of the regional cancer networks to be. There was a wide range of responses from the 226 people who answered the question, although there were common themes relating to (in order of mention down to 10 mentions):

- Working to reduce inequalities / improve equity of access across the region (30)
- Work with stakeholders, involving wider sector, consumers (24)
- Co-ordinating services between providers (20)
- Improving the patient experience, streamlining the service for patients (18)
- Increasing efficiency, better use of resources (15)
- Working collaboratively (15)
- Increasing consistency between providers (13)
- Reducing the impact of cancer (13)
- Identify gaps / needs in the sector (13)
- Implementing the Strategy and Action Plan (12)
- Communicating / sharing information about how sector fits together (10).

Other purposes mentioned by several people included working across the continuum, promoting best practice, implementing national policies, improving access, leading innovation and change, monitoring, promoting screening and wellness, lobbying government for more resources, setting priorities for screening or treatment.

This result suggests that in general stakeholders understand that the reason for having a regional cancer network is to improve collaboration between stakeholders with the aim of increasing co-ordination and consistency of service provision and improving the patient experience; this aligns with the stated purpose(s). It is interesting to note that very little mention was made of the network being a source of information for cancer patients or the public.

While most of these themes were also reflected in the interviews, a number of interviewees acknowledged that there is variable understanding between stakeholders of the purpose of the regional cancer networks.

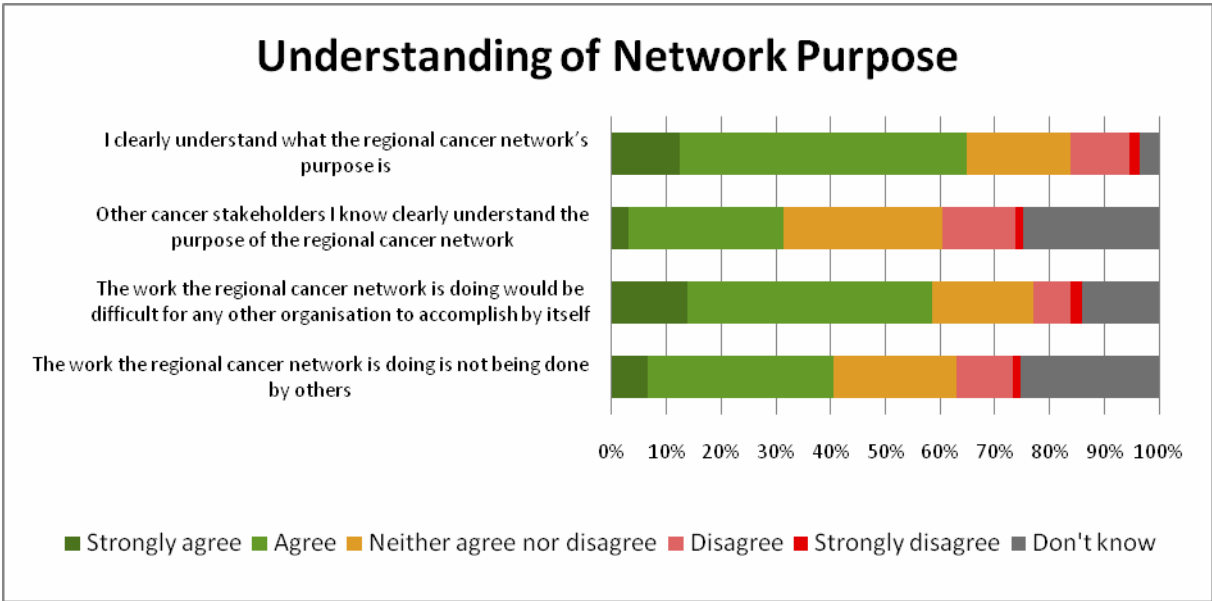
“There seems a lack of clarity as to whether the role of a regional cancer network is population focussed or personal health focussed, and once again, if the latter, how does this align with the role of the service provider.”

“There has continued to be no clarity around what the purpose, scope and parameters of the regional cancer network are.”

“Roles need to be clarified and targets etc, outcomes measured and the governance group built to reflect that purpose.”

Figure 6 summarises the responses to the questions asked in the survey about network purpose. All survey respondents were asked this question and 320 people answered it.

Figure 6 – Understanding of regional cancer network purpose



Less than 65% of cancer stakeholders on average across the four networks agreed that they clearly understood what the regional cancer network's purpose was (the result was lower in Southern than the other networks) and only 30% thought other cancer stakeholders understood it (although 25% didn't know or didn't like to comment on what others thought). This suggests that there is room to more clearly communicate the network purpose to cancer stakeholders.

While nearly 60% of respondents agreed that the work the regional cancer networks were doing would be difficult for any organisation to accomplish by itself, only 40% of respondents believe the work the regional cancer networks are doing is not being done by others. This suggests that although cancer stakeholders generally understand that the purpose of the regional cancer networks is to collaborate in areas where working alone is difficult, there is further work to be done to ensure that network activity is focused on areas that is not duplicating work of others. This is discussed further in section 4.5.

4.3 Commitment to and ownership of network

4.3.1 Introduction

In the previous section we examined the purpose (the 'what') of regional cancer networks which can be summarised as change management via a range of collaborative approaches. In this section we start to examine this notion of collaboration and what that means to the way the networks work (the 'how').

In her foreword to the Action Plan, Hon Annette King talked of greater collaboration across the health sector as being key to reducing the incidence and impact of cancer. As noted in the previous section, the Action Plan saw one of the purposes of regional cancer networks as being to: *enhance cooperation and collaboration for cancer control*. The CFA states that networks are to: *promote a*

collaborative approach to service planning and delivery and all networks have: *increased regional collaboration* as a key purpose in their strategic plans.

There is a two-way relationship between a sense of commitment and ownership to the regional cancer network and a sense of collaboration. Commitment to and ownership of the network will come from stakeholders working collaboratively and a sense of collaboration will evolve when stakeholders feel commitment to and ownership of their regional cancer network.

The terms communication, coordination, cooperation and collaboration are often used interchangeably. However, these terms are not synonyms – they are about different ways of acting – they are points on a continuum:

- Communication – separate entities letting each other know what they’re up to
- Coordination – separate entities aligning what they’re up to
- Cooperation – working together but as separate entities
- Collaboration – working together so that they act as one.

An easy measure of whether parties are collaborating (as opposed to communicating, coordinating or cooperating) is that the sense of ‘I’ disappears and becomes ‘we’ – the sense of a collection of separate entities is replaced by a sense of collective commitment and ownership to a single entity or initiative - in this instance from a collective commitment to and ownership of the regional cancer network. Collaboration requires the parties to take a conscious and deliberate decision to act differently.

4.3.2 Conclusions

Cancer stakeholders generally accept the benefits of working collaboratively via the regional cancer networks and hence have a sense of commitment to the networks.

The ultimate aim however is to achieve stakeholder ownership of the network - when they are all acting as one. We only found isolated examples of stakeholders feeling the sense of ‘we’ that signals collective ownership.

This is one area where there is opportunity for measurable improvements over the next two to three years.

4.3.3 Evidence and discussion

Respondents repeatedly talked about the regional cancer networks’ lack of mandate and how this makes it particularly difficult to bring about change. Regional cancer networks do not have the traditional top-down management mandate or authority to require change to happen, nor do they have funding leverage to entice their stakeholders to change. However, they do have a mandate to collaborate or at least to ‘promote a collaborative approach’ with the expectation being that once stakeholders start collaborating they will take collective ownership of the need for change.

It is via this collaboration mandate that the regional cancer networks are expected to facilitate, to influence and to bring about change in the sector: *“The power of persuasion then becomes more acceptable.”* Therefore if the regional cancer networks’ mandate is collaboration, developing commitment to and ownership of the networks is a critical function.

Interviewees talked about collaboration or the commitment to and ownership of the regional cancer network as involving:

- Partnership, networking, linking
- Persuasion being more effective than coercion
- People with narrow views working as one with people with big picture views
- Being able to leave your own agenda at the door
- Stakeholders needing to feel they have created the regional cancer network
- Being able to stand in someone else's world and see what's happening there
- Rather than talking 'to' stakeholders, working 'with' each other in common discussion.

Interviewees also provided valuable insights into the challenges and opportunities of developing a sense of ownership, commitment and collaboration:

- There is a tension between stakeholders wanting to be at the table to be represented, involved and informed, and those same stakeholders developing a shared vision, a collaborative way of working
- It isn't possible to get this sense of 'we' by force of personality: *"You have to bring people with you"*
- Collaboration evolves as stakeholders develop a common understanding via experience – as the regional cancer network has some wins, stakeholders start to see the benefits of this way of working and they engage more
- Building relationships and trust between stakeholders and the regional cancer network and between different stakeholder groups is key
- Stakeholders must have time to participate and there must be good communication.

One interviewee described this notion of collaboration between stakeholders as them each wearing multiple hats, for example a member of the regional stakeholder collaborative group will have the hat of their own agency (let's say an NGO), they are on the regional stakeholder collaborative group as the NGO representative and hence they also wear a hat of 'all NGOs'. And in many instances they are also representing the region they come from and/or their Local Cancer Network – this makes three hats. When that person comes to a regional stakeholder collaborative group meeting (or is working on any regional cancer network activities) they put on a fourth hat – the regional cancer network hat. Thus all stakeholders are wearing a common 'we' hat at any time they are involved in regional cancer network business. Collaboration does not require stakeholders to remove their other hats, in fact it is the variety of other hats that all stakeholders wear that ensure representation of a wide variety of interests at the table, and collaboration partners need to recognise and respect the hats others are wearing. When collaboration is truly occurring stakeholders will all have one common hat on, and while wearing their 'regional cancer network hat' they will view themselves collectively as 'we': *"At the heart of collaboration is trust."*

The challenges of developing a sense of collaboration are acknowledged and most stakeholders interviewed agreed that there is a way to go before regional cancer networks achieve this.

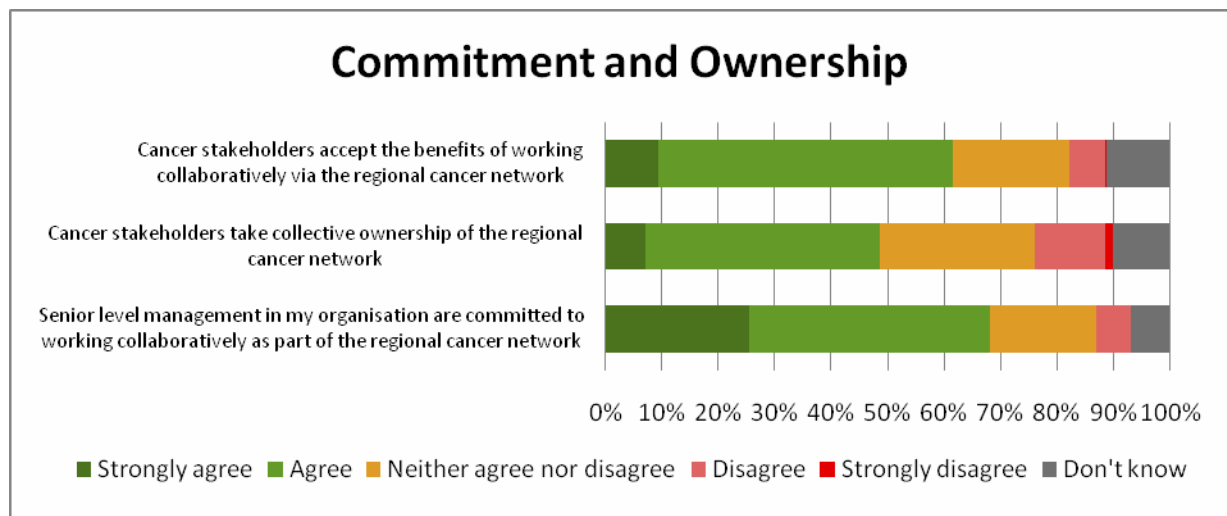
"There has been a lot of talk about collaboration but no-one has nailed it yet."

"Everyone's doing things differently – they are all applying for different funding – they all have an attitude of we'll do it and then tell you. This "me" attitude

doesn't make it easy to find a "we" approach required for collaboration or to work collaboratively."

Interviewees generally feel that there are reasonable (but sometimes fluctuating) levels of commitment but not necessarily any sense of collaboration or ownership from some stakeholders. These findings are reflected in the survey results (see Figure 7) with nearly 70% of respondents agreeing that senior management level in their organisation is committed to working collaboratively as part of the regional cancer network but fewer than 50% of stakeholders agreeing that cancer stakeholders take collective ownership of their regional cancer network.

Figure 7 – Commitment and ownership of regional cancer networks



Only those involved in a regional or local cancer network group or project were asked these questions and 218 people answered. These results are similar across the networks, although there appears to be slightly less commitment in the Central region in all three areas questioned about.

4.4 Governance and structure

4.4.1 Introduction

In the previous two sections we examined issues around purpose, collective ownership and commitment and the regional cancer networks' mandate of collaboration. A network's governance and structure arrangements are key vehicles for achieving the network's purpose and developing a sense of collective ownership and commitment and hence these three sections should be considered together.

The CFA states that the regional cancer networks need to:

Bring together all constituent organisations, professionals and interest groups involved with cancer, and provide a formal governance structure that:

- *Involves patients, their families, whanau and the public*
- *Ensures input of all DHB and NGO cancer service providers across the region, including PHOs*
- *Includes identified Māori leadership and a framework to support participation of Māori*
- *Links to DHB funding and planning*

- *Links to national groups, in particular the New Zealand Cancer Treatment Working Party, the joint Ministry / DHB steering group and the other networks; and*
- *Is accountable to constituent DHBs.*

This section focuses on the regional stakeholder collaborative group of each network and the links to DHB funding and planning and national cancer control groups. It is not possible for all cancer stakeholders to be represented on the regional stakeholder collaborative group and therefore there need to be links to the wider sector via other structures and /or communication mechanisms. These are discussed in more detail in the section on stakeholder involvement – see section 5.

4.4.2 Conclusions

All the regional cancer networks have made excellent progress in establishing clear governance structures and a wide variety of network groups.

We found areas for improvement in some of the regional stakeholder collaborative groups that would enhance the sense of independence from any particular agency and facilitate the spirit of collaboration including:

- The chairperson of each regional stakeholder collaborative group has a key leadership position. Either the chairperson or the deputy chairperson of each regional stakeholder collaborative group should be non DHB management i.e. a DHB clinician or from a non DHB agency
- The membership of the regional stakeholder collaborative group should be representative of their constituent local DHB districts and stakeholder groups and provide an appropriate balance of DHB and non DHB members
- There should be a clear separation between the network staff and the stakeholder members i.e. the manager and clinical director(s) should be ex officio members who report to the regional stakeholder collaborative group.

Linkages between the networks and DHB funding and planning teams appear to be a weak point and all four regions need to improve in this area.

The roles and responsibilities of stakeholder representatives are not well articulated or understood. All networks are urged to clarify this with the stakeholder representatives on the regional stakeholder collaborative group or any other network groups. All stakeholders should be aware of who their representative is and how they can link into the network via these representatives.

National linkages with other agencies and between networks are operating well although we suggest the Ministry, the lead CEOs and the network leadership (chairperson of the regional stakeholder collaborative group, clinical directors and managers) consider rotating representation (perhaps two-yearly) from the networks on CCSG thus giving each network a turn at representing the networks at this national governance group.

4.4.3 Evidence and discussion

The key structures within each regional cancer network include: a lead DHB (that holds the contract with the Ministry for the regional cancer network), a lead CEO (who oversees the regional cancer network activities and links the regional cancer network to the other DHB CEOs in that region), a

regional stakeholder collaborative group and a different array of other groups including local cancer networks, tumour groups, stakeholder engagement groups and other service development groups.

Table 9 summarises the high level governance and reporting arrangements for each network as at May 2010.

Table 9 – High level governance and reporting arrangements

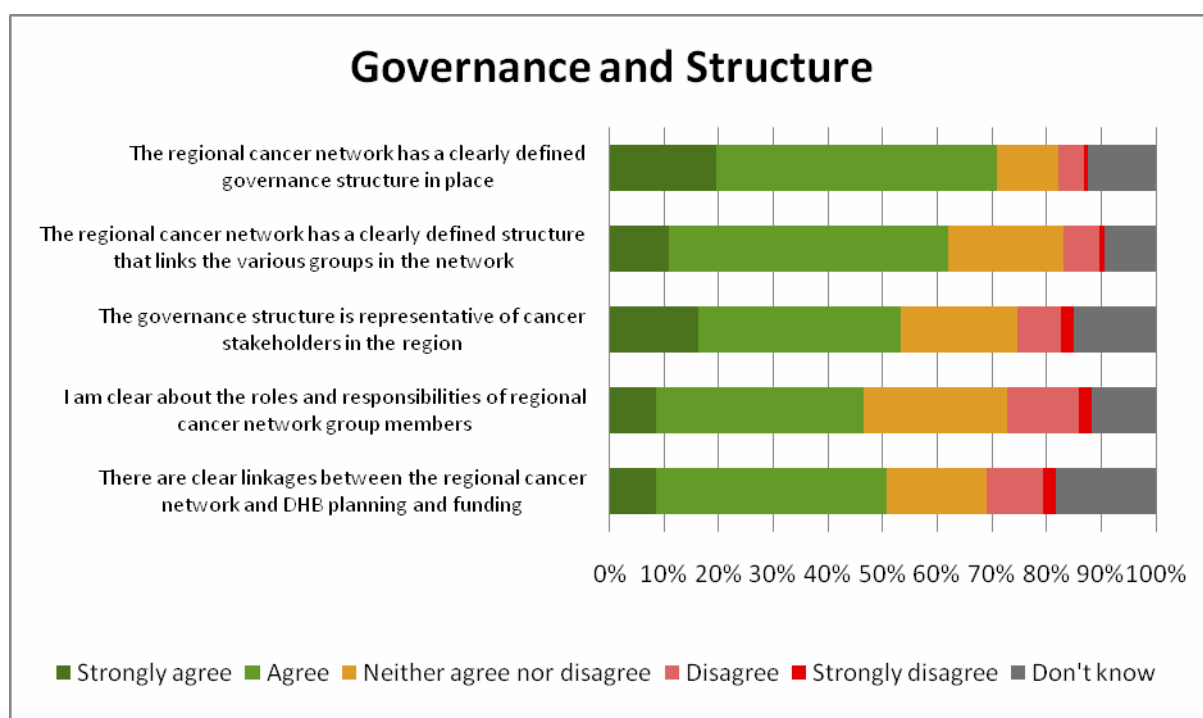
	Northern	Midland	Central	Southern
Lead DHB (for funding purposes)	Auckland DHB	Waikato DHB	MidCentral DHB	Canterbury DHB
Lead CEO	Auckland DHB	Waikato DHB	MidCentral DHB	Southern DHB
Network location	NDSA	Waikato DHB	MidCentral DHB	SISSAL
Network Manager reporting arrangements	NDSA manager (employment) Lead CEO (functional)	COO, Waikato DHB who is the Midland COO rep	Funding and Planning manager, MidCentral DHB	SISSAL manager (employment) Lead CEO (functional)
Clinical Director(s) also employed by	Auckland DHB	Waikato DHB	MidCentral DHB Capital and Coast DHB	Southern DHB Canterbury DHB
Governed by	Northern Cancer Collaborative since November 2009 ³³	MCN Executive group	CCN Governance group	South Island CEOs Group
Regional stakeholder collaborative group	Northern Cancer Collaborative since Feb 2008	MCN Executive group since 2006	CCN Governance group since May 2007	SCN Steering group since April 2009
Number of voting members	24 (incl 3 vacant)	21 (incl 2 vacant)	14 (incl 1 vacant)	19
Quorum	7	½ of membership plus 1	½ of membership plus 1	½ of membership plus 1
Meeting frequency	Bi-monthly	Quarterly since June 2010, prior was monthly via teleconference and quarterly face to face	6-8 weekly Alternate teleconference / face-to-face	6-8 weekly
Chairperson of regional stakeholder collaborative group	Independent (also a carer and a consumer)	COO, Waikato DHB	Funding and Planning manager from 1 of the DHBs (has been MidCentral DHB since network started)	Independent clinician (haematologist) from Canterbury DHB elected by the stakeholders
Deputy chairperson of regional stakeholder collaborative group	Appointed by the Chairperson on as needed basis to chair meetings in his absence	Network Manager chairs meetings in the Chairperson's absence	No formal Deputy Chairperson but if the Chairperson is absent from meeting he will ask another member to chair	To be decided at 14 Sept 2010 meeting
Network staff links to regional stakeholder collaborative group	Network Manager and CD Both ex officio	Network Manager and CD Both voting members	Network Manager (attends) 2 CDs (ex officio)	Network Manager and 2 CDs All ex officio

³³ Network Executive Group prior to November 2009. This group was made up of the following members: lead CEO (Chair), Chair of Northern Cancer Collaborative (steering group of the Northern Cancer Network) (Deputy Chair), Chair of Māori Leadership Group, Regional Oncology Operations Group (ROOG) Chair, Regional Funders Forum representative, (CD and Network Manager attend ex officio).

Only those people who were on a regional cancer network group or heavily involved in a regional cancer network project were asked to respond to the questions around governance and structure and 220 people responded. These results are shown in Figure 8.

An average of 70% of respondents across the four networks agree that their regional cancer network has a clear governance structure in place, with higher levels of agreement in the Northern region and lower levels of agreement in the Southern region where 24% of respondents didn't know if there was a clear governance structure in place (this is perhaps not a surprising result when the Southern networks governance structure has been active for less time).

Figure 8 – Governance and structure of the regional cancer networks



The key success factors relating to governance that were most frequently mentioned by interviewees included:

- A well functioning regional stakeholder collaborative group is key to the regional cancer network's success and is key to developing a shared vision for the regional cancer network
- Arrangements should provide a forum that allows respect between stakeholders to build
- Everyone must have an opportunity to be heard and to have their views respected and represented. We were told of a regional stakeholder collaborative group where the different stakeholders are asked to present to the full group about their sector and their issues, to help the other members develop a shared understanding and allow them to 'stand in one another's shoes'
- The regional cancer network structure needs to be the glue that links national and district levels together regionally, that glues policy with service delivery and glues primary, secondary and tertiary levels of cancer control together
- The competency of the regional stakeholder collaborative group chairperson was mentioned frequently as a key success factor in facilitating the sense of collaboration between the multiple stakeholder groups: "[I've] never before come across a chairperson who is so able to listen to a

whole raft of arguments about an issue – then when everyone has had a say, sums it up and puts a collective view”.

Interviewees talked about the challenges of maintaining the impetus of collaboration within the regional stakeholder collaborative group. Matters that exacerbate this are:

- The frequency with which stakeholder representatives on the regional cancer network groups change. This is a barrier to the smooth functioning of the network and appears to be mostly occurring with DHB representation and is seen to create a stop/start situation whereby the network spends time getting key people engaged only to find they have moved on and a new representative appears at the network table
- Non-attendance of members at regional stakeholder collaborative group meetings. Competing demands resulting in the non availability of key leadership personnel within the networks was also identified by respondents as a barrier to success. Lead CEOs and clinical directors are often not able to attend key network meetings due to competing priorities. In one instance we understand one of the chairpersons of the regional stakeholder collaborative group has only attended two or three meetings in the past two years. Another area cited by several respondents was with Māori representation - if there is only one Māori representative on the regional stakeholder collaborative group and that person doesn't regularly attend meetings then there is in effect no Māori voice at this level
- The third area mentioned by several respondents is the tendency for the regional stakeholder collaborative groups to be used primarily for information sharing as opposed to active participation by stakeholders, or conversely the group process becomes one where members are merely approving matters that appear to have been decided outside the group: *“There is little or no discussion of the issues at the [governance] group – initiatives are presented as a done deal.”.*

In three of the four networks the terms of reference for the regional stakeholder collaborative group gives them the role of overseeing (governing) the network. In the Southern Cancer Network this governing role is held by the Lead CEOs Group for the region. A similar separate governance group was in place in the Northern Cancer Network until late 2009 at which time the network agreed that the regional stakeholder collaborative group was sufficiently mature to undertake the governance role. Despite having the mandate to 'govern' in reality accountability rests with the CEOs, in particular the lead CEO as they are contractually accountable to the Ministry for the network funding and delivering against the specifications in the CFA. However it seems that over time the CEOs have developed increasing confidence and trust in the competence of the regional stakeholder collaborative groups to make appropriate decisions.

Aside from these differences in their governance mandate, the differences between the four regional stakeholder collaborative groups is evident from their different names and confirmed on closer examination of their stated purposes (refer Table 10).

The purpose of the SCN Steering group, the CCN Governance group and the Northern Cancer Collaborative appear very similar - to consider and prioritise advice and recommendations and to oversee the development of the regional cancer network strategic and annual work plans. In contrast the purpose of the MCN Executive group, as its name suggests, is more focused on providing leadership governance.

Table 10 – Stated purpose of regional cancer network’s stakeholder collaborative group

	Stated purpose
Northern Cancer Collaborative	Consider and prioritise advice and recommendations from other Northern Cancer Network groups, and to oversee the development and implementation of the regional strategic plan and annual work-plans for the Northern Cancer Network in order to achieve the Network vision.
MCN Executive group	The Midland Cancer Network Executive Group will take a leadership role and approach to reduce the inequalities, incidence and impact of cancer across the cancer continuum for the network area. This group provides governance for the Midland cancer control activities of the network and its constituent organisations.
CCN Governance group	The purpose of the Governance Group is to consider and prioritise advice and recommendations from other Network groups, and to oversee development and implementation of the annual work-plans and regional strategic plan for the Central Cancer Network in order to achieve the Network vision.
SCN Steering group	Have an advisory and directional role to provide guidance to the current SCN management team and to oversee the development of the annual work plans, work streams and regional strategic plan for the Southern Cancer Network. The Steering Group will also consider and prioritise advice and recommendations from other Network groups in order to integrate funding and population requirements to achieve the Network vision

DHB and non DHB interviewees talked about the importance of the regional cancer network structures sitting slightly outside the formal structures – recognising that whilst the DHBs are important players, regional cancer networks are much broader and hence must not be seen as part of any one DHB.

As can be seen in Table 9 the Central Cancer Network and the Midland Cancer Network are more closely connected to a single DHB (Midcentral and Waikato DHBs respectively) than the Northern Cancer Network and Southern Cancer Network. This structural difference may mean that these two networks are seen as being less independent. This appears to be especially so with the Midland Cancer Network with community stakeholders making comments such as:

“This network is very DHB focused – 70 to 80% of people around the table are always DHB people.”

“The network here is just so DHB focused. It reflects the same attitude to hospital cancer care here i.e. there is no acknowledgement that cancer patients exist in the community. It is difficult for stakeholders to have a voice.”

The chairpersons of both the Midland Cancer Network and the Central Cancer Network are DHB managers, the Chief Operating Officer of Waikato DHB and the Funding and Planning Manager of Midcentral DHB respectively. The Chairperson of the Northern Cancer Collaborative is independent of the DHB altogether and the Chairperson of the Southern Cancer Network Steering Group is an independent clinician from the DHB i.e. he is not involved in the management of the regional cancer network in any other capacity, further adding to the sense of separation from the DHB structure in these networks.

The four regional cancer network stakeholder collaborative groups have quite different mix of DHB and non DHB membership. As shown in Table 11 Midland Cancer Network has the lowest ratio of non DHB to DHB members.

Table 11 – Mix of DHB and non DHB members on each regional stakeholder collaborative group

	Northern	Midland	Central ³⁴	Southern
DHB members ³⁵	10	14	7	9
Network staff members		2		
Non DHB members	11	3	6	7
Vacancies	3 (pacific, allied health and research)	2 (pacific and primary care)	1 (may be DHB or non DHB depending on who fills position from DHB area)	

There appears to be some lack of clarity around the role of network staff members and the regional stakeholder collaborative group. In the Northern, Central and Southern Cancer Networks the Clinical Director(s) and Manager attend the regional stakeholder collaborative group in an ex officio capacity. The boundary between the network management team and the collective of stakeholders who make up the regional stakeholder collaborative group is somewhat blurred in the Midland Cancer Network where the Clinical Director and Manager are members of the group with full voting rights. This creates a situation whereby the staff paid to manage the development and execution of the regional cancer network's activities are 'reporting to' themselves, as group members, for their performance. The separation of roles is further confused in the Midland Cancer Network where the Network Manager chairs the MCN Executive Group whenever the Chairperson is absent creating a situation whereby she is both 'reporting to' the group and chairing it (refer Table 9).

Stakeholder representation

Only just over 50% of survey respondents believe the regional cancer networks governance structure is representative of cancer stakeholders across the region (see Figure 8); a result that was similar across all networks, although slightly lower in Central region, perhaps not surprisingly given that they have eight DHBs to include in their representation and the lowest number of members on the group. Table 12 shows the make-up of the membership of the regional stakeholder collaborative group in each region excluding the network managers and clinical directors as at June 2010.

There was only 60% agreement across the four networks that the regional cancer networks have a clearly defined structure that links the various groups in the network. Further detail about the other groups in the network structure can be found in Appendix E and more detail about how some of these groups link to the regional stakeholder collaborative group can be found in section 5 in discussing the involvement of stakeholders within the network.

Fewer than 50% of respondents are clear about the roles and responsibilities of regional cancer network group members. This result is concerningly low particularly when almost all those who answered this question were on a regional or local cancer group. Even when only looking at those on the regional stakeholder collaborative group (although caution needs to be applied given the small numbers) only an average of 80% across the regions agreed that they were clear about the roles of

³⁴ This information is reflective of the situation in May 2010. Spread of membership changes due to nominations for districts representation coming from the local cancer networks. Primarily chosen for region (and then a mix of sector representation)

³⁵ Including Regional Public Health staff

responsibilities of group members; this result was higher in Northern and Southern networks and lower in Midland and Central.

It is important that network group members know what their roles and responsibilities are within the network as it is very difficult to promote a collaborative approach without this understanding. As part of the interview process, stakeholder representatives were asked what they saw as their responsibilities for linking regionally to others in their sector. We found no consistency and considerable confusion about whether they are responsible for feeding back to just their own organisation or the stakeholder group they represent and likewise whether they are responsible for bringing the views of their wider sector to the table or just their own organisation. For example is an NGO representative on a regional stakeholder collaborative group bringing the views of (and feeding back to) just their own NGO organisation or of all cancer control NGOs in their region? Likewise if there is one DHB funding and planning representative on the regional stakeholder collaborative group (or any other network group) are they responsible for linking with the funding and planning team at their own DHB or the funding and planning teams at all the region's DHBs?

One NGO/hospice representative has established her own very effective mechanisms (largely email based) for linking with other hospice stakeholders throughout her region thereby enabling all hospice stakeholders to feed into the regional cancer network processes and to be kept informed of regional cancer network issues and activities. The only formal region-wide networking appears to be occurring where there is a regional leadership group, reference group or other forum as part of the regional cancer network or via regional DHB forum such as regional funding and planning forum.

Table 12 – Stakeholder members of regional stakeholder collaborative group

	Northern	Midland³⁶	Central³⁷	Southern³⁸
DHB – provider managers	4 - 1 from each DHB	5 ³⁹	1 - Ops Manager for Cancer Services, CCDHB	1
DHB – clinical	4 - 1 from each DHB	2 - 1 public health physician and 1 oncology nurse ⁴⁰	1 - public health physician	6 (incl Chairperson)
DHB – funding and planning	Regional Funding Forum rep	3 - 1 from each DHB	5 (incl Chairperson)	1 ⁴¹
Regional cancer centre	1 - is also an ADHB rep	2 – regional cancer centre CD and Oncology Nurse Manager ⁴²	Ops Manager CCDHB as previously identified	1 - oncology nurse
NGO	2 - Cancer Society and Breast Cancer Aotearoa Coalition	1 - Cancer Society	1 - Cancer Society	1 - Cancer Society
Consumer / carer	1 (plus Independent Chairperson who is also a carer)	2	1 - Cancer Voices	2 (1 shared consumer / Kaitiaki role)
Māori	2 - Chairperson of Māori Leadership group plus one other	1 - GM Māori Health Services – Waikato DHB, who is the Midland GM Māori health services rep.	1 - Cancer Nurse from Māori provider, Taranaki 1 - Vacancy	3 ⁴³
Pacific	1 - Vacant	1 - Vacant	2 ⁴⁴	
Primary Care / PHO/GP	3	1 - Vacant	2	4 ⁴⁵
Palliative care / Hospice	1 - Hospice			2 – 1 Hospice and 1 Palliative care
Public health	1 - CD from Auckland Regional Public Health Service	2 - Waikato DHB population health manager and public health physician	1 – Hutt Valley DHB public health physician (plus 1 of the Pacific reps)	Vacant ⁴⁶
Allied health	1 - Vacant			
Research	1 - Vacant			1
Other	1 - Chairperson of Regional Cancer Care Co-ordinator Forum	1 -Director of Nursing and Midwifery, Waikato DHB, who is the Midland DON rep		
Other non voting members	Lead CEO Sponsor (ex officio) National observer (ex officio)	GM Funding and Planning – Lakes DHB (advisory role)	TAS (ex officio)	

³⁶ MCN governance framework links to Midland DHB Collaborative principles and forums since 2007

³⁷ This information is reflective of the situation in May 2010. Spread of membership changes due to nominations for districts representation coming from the local cancer networks. Primarily chosen for region (and then a mix of sector representation)

³⁸ Chosen for a matrix of region and sector representation

³⁹ Since 2010 lead COO and 1 service manager from each of Lakes and BOP, 2 Waikato DHB managers - elective and acute services - prior to Waikato DHB restructure lead COO and 1 from each DHB and Surgical Services Manager Waikato DHB

⁴⁰ Both also included elsewhere in this table

⁴¹ Clinical Directors and SCN Manager meet quarterly with F & P Managers) and provide monthly reports to the group

⁴² Waikato Hospital 2009-10 restructure – Nurse Manager replaced service manager at the regional cancer centre

⁴³ (1 shared consumer / Kaitiaki role) Nga Ratonga Hauora (Māori Health Services CDHB) CEO Māori primary health provider/Consumer

⁴⁴ 1 also included as DHB funding and planning and 1 also a public health physician although his current role is as CEO of Pacific Island Affairs

⁴⁵ (1 PHO, 1 GP, 1 primary sector) plus 1 of Māori representatives also involved in primary care

⁴⁶ Seconded as appropriate (SISSAL GM is a public health physician and provides input as necessary)

In the absence of any clarification around the role of the stakeholder representatives it is largely dependent on the motivation of the individual.

“Governance group members are expected to champion the network back at this bases but I know this is variable – this is an improvement opportunity for us to better support them to do that.”

“Sort out network group processes (and membership?) so that all are clear of the kaupapa/purpose and are those prepared to work constructively towards a common purpose (not ego). Any face-to-face or other consultation/participation needs to ensure that participants know they are being actively heard and responded to ie that their participation can actually make a difference to improve health service users receive ie. is not just a tick box 'consultation' exercise.”

The role of stakeholder representatives is discussed further in section 4.7.3 when we examine the terms of reference for the four regional stakeholder collaborative groups to see what they say about the roles and responsibilities of regional cancer network group members (see Table 15).

We would suggest that an important factor in facilitating the sense of commitment to and ownership in the network as discussed in the previous section is for regional cancer network stakeholders to develop a clear understanding of their roles and responsibilities to the network and to the sector and or district they represent. We recognise that any stakeholder representatives taking responsibility for networking across their region outside their regular employment would need to be financially reimbursed for this work.

Links with DHB funding and planning

All regional cancer networks have arrangements in place to link to DHB funding and planning (refer Table 12). However, only 50% of cancer stakeholders across the four regions feel there are clear linkages between the regional cancer network and DHB funding and planning teams, indicating that the functioning of linking isn't following the form or structure set up to facilitate such linkages. The results are very similar across the four networks (and only slightly higher in Midland (where a funding and planning representative from each of the three DHBs is on the executive group) and slightly lower in Southern (where only one funding and planning representative is on the Steering group).

This difference is accentuated when looking at the responses of the few funding and planning staff that answered the survey with Midland funding and planning staff agreeing that there are clear links, no Southern funding and planning staff agreeing that there are clear links and 50% of Northern and Central funding and planning staff agreeing that there are clear links⁴⁷. Interestingly, regional stakeholder collaborative group members also feel there is some room for improvement in this area with an average of only 70% agreeing that there are clear links with funding and planning staff (the result being slightly lower in Central).

⁴⁷ These sample sizes are small and hence this result should be treated with a degree of caution

These results strongly suggest that meaningful involvement from DHB funding and planning stakeholders appears to be a weak point. This is reflected elsewhere in this report in particular in section 4.5 in the interface between DHB funding and planning and the regional cancer network planning and prioritisation process, in section 5.6 in respect to stakeholder engagement and in section 9.3 where we note that DHB funding and planning teams were most commonly cited as a barrier to implementation. Whilst DHB funding and planning is represented at regional stakeholder collaborative group level there appears to be further work to do in most regional cancer networks to create a greater sense of ownership and commitment with the funding and planning sector.

National linkages

Since the 2007 review and in response to the review's recommendations, there have been advances in the way in which the regional cancer networks link to other national cancer control bodies and to each other. While the regional cancer networks primarily work autonomously of one another, they also work closely together at a management level to share experiences and best practice. Various initiatives of one network have been adopted by others (for example Central and Southern networks are working to implement the Māori leadership group model implemented in the Northern network and the Southern network are proposing adopting the reducing inequalities fund to local cancer networks introduced first in the Central network). There are also increasing moves to share work between the networks rather than do things four times over.

At the beginning of 2008 the network managers and clinical directors formed the New Zealand Regional Cancer Network Forum (NZRCN Forum) to enable them to work closely together. The purpose of the group as set out in the terms of reference is to 'work collaboratively to advance the Cancer Control Strategy and Action Plan' and to 'share learning and reduce duplication of effort'. The NZRCN Forum has met quarterly since early 2008 (one meeting was also held in 2006 and one in 2007 in a more informal way). While the Ministry Cancer Control Programme staff are not members of the forum they attend all the meetings and the Ministry provides support for this group in terms of minute taking. The regional cancer network managers and the Ministry report strong formal links between this forum and CCSG and CTAG, and a strong working relationship between the four networks and between the networks collectively and the Ministry.

The NZRCN Forum holds no formal status in terms of governance or mandate within the sector and is not shown as part of the governance structure for the Cancer Control Programme (Figure 1), however, it is a key part of the cancer programme with regard to information exchange and advice. CCSG is seen as the primary national governing body for the Cancer Control Programme and the regional cancer networks, and hence forms a key part of the governance and structure of the regional cancer networks. The networks are represented by one of the network managers on this group. The Manager of the Midland Cancer Network has always been the network representative on this group⁴⁸ and there doesn't appear to be any rotation policy. As discussed throughout this report, the regional cancer networks are all different and therefore having national representation from only one network could limit opportunities for other approaches and experiences to be viewed at this national governance forum.

⁴⁸ Prior to February 2009, when the CCSG Terms of Reference were revised, all network managers were able to attend the CCSG ex officio

The regional cancer networks are linked to CTAG via the clinical directors of each network being on this group. More recently, a national lung tumour group has been established to further co-ordinate the work of the regional lung cancer tumour groups and as a means of working collaboratively and not duplicating effort. The national lung tumour group is linked to the regional cancer networks via the chairperson of each regional lung group being on the national group and is chaired by one of the regional cancer network clinical directors.

4.5 Evidence based planning, prioritising and decision making

4.5.1 Introduction

Planning, prioritisation and decision making processes pull together the issues discussed in the previous three sections:

- The network purpose guides what the focus of planning and prioritising should be
- Commitment to and ownership of the network with stakeholders working together collaboratively is the manner in which planning, prioritising and decision making should happen
- Governance and structure provide the vehicle for this to occur.

A particular challenge for the regional cancer networks is that their only mandate is to work collaboratively. The networks have no mechanism for forcing any part of the sector to implement the changes or new initiatives the networks propose. Collaboration between all stakeholder groups must therefore be fundamental to all planning, prioritising and decision making.

The regional cancer networks have multiple masters – they need to consider the priorities of the Ministry, their constituent DHBs and wider cancer sector stakeholders across a range of organisational boundaries. As noted in section 4.2.3, the Ministry’s website, the CFA and the Cancer Control Programme all talk of the networks working ‘across organisation boundaries’. Table 8 shows this reflected in the network statements of purpose: ‘Supporting regional integration across traditional silos’ (Northern); ‘...not constrained by organisational, service or professional boundaries’ (Midland and Central); ‘.... across cancer control groups and services...’ (Southern).

It is important for networks to focus on planning and prioritising against their purpose, their targeted outcomes (refer section 7) and their contractual requirements to the Ministry (identified in the CFA and the National Cancer Programme) in a manner that engages with and leads to collaboration between their multiple stakeholders.

For networks to most effectively add value it is important that they are focused on filling gaps, on doing work that no-one else is doing or can do in a collaborative way, and not overlapping with work already being done by others. If networks start doing work that is the primary responsibility of others, this will not only water down the point of difference between the networks and other parts of the cancer control sector but would serve to pull the networks towards one or other of their stakeholder groups and in doing so is likely to be seen as a bias.

4.5.2 Conclusions

As discussed in the previous section, all the regional cancer networks have well defined collaborative structures to guide and manage the network's planning, prioritisation and decision making processes. All networks have ongoing processes for strategic and annual planning and each network has developed a five year strategic plan.

Most respondents felt the mechanisms to feed their ideas and suggestions into the network operate reasonably well but the presence of multiple stakeholders with competing priorities and different levels of influence was identified by a number of interviewees as a barrier to the network.

However a disappointingly high number of survey respondents and interviewees don't have a clear understanding about how decisions are made and don't believe the network's prioritisation and decision making processes result in defined, clear or realistic activities.

Indications are that the network's efforts to juggle the priorities of their multiple stakeholders in a collaborative way have resulted in the work programmes of all the networks getting wider and wider to a point where they now appear to be overloaded and the small network management teams are at risk of spreading themselves too thinly. This could easily lead to the networks failing to deliver in some areas, simply because they have taken on too much.

Competing priorities coupled with limitations on resources have the potential to create tensions between stakeholders and may jeopardise stakeholder's commitment to and ownership of the network. Stakeholders need to have collective ownership of and commitment to the network's mechanisms for planning, prioritisation and decision making.

4.5.3 Evidence and discussion

Each network has developed a five year strategic plan and three of the four networks have developed health needs assessment documents which contributed to the strategic plan. Stocktakes of cancer services and inequalities stocktakes have also contributed to the development of the strategic plans.

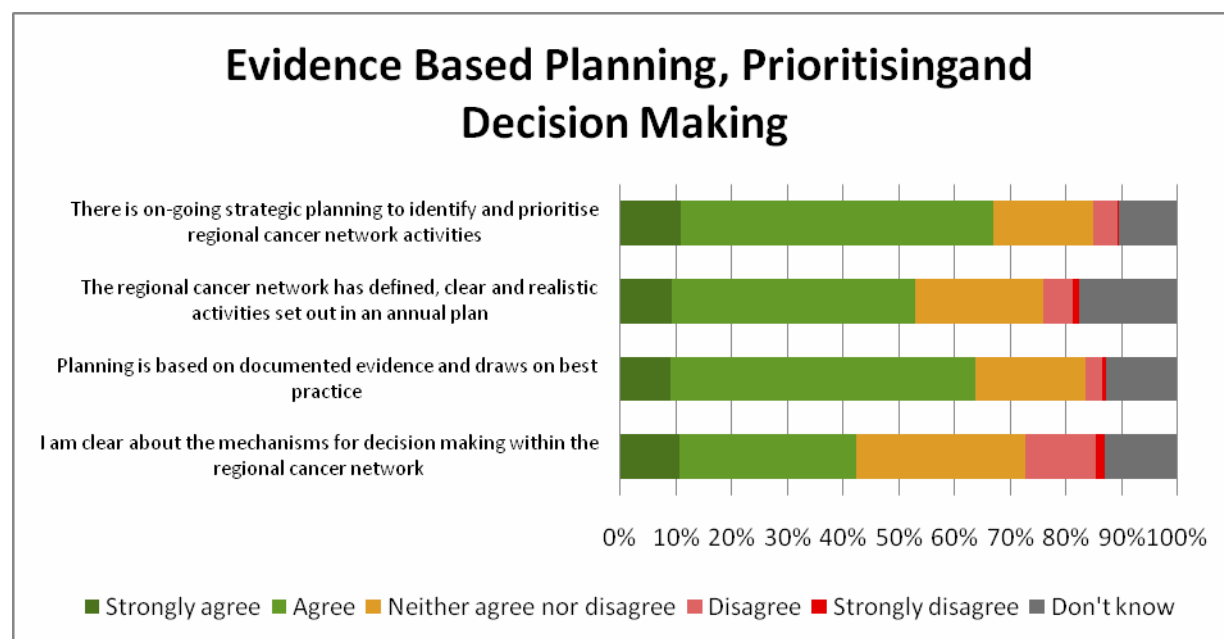
Table 13 – Overview of when strategic plans and health needs assessments produced

	Northern	Midland	Central	Southern
Strategic Plan	2009-2014 Produced in Sept 2009	2009-2014 Produced in Aug 2009	2009-2014 Produced in Oct 2009	2009-2014 Produced in Oct 2009
Health Needs Assessment	Produced in Aug 2009	Produced in Feb 2009	Produced in Jan 2009	Contracted to SISSAL Information and Analysis team - first draft produced June 2010 – final due September 2010

A range of quantitative questions relating to planning, prioritising and decision making were asked as shown in Figure 9. Nearly 70% of the 212 stakeholders who responded to the questions (all of whom are involved in a regional or local cancer network group and/ or regional cancer network project) agree there is on-going strategic planning to identify and prioritise regional cancer network

activities. Midland's results are higher than the other networks on the issue of on-going strategic planning indicating a strength in this area and likely to be a reflection of the fact that many of their activities involve the facilitation of cancer treatment strategic planning (refer section 6.5).

Figure 9 – Evidence based planning, prioritising and decision making within regional cancer networks



Over 60% of the survey respondents appear satisfied that regional cancer network planning is based on documented evidence and draws on best practice. Some networks reported good evidence being provided by data analysis while others talked about the limitations of evidence in particular how difficult and time consuming it can be accessing up to date and relevant data from service providers to inform the prioritisation process.

Of concern is that only just over 40% of survey respondents are clear about the mechanisms for decision making within the regional cancer network. This quantitative result is supported by the fact that many interviewees talked extensively about the challenges and difficulties of the prioritisation and decision making processes.

The particular challenges facing the regional cancer networks in undertaking their regional prioritisation and decision making processes are that they have multiple stakeholders/masters to consider, their mandate is to collaborate and they are required to work across organisational boundaries. This will inevitably lead to these multiple stakeholders believing they have a mandate to contribute to the network's work programme. Most respondents felt that the mechanisms to enable stakeholders to feed suggestions and priorities into the regional cancer network operates reasonably well. We found the process akin to a potpourri, with proposals coming from multiple sources, sometimes as part of the annual work planning cycle and at other times randomly during the year. These need to be prioritised in some way and decisions made about which of these the network will adopt into their strategic and annual plans. The main factors to be considered are whether the potential initiatives will meet the network's contractual requirements, align with their purpose and

contribute to their target outcomes (i.e. are 'fit for purpose') and how many initiatives they can take on in any given year within their capacity ('fit for capacity').

The Government has priorities for the state funded sector – their current emphasis is on the improved waiting times targets and smoother, faster progress through the treatment pathway. The Ministry and the regional cancer networks collectively agree priorities for all networks – these are detailed in the Cancer Control Programme work plan. The Ministry has national priorities it wishes DHBs and regional cancer networks to undertake. These are outlined in the CFA and other specific communications, for example a letter dated 17 December 2009 from the Ministry to DHBs states: *'.....the Ministry of Health, endorsed by the Cancer Control Steering Group, expects DHBs and Regional Cancer Networks to focus on the following priorities for 2010/11:*

- *meeting the Cancer Health Target for radiotherapy*
- *improving medical oncology reporting via the Indicator of DHB Performance (IDP)*
- *developing lung and bowel tumour streams*
- *supporting national and regional work to standardise a range of models of care and treatment pathways'.*

Many of the regional cancer network initiatives have a direct impact on the DHBs – it is therefore important wherever possible to align the regional cancer network annual plan and work programme with the DAP and any prioritisation/planning processes at DHB level. Indications are that the regional cancer networks are having more and more input into drafting the DAPs for their member DHBs and this is reportedly making it much easier to align regional cancer network plans with DHB plans. As one interviewee pointed out *"The work programme of the regional cancer network must match the DAPs because if a new initiative is not funded by the regional cancer network or in the DAP it's never going to happen"*.

These factors can result in the initiatives of the Ministry and the DHBs having the greatest priority. This can lead to frustration from other, less influential, stakeholders if their initiatives are not prioritised. One primary care representative reported: *"Primary care feel if they make suggestions for improvements they come up against heaps of barriers – funding and planning focuses on funding DHB provider arms and do not have any new money for primary care initiatives. There is a lot of self interest."*

Furthermore, we found evidence that in some instances the regional cancer network has been seen as a resource for DHBs to use, perhaps because they have the funding and/or skilled personnel available to do this work; for example Midland Cancer Network being asked to work on planning for the upgrade of the Waikato hospital facilities and the regional cancer centre facilities. In other instances the regional cancer networks appear to be taking on work that the local DHBs feel is more their domain.

"The connection/doubling with DHB workplans is not always clear and therefore can result in the network starting work that is already progressing at a local/regional level ie between more than one DHBs."

"Not sure if it is the network's role (or perhaps just the best use of their resources) to do service delivery type work such as the cancer services directory or the recognition of lung cancer symptoms by Māori - should their role be to

work with stakeholders to evaluate the need and pull the appropriate organisations together to meet it rather than provide the service/do the campaign themselves?”

Because the regional cancer networks have no mandate to instruct others to implement what they plan it is imperative that they engage their stakeholders in the prioritisation and decision making processes. This appears to be done both formally via the network management team, the regional stakeholder collaborative group, regional cancer network sub groups and LCNs and less formally with the wider stakeholders for example all those on the regional cancer network database.

Different regional cancer networks use different processes for planning and prioritising their annual work plans. Most networks appear to use the network management team at some stage in the planning, prioritisation and decision making process to assess all the ideas/suggestions against a variety of factors, including the evidence, funding requirements, and aligning with DHB and Ministry priorities. This step generally includes passing an ‘inequalities lens’ over all the possible projects/initiatives to determine which are most likely to have a positive impact on reducing inequalities, although some regional cancer networks reported this had worked effectively in their region while others saw this as an issue that required further attention.

“We tend to go to where the energy is – to where the opportunities are.”

“Prioritisation is largely about timing and focusing on the projects that are most likely to be successful.”

The regional stakeholder collaborative group should be central to the formal planning, prioritisation and decision making process. We found differing views on how effectively this is happening:

“The establishment of a way of coordinating the prioritisation of efforts across primary, secondary and tertiary care and involving NGOs is one of the networks greatest successes.”

“The [governance] group doesn’t necessarily prioritise the same way individual contributors would – some things have to be done and some things [need to be done] and some things are more wants.”

“People currently appear to be just going through the motions – just attending – not really committing – many people appear to be burnt out.”

“The early days the network set very positive goals and messages across the sector and got off to a great start. Since then there are so many projects and so few clear outcomes that the purpose of the network and the role of the governance group in that is no longer clear to me.”

The regional cancer networks have to engage with the funding and planning teams in each of the 20 DHBs (see sections 5.6) as a key part of the collaborative approach to planning, prioritisation and decision making. Whilst DHB funding and planning is represented on each of the four regional stakeholder collaborative groups (see section 4.3.3 and Table 12) and appears to be participating in

the collaborative process, all regional cancer networks talk of difficulties when they need to get the commitment of all the funding and planning teams from their constituent DHBs.

“We struggle to penetrate the DHB funding and planning processes.”

“Implementation of our initiatives has frequently been blocked by lack of engagement with funding and planning - there would certainly be a huge advantage if there was a regional funding and planning function.”

The network management teams can easily find themselves dancing to multiple tunes as they attempt to collaborate with these multiple masters - wanting to collaborate with their stakeholders, to show they can add value, and to demonstrate this by assisting others with their core business. The network management team can quickly become overloaded, taking on a far more ambitious work programme than they can successfully complete, or they find themselves doing more and more work that should be done by others and consequently less and less time doing things that only a collaborative network working across multiple districts can achieve. This is reflected in the fact that only just over 50% of the survey respondents on average believe their regional cancer network has defined, clear and realistic activities set out in an annual plan, and in numerous comments made by interviewees:

“Networks have been seen as a panacea – the Ministry and DHBs have all deferred to the regional cancer networks and at the same time the demands/requests from the multiple parties have meant the regional cancer network work programme has got wider and wider.”

“Regional cancer networks have tried to be the answer to everything – staff are now stretched to the max.”

“[There are] too many projects and [it is] sometimes unclear why they need or are driven by the network.”

“The volume of activities in the current plan is large and maybe not achievable considering the limited resources available.”

“The strategic and workplans are well developed but the number of projects that are being undertaken is large.”

“There is a lot of uncertainty from a DHB perspective as to how much work the regional cancer network should be taking on.”

The presence of these competing priorities and decision making processes was identified by a number of interviewees as a barrier to the success of the networks. A closely related issue also mentioned by a number of interviewees as a barrier to network success is the limitation of resources restricting the scope of the regional cancer network work programme. The lack of sufficient resources to address the competing priorities appears to be resulting in some non DHB stakeholders becoming cynical about the ability of the network to affect change. These matters have the potential to create tensions between stakeholders over whose needs are the greatest and hence who should have first call on any discretionary components of the regional cancer network budget. Such

tensions could jeopardise stakeholder's commitment to and ownership of the network and undermine the spirit of collaboration the networks are striving for.

Network stakeholders need to have collective ownership of and commitment to the network's mechanisms for planning, prioritisation and decision making. The networks each need a robust mechanism for collaborative prioritisation and decision-making around the multiple ideas, suggestions and requirements of their multiple stakeholders to ensure they are 'fit for purpose' and 'fit for capacity' (ie can be achieved within budget). It is important that the network stakeholders have collective ownership of and commitment to these mechanisms.

4.6 Communication

4.6.1 Introduction

Communication is a key mechanism to connect stakeholders together, to foster the commitment to and ownership of the network and to connect all parties together with the network's planning, prioritisation and decision making process, as well as being a key change management tool for the networks.

Communication scored the highest of all criteria for successful network functioning with 94% of respondents saying communication was either extremely important or very important to the success of regional cancer networks.

4.6.2 Conclusions

All networks appear to be sharing large quantities of high quality data. However, this is beginning to have a counter-productive effect on network stakeholders as they feel overwhelmed and unable to determine which parts of the material is relevant to them.

Network stakeholders see communication as the most important criterion for successful network functioning - 94% of respondents said communication was either extremely important or very important to the success of regional cancer networks. All networks could benefit from adopting some new communication strategies to ensure stakeholders are well informed about network functioning and activities and to enable stakeholders to more easily determine which written or electronic material is relevant to them.

There could be opportunities for the four regional cancer networks to work together with a communications advisor to develop some more effective communication techniques.

4.6.3 Evidence and discussion

Each regional cancer network has an extensive network of stakeholders. Their email database lists ranges from over 200 (Midland Cancer Network) to over 800 (Southern Cancer Network) and are made up of consumers, community leaders, primary care providers, senior clinicians, DHB managers and many more. Very few stakeholders are full time engaged in cancer hence they have competing demands on their time, competing communication requirements and multiple sources of information.

Different stakeholders have different communication interests and needs. The networks use a variety of communication mechanisms from face to face meetings, to video and teleconferencing, to email communications to those on their database. The key communication platforms used by each network is summarised in Table 14.

Table 14 – Communication mechanisms used by regional cancer networks

	Northern	Midland	Central	Southern
Website	Since July 2008	Since Feb 2009	Since Oct 2009	Under development (due to go live in August 2010)
Database	414	234	548	832
Newsletters	Sept 2008 August 2009 March 2010	Nov 2008 Mar 2009 June 2009 Sept 2009 Dec 2009 March 2010 July 2010	Quarterly reports to stakeholders from June 2007 to 2009 Newsletter in Jan 2010 April 2010 July 2010	Dec 2008 March 2009 June 2009 August 2009 December 2009 May and July 2010 newsletters being released via website

Between 52-57% of on-line survey respondents (see Figure 10) said that they had read the newsletters of their regional cancer network and between 32-43% had looked at the website (lower number for Southern network which does not have a full website as yet).

Improvement in communications was the most commonly mentioned opportunity for improvement from survey respondents but one of the least frequently mentioned issues for interviewees. We suspect this reflects that the stakeholders on the network management team or the regional stakeholder collaborative group (the interview sample) are more satisfied with communication arrangements than the wider group of network stakeholders (the survey sample). There appear to be a few discrete areas where communications are problematic:

Quantity versus quality

The dissemination of useful information and improved communication between providers was mentioned as a success by a number of respondents.

“The quality of information is good, particularly the data analysis reports which are excellent.”

“There has been improved communication between managers and clinicians across the region.”

“The Central Cancer Network distributes a truckload of information – of exceptional value is their recently developed quarterly report – this is something that could and should be driven nationally.”

“The establishment of a formal multi-level communication strategy across the region (has been a key success of this network).”

These positive comments were however, tempered by many comments urging the regional cancer networks to improve the relevance of the communication. The quantity of the information disseminated by the regional cancer networks has clearly been overwhelming many recipients and indications are this is having a counter-productive effect. Respondents acknowledge the technical quality of network documents but are getting lost in the detail, not having time to digest the full extent of the material being sent. Survey respondents identified this as an issue across all the networks but this was more often mentioned in the Central network. Negative comments about communications were evenly spread across all four networks from interviewees:

“Communication is generally poor – we are bombarded with information – need less information and more communication. At present it seems that quantity of information is being equated to quality and it’s not being received that way.”

“We get considerable amounts of information and it is often difficult to filter what we need vs. what is irrelevant.”

“The network provides too much information which I do not have sufficient time to read. Brief executive summaries would be more useful covering key points and developments only otherwise it becomes irrelevant.”

“We get sent copious amounts of paper; my printer can’t keep up with it.”

“At times the volume of information sent to stakeholders is overwhelming and it seems to be an insurmountable task to get through – too much information is disseminated – I receive everything but I don’t need everything.”

Suggestions made by respondents include:

- A précis of information to enable the recipient to easily determine whether the document is relevant to them with clear links to where full documentation can be found
- Stakeholder databases being set up so that the network management team send different information to different stakeholders depending on which areas are relevant to them
- Short two monthly teleconference updates for groups of stakeholders rather than them having to wade through large amounts of written word
- More regular e-newsletters with links to where full documentation can be found
- A secure website as a portal for stakeholders to access documentation as and when they choose

Information as a change management tool

Over recent years each regional cancer network has produced a significant amount of written material particularly in the form of reports. In many instances these reports have been seen as the vehicle to lead to the implementation of change i.e. they are the outcome of regional cancer network planning activities and the networks are using this material to provide the justification to relevant stakeholders that the change proposed in these reports is necessary. We found evidence to suggest that using detailed documentation as a change management tool may be less effective than intended.

“They produce documents that are long winded and difficult to read – they need to be much more succinct – the reader gets lost in the detail and they are far less likely to get any action as a result.”

“Reports are laboriously long and involved, making reading tiresome. Too much terminology without explanation. They need to be succinct.”

“No document produced by the network should be longer than ten pages – rather than focusing on very high level projects and taking so much time to plan and write lengthy reports about complex changes that take forever to implement they should hone in on the areas that need improvement, the current blockages, and work with the various players to facilitate change.”

Suggestions made by respondents include:

- Documentation to be simplified and in plain English with clear, practical outcomes
- Short sharp updates – publications of results
- Some form of scorecard to update stakeholders at a glance on progress against goals.

Two way flow of communication

There is a perception and to a large extent a reality that the network management team is the sender of information and the stakeholders are the receivers. The primary flow of information is from the centre out - much less information flows from stakeholders either back to the network management team or out to other stakeholders. Two way communication is at best occurring between LCNs and network project and special interest groups to the regional stakeholder collaborative group and to the network management team. The importance of stakeholders communicating with others in their sector is discussed in sections 4.4, 4.7 and 5. We found very little evidence where stakeholders use the regional cancer network as a means of communicating within their sector.

“The communication [from stakeholder representatives] back to the sector is patchy.”

“Some stakeholders use the network to share information with others in their part of the sector eg other palliative care providers, but this is not widely done.”

“It is difficult at times to establish what I should circulate out to my colleagues in other districts.”

Meetings being used to disseminate information

With so many stakeholders spread out across a geographical region it is easy to see how meetings can easily become a forum for sharing information – from network staff to stakeholders or between stakeholders. However, as summarised in Table 10 the regional stakeholder collaborative groups are intended to ‘give advice’, ‘provide guidance’, ‘prioritise and make recommendations’ and ‘provider leadership’ – they are not designed as forum for the regional cancer network to provide information to its stakeholders.

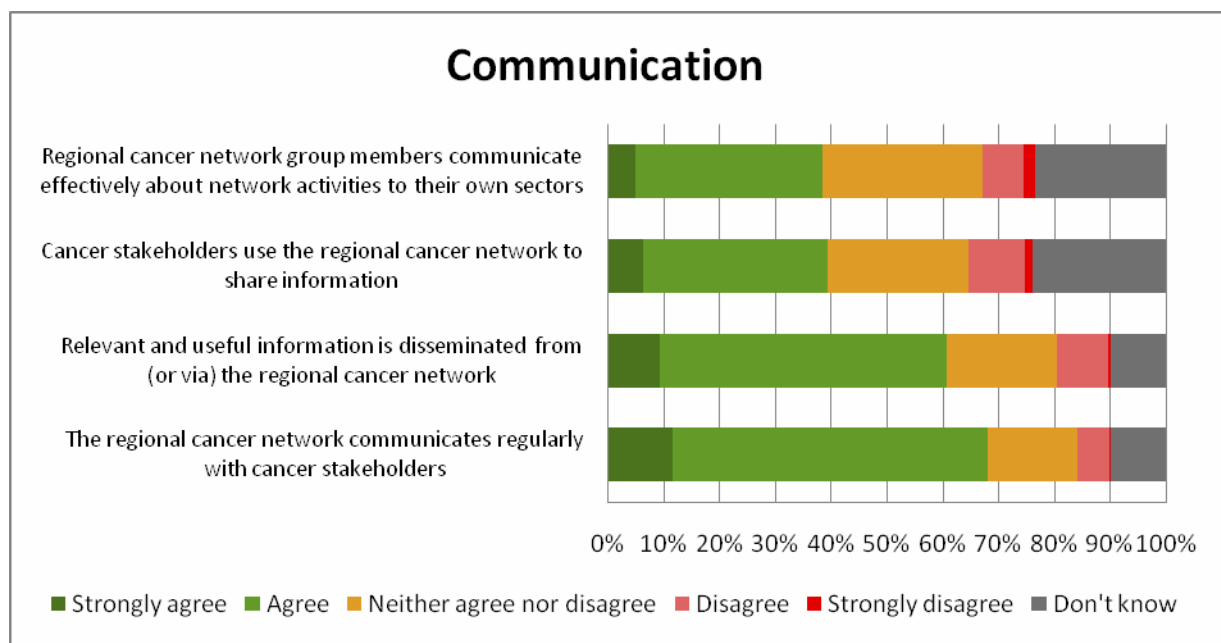
“We need to focus more on planning and implementation – many meetings are currently largely used to share information.”

“The executive group has become an information sharing process.”

“Most communication happens at meetings, but it needs to be better at other times.”

Figure 10 shows responses to the questions asked about communications in the survey. All stakeholders were asked these questions and 312 people answered them. Respondents appear to be slightly more positive than the quotes above suggest - nearly 70% of respondents agreed or strongly agreed that the regional cancer network communicates regularly with cancer stakeholders (quantity). However, 20% of respondents either didn't know or disagreed that network communications were relevant and useful (quality).

Figure 10 – Communication within regional cancer networks



Fewer than 40% of respondents on average agreed that regional cancer network group members communicate effectively about network activities to their own sectors or use the regional cancer network to share information amongst their own sector.

4.7 Leadership

4.7.1 Introduction

There are four key leadership positions in each of the regional cancer networks:

- Lead CEO
- Chairperson of regional stakeholder collaborative group
- Clinical Director (s)
- Network Manager.

These four leadership positions are, in many respects, what binds a network together. The lead CEO is responsible for taking a leadership role, on behalf of the regional cancer network, with the other CEOs of their region. The chairperson of the four regional stakeholder collaborative groups plays an important leadership role in bringing these stakeholders together to work collaboratively in the form of a representative group of sector leaders. Each regional cancer network has a manager and one or two clinical directors⁴⁹ and a small number of staff.

As we discussed in section 4.3 the major challenge for the regional cancer networks is that their only mandate to bring about change is one of collaboration. Likewise regional cancer network leaders only have a mandate to collaborate. Their challenge is to facilitate the cancer control sector in their region towards collaboration – towards a common sense of purpose – a commitment to and ownership of the regional cancer network and its work programme.

4.7.2 Conclusions

The six clinical directors and four network managers are commended for their leadership and we urge them to continue to explore all opportunities for building a sense of commitment and ownership with their stakeholders.

The clinical directors are all seen as great leaders for the regional cancer networks but indications are they need to become more visible in the region and at the regional stakeholder collective meetings.

There is further opportunity to develop distributed leadership amongst network stakeholders, thereby facilitating shared ownership.

4.7.3 Evidence and discussion

Most respondents spoke highly of the individual managers and all received positive comments about their leadership role within the cancer network; it was acknowledged that the role was a difficult and challenging one that the current managers were succeeding at. They also spoke of the obvious challenges and difficulties of the role and recognised that it requires a particular kind of individual to successfully lead a regional cancer network.

“The network’s manager provides continuity and leadership, conveying progress across a wide range of network activities and leading planning and reporting activities.”

“The Network Manager is very capable and could develop her leadership skills further.”

There was some concern expressed that the networks’ six clinical directors, with already full workloads, were not visible and/or not able to devote enough time to leading the network.

⁴⁹ The regional cancer networks that have one regional cancer centre have one clinical director (Northern and Midland) and the regional cancer networks that have two regional cancer centres each have two clinical directors (Central and Southern).

“There are excellent leaders and participants (clinical and non clinical) with skills, knowledge and mana within the Network to lead and communicate the work and purpose of the Network, engage and motivate. The “thinking” has definitely been done. Unfortunately these people are too stretched therefore have not the profile or time to full fill the leadership/communication roles.

These aspects are particularly important when you are making significant change to the way in which we develop and evolve our strategies – this is major change management and it takes time and commitment. There is no lack of commitment among those in the Network, but there is lack of time.”

“The clinical leader has not attended meetings this year and has had little perceivable input into the leadership of our network. He may provide leadership outside meetings but this is not evident to those of us who do not work for his DHB.”

“I have not observed a clinical director presence for the past 3 to 6 months, however it was evident prior.”

Clinical leadership is critical at all levels of the regional cancer networks. However, finding clinical leaders who can inspire and lead in a collaborative way as well as dedicate the time required to take on a leadership role within the regional cancer network is a major challenge. Clinicians who do step up and make a difference are seen as leaders and the demands on their time become even greater.

“There is an availability and credibility challenge with the clinical leaders that needs to be resolved if the network is to move to the next level.”

“There are so many conflicting challenges for time and energy it becomes very easy to be distracted. The depth of clinical leadership across the region is paper thin.”

Figure 11 shows responses from the 214 people who answered the survey and who are on a network group or project about leadership within the network. The majority of respondents agreed that the clinical leaders and network managers have the skills and experience to lead the network and that they worked effectively together. This supports the model of a shared management and clinical leadership being used by all four networks.

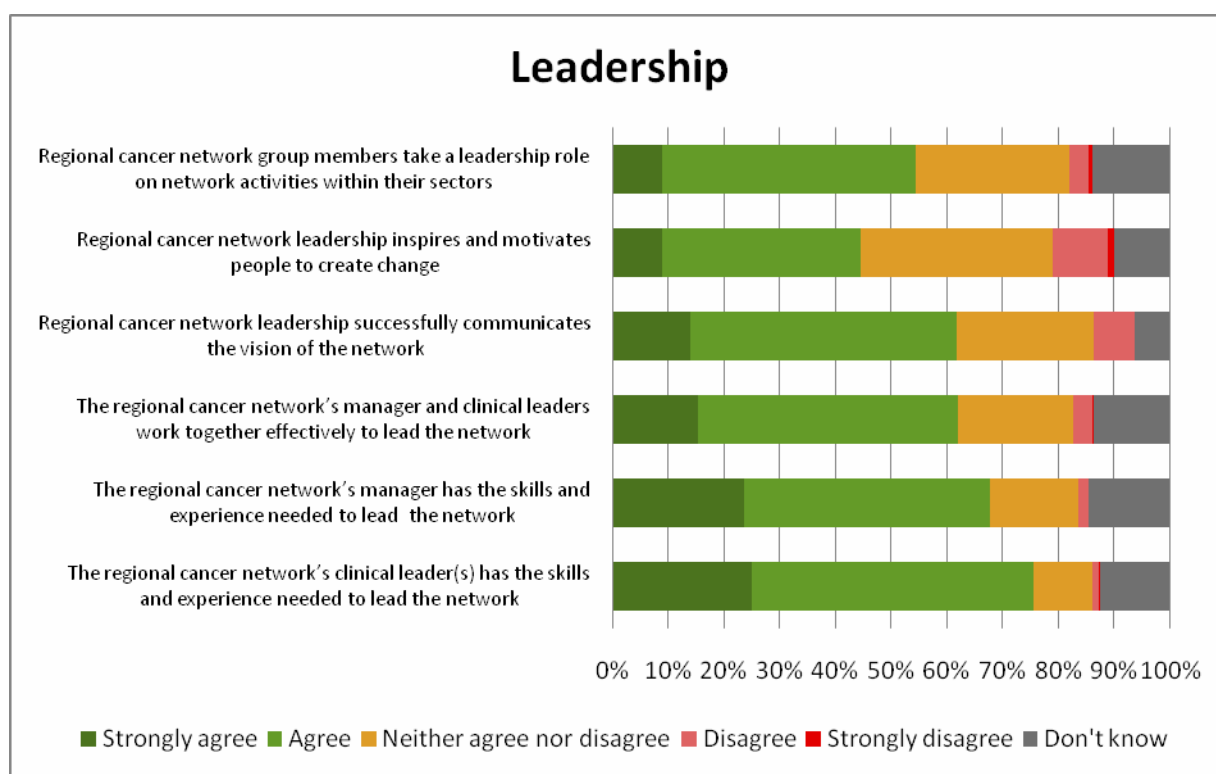
Only just over 40% of respondents felt the regional cancer network leadership inspired and motivated people to create change. This result is disappointing particularly as the central purpose of the regional cancer networks is change management. We found no evidence that this disappointingly low result is due to the calibre of any individuals.

However, only just over 50% of respondents believe that regional cancer group members take a leadership role of network activities within their sectors. All the stakeholder representatives who are members of the regional stakeholder collaborative group or any other regional cancer network groups are participating as representatives or leaders of their sector.

“I am not sure if other network members take a leadership role on their network but certainly being a governor for our area I have allowed myself to

morph into a ‘cancer champion’ and have taken a watchdog role to ensure our population have good access to services.”

Figure 11 – Leadership within the regional cancer networks



In section 4.4 we noted the confusion there is around the roles and responsibilities of stakeholder representatives in relation to representing or liaising with their sectors. We examined what the terms of reference for the four regional stakeholder collaborative groups state about this. Table 15 shows that the terms of reference are all largely silent on mention of any leadership role for sector representatives on these groups.

Table 15 – Terms of reference relating to leadership roles of members

	Stated purpose
Northern	The group is accountable for accurately representing the views of network stakeholders Brief to : Provide advice, from a stakeholder perspective, as and when required; Members are expected to take ownership and actively work to ensure success of the NCC. This includes supporting the network amongst colleagues.
Midland	Promote and facilitate information dissemination and knowledge sharing
Central	To develop effective working relationships with key organisations associated with cancer services within DHBs, PHOs, private and voluntary sectors To communicate effectively with stakeholders, including the provision of quarterly and annual reports Members are expected to take ownership and actively work to ensure the success of the Network Executive Group. This includes supporting the Network amongst colleagues
Southern	To share knowledge and developments To develop effective working relationships with key organisations associated with cancer services across the cancer continuum

4.8 Staffing

4.8.1 Introduction

While staffing of the regional cancer network did not rate as high in terms of importance as some of the other criteria for successful network functioning discussed so far in this report, perhaps a better indicator of the importance of staffing to each network is the fact that almost all interviewees said the skills, competencies and attitudes of network personnel is the single biggest enabler to the network's success (refer section 9.3 for further details).

4.8.2 Conclusions

All indications are that the regional cancer network staff are doing an excellent job given the new territory they are working in. Staff of all networks should be encouraged by the positive feedback from their stakeholders.

There is opportunity to improve staff skills in project management, quality improvement, change management and facilitation.

All networks appear to have work programmes that are considerably more ambitious than the number of staff available to undertake the work. There is a risk that staff will become disillusioned or burnt out if the work programme is unachievable.

4.8.3 Evidence and discussion

The regional cancer networks survive or fail on the skills and competencies of their staff. With each network having fewer than six full time equivalent staff members and the largest region (Central Cancer Network) having eight DHB districts, staff will be spread thinly no matter how they are used or how extensive the work programme is.

The staffing levels of each regional cancer network are limited by the available budget. Each regional cancer network has been able to determine the staffing arrangement applicable to their region. However, there are many similarities between the staffing of the four networks as shown in Table 16.

Table 16 – Staffing arrangements at June 2010 funded from core funding

	Northern	Midland	Central	Southern
Full time equivalents (FTEs)	5.9 FTE	5.4 FTE	4.6 FTE	4.625 FTE
Clinical Director	0.4 FTE Appointed May 2007 regional cancer centre medical oncology CD	0.2 FTE 1st appointment was regional cancer centre medical oncologist CD in 2006, resigned May 2008. 2 nd appointment regional cancer centre radiation oncologist appointed Jun 2008	2 x 0.2 FTE Appointed Jan 2007 regional cancer centre CDs	2 x 0.2 FTE Were regional cancer centre CDs when appointed in 2007 – neither currently holds the position of a regional cancer centre CD although both still have lead roles in the two southern regional cancer centres
Network Manager	1 FTE Appointed Nov 2007	1 FTE Appointed Oct 2006	1 FTE Appointed July 2007	1 FTE 1 st Network Manager appointed Sept 2007. 2 nd Network Manager appointed January 2008. 3 rd Network Manager appointed Sept 2009
Administration staff	1 FTE from July 2008	0.5 FTE from Oct 2007 1 FTE from July 2008	1 FTE from Dec 2007 Changed once in Oct 2008	.625 FTE from Jan 2008 .625 from March 2010
Project managers / service development facilitators	1.2 FTE from Dec 2008	0.8 from Jan 2007 1 FTE from Jan 2008 2 FTE from April 2008	1 FTE from Feb 2008 ⁵⁰	1 FTE from April 2008 2 FTE December 2009
Data analyst	0.5FTE from July 2008 via NDSA Decision support	0.2FTE – contracted with external provider from July 2008 ⁵¹	Contracted out to TAS	Provided by SISSAL Information and Analysis team
Reducing inequalities project managers / service facilitators	1 FTE Appointed June 2008	1 FTE 1 st appointment April 2008, resigned Oct 2009 0.2 FTE casual from April 2009 –July 2010 2 nd appointment June 2010	1 FTE Appointed July 2008 0.2 FTE Pacific Appointed Jan 2009	1 FTE Appointed June 2009 Resigned April 2010 New appointment July 2010
Public Health Medicine Specialist	0.8 FTE			

⁵⁰ Additional contractors have also been used for specific pieces of work for 3-6 month periods

⁵¹ Formal agreement commenced on this date – did employ prior to this

Each regional cancer network has had some additional funding for special projects (refer budget details in section 3.5). Table 17 outlines the staff appointments funded from this additional funding.

Table 17 – Staffing positions funded from additional revenue sources

Northern	Midland	Central	Southern
HRC Research 1.3 FTE ARPHS 0.8 FTE for 2007/08 (now covered in baseline)	1 FTE from Aug 2007 - June 2008 – AYA project one off 1 FTE for Jan 2009 – one off funding initiatives 1 FTE from July 2008 – Jan 2009 Cancer Control Implementation Fund initiatives 1 FTE fixed term from April 2010 – Feb 2011 Cancer Service Development Fund initiatives (plus responsible for Waikato palliative care service improvement facilitator 1 FTE fixed term from April 2009 until March 2015) ⁵²	1 FTE from Oct 2008 – Feb 2009 – fixed term to progress specific projects 1 FTE from Nov 2009 – Apr 2010 – Cancer Services Development Fund project 0.2FTE from Dec 2009 – Jun 2010– Cancer Services Development Fund project	0.2FTE from May 2010 which increased to 1 FTE from July 2010 - project manager from CSDF funding for SI Clinical Cancer Information System project

Table 18 summarises each regional cancer network's spending on staffing since the networks were established. These figures have been extracted from the full budget summaries contained in Table 7.

The 2010/11 staffing budgets show comparable staffing expenditure between the four regions, with the higher staffing costs in the Northern Cancer Network budget being offset by the additional revenue they receive from the HRC research grant (refer Table 7).

Table 18 – Expenditure on staffing for each regional cancer network

	Northern	Midland ⁵³⁵⁴	Central	Southern
2006/7	0	164,729	0	0
2007/8	162,574	379,796	277,000	99,242
2008/09	485,503 ⁵⁵	441,912	491,000	361,408
2009/10	758,870	395,982	450,000	429,046
2010/11 budget	672,852	469,632	498,000	493,131
Total	2,079,799	1,852,051	1,716,000	1,382,827

⁵² Not included in the budget outlined earlier in the report

⁵³ Note this budget does not include funding for facilitation of the Waikato Palliative Care Network that the regional cancer network manager is also responsible for

⁵⁴ Accounting internal recharge and outsourced rule changes over the 4 years, overhead charges not included in accounts therefore an estimation has been made

⁵⁵ \$100,000 of this was funded by a one-off budget transfer from Auckland Regional Public Health Service to cover the salary of a Public Medicine Registrar

Interviewees were almost universally of the view that the network staff do a great job considering their ambitious work programmes, the multiple demands upon their time, the constantly changing environment, working with multiple stakeholders (many of whom they never meet), and trying to effect change where their only mandate is to collaborate. The regional cancer network staff can be complemented for their efforts. *"The team appear very skilled, very helpful and produce sound work."*

Several interviewees noted the range of competencies required for network staff to collectively undertake the wide variety of network activities means it is very difficult for each network to capture all skills at all times in so few staff. One of the regional cancer network managers commented that it takes time, with a new staff member, for her as the manager to see their specific style. The first challenge is to appoint the right staff and then to have an innate sense of matching staff members to different projects and staff skills to the approach that will be taken. One of the regional cancer network managers noted: *"To a large extent it is about 'learning as we go' while trying to minimise setbacks and mistakes"* or as another respondent said *"You only need one staff member not operating appropriately and this can set the whole thing off keel."*

The situation becomes even more challenging if one staff member leaves as it is difficult for the network to replace that person with someone with exactly the same skill mix, meaning the total skill mix is likely to vary over time. This appears to be further exacerbated by changing expectations of network stakeholders over time and the changing focus of the regional cancer network work programme. For example the focus of the current Minister of Health on developing clinical networks is leading to the regional cancer networks considering whether changes in national policy will impact on their required staffing skill mix.

Figure 12 shows the responses from the 212 cancer stakeholders who answered this question. Only those on a regional or local cancer network group or closely involved in a regional cancer network project were asked these questions. Not all these people will have necessarily had enough contact with network staff in order to be able to form an opinion so we have also produced a chart (see Figure 13) which excludes the 'don't knows' to provide a clear picture of the respondents who are best placed to have an opinion.

Figure 12 – Staffing in the regional cancer networks

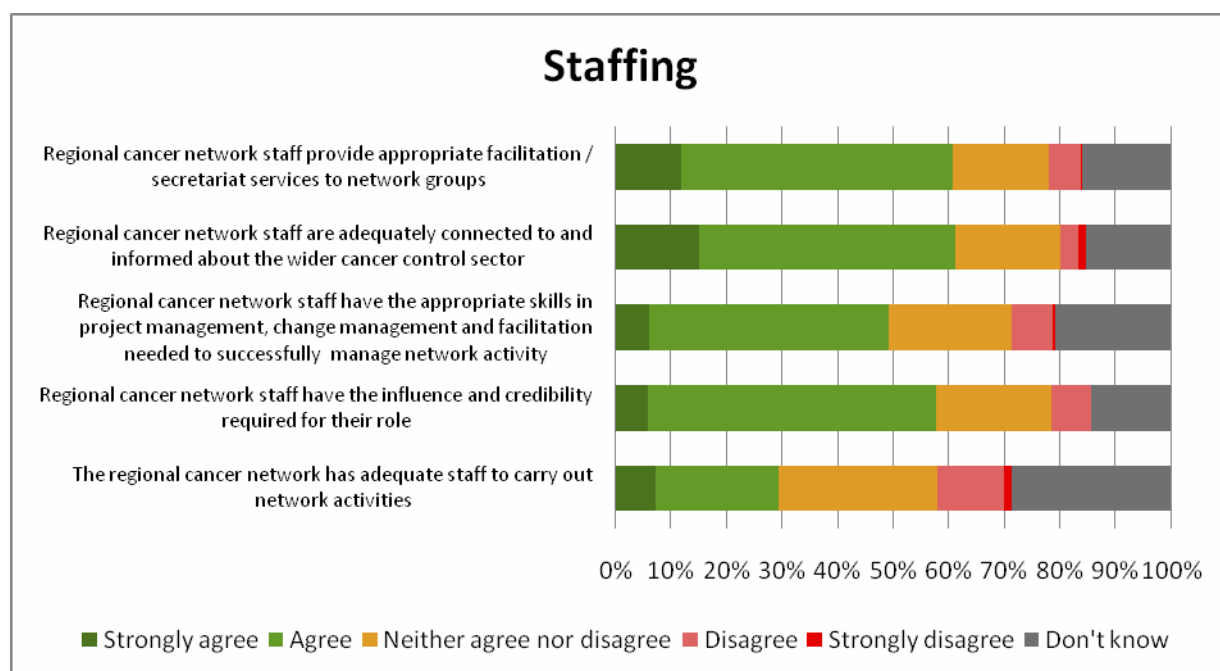
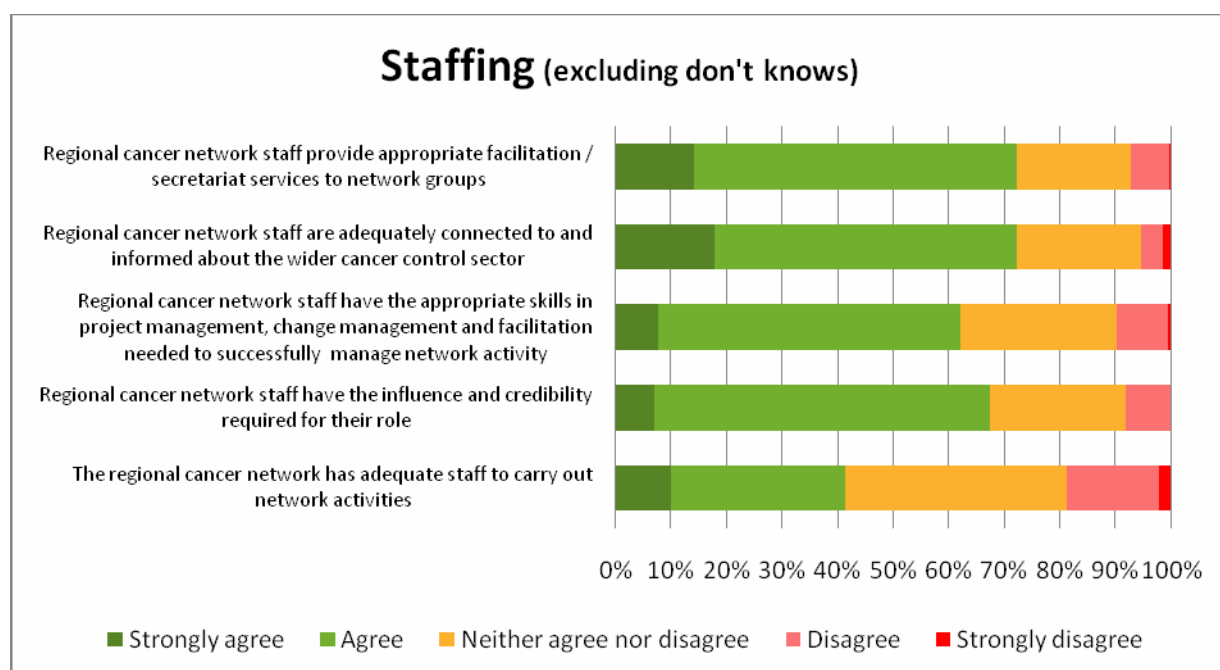


Figure 13 – Staffing in the regional cancer networks (excluding don't knows)



Just over 60% of all respondents (excluding don't knows) strongly agreed or agreed that the regional cancer network staff have the appropriate skills (project management, change management and facilitation); several interviewees identified skill deficits in some of the network management teams:

“The team needs to strengthen skills in quality improvement techniques.”

“There is varying expertise around project management in our team.”

“From my perspective there have been fluctuating levels of appropriate skills – the levels of skills and expertise in regard to change management and facilitation was not at the right level [for a particular project].”

The result of greatest concern for this section is that only 40% of respondents felt the regional cancer networks have adequate numbers of staff to carry out network activities. Many interviewees commented on this. Unsurprisingly the regional cancer network managers were the most likely to mention staff shortages:

“There is a limit on what the team can achieve on current head count. I don’t believe we can continue much longer with only two tumour streams. Stakeholder expectations are that we need to soon be introducing other tumour stream projects. But I can also see that there is a need to keep up the momentum on the current two tumour stream projects and this is not going to reduce any time soon.”

“The current staffing levels are inadequate to deliver the work plan within the proposed timeframes. This is due to a number of factors including: number of projects on the work plan; size of the region and therefore the numbers of stakeholders; the team needing to be more involved in implementation level activities that initially expected; additional priorities being identified over and above planned activities.”

These findings serve to reinforce our discussions in section 4.5 and support our finding that the regional cancer networks are taking on more ambitious work programmes than can be achieved with the current staffing levels. This also reinforces the need for the networks to clearly define their purpose and roles, their boundaries with other agencies and their planning and prioritisation processes. Many of the conclusions and recommendations of this evaluation will create additional demand on the management and staff and hence will also need to be factored into the overall prioritisation process.

4.9 Reducing inequalities focus

4.9.1 Introduction

One of the two overarching goals of the New Zealand Cancer Control Strategy is to reduce inequalities. Hence this is a key component of network functioning and one of the critical areas for network success.

The Ministry’s website⁵⁶ summarises inequalities in the health sector as follows:

A major health challenge for New Zealand is the inequalities in health between Māori/Pacific and non-Māori/non-Pacific peoples. It is well documented that people of Māori and Pacific ethnicity and low socio-economic status (income, education, occupation, housing) have consistently poorer health outcomes in comparison with the rest of the population.

⁵⁶ <http://www.moh.govt.nz/inequalities>

While inequalities in health are not random, the causes of health inequalities are complex and multifaceted. To address health inequalities requires a strong evidence base and a strategic approach from the health sector and other sectors to reduce health inequalities for those that are disadvantaged.

The Ministry has allocated \$250K per annum to reducing inequalities activity within each regional cancer network and the CFA requires regional cancer networks to:

- *Includes resources in the Network management team with a specific focus on inequalities*
- *Raises awareness of inequalities among cancer service providers and other cancer stakeholders*
- *Works to better identify the causes of cancer inequalities and address those inequalities, by:*
 - (i) Promoting the consistent collection of ethnicity data by providers and the inclusion of ethnicity data in routine data reporting;*
 - (ii) Undertaking, sponsoring or facilitating appreciative enquiry to better understand the inequalities in access apparent through data;*
 - (iii) Sponsoring or facilitating innovative pilot or demonstration projects to reduce inequalities in service access and/or improve service effectiveness and acceptability for different populations groups. The network may allocate funding to small-scale, one-off projects or initiatives, but is not expected to sustainably support service delivery;*
 - (iv) Ensuring that information on successful initiatives is widely disseminated and that other providers or stakeholders have the opportunity to learn and benefit from these successful initiatives;*
 - (v) Promoting system-level changes that can reduce access barriers for population groups, including changes that may be required beyond dedicated cancer services;*
 - (vi) Providing advice to funders and planners of both DHB and non-DHB services on strategies for reducing inequalities and the highest priorities from an inequalities perspective; and*
 - (vii) Consulting with and ensuring the participation of Māori and other population groups in service delivery planning as well as at governance levels.*

Whilst the proportion of the population that identifies as Māori differs between the Northern Cancer Network, the Midland Cancer Network and the Central Cancer Network the actual number of Māori in these three regions is comparable as shown in Table 19.

Table 19 – Proportion of Māori in each regional cancer network

	Northern	Midland	Central	Southern
Percentage of the population identifying as Māori	13.5%	23%	17%	8%
Number of Māori	207,900	145,360	167,110	78,800

Both the proportion and total number of Pacific and Asian peoples varies significantly between the four regional cancer network regions as shown in Table 20.

Table 20 – Proportion of other ethnic groups in each regional cancer network

	Northern	Midland	Central	Southern
Percentage of the population identifying as Pacific	12%	3%	4%	1.6%
Number of Pacific people	184,800	18,960	39,320	15,760
Percentage of the population identifying as Asian	16%	4%	5%	4.1%
Number of Asian	246,400	25,280	49,150	40,385

Inequalities can also arise due to geography. All the regional cancer networks have some areas that are geographically isolated but the vast size of the Central Cancer Network and the Southern Cancer Network poses particular challenges for equality of access in those regions

Māori are often impacted on both counts – because of the ethnicity inequalities and also because Māori are over-represented in the most isolated geographical areas for example the far north and the east cape of the North Island. Furthermore Māori living in most isolated areas tend to have poorer access to transport than other rural dwellers and therefore these populations are at risk of being especially disadvantaged.

Therefore the primary focus of reducing inequalities for all the regional cancer networks needs to be Māori (as highlighted in the CFA), but attention also needs to be paid to lower socioeconomic, geographically isolated areas, Pacific, and other minor ethnicity groups. This section should be read alongside sections 5.7 and 5.8 which focus on the involvement of Māori and other ethnic groups in the networks.

4.9.2 Conclusions

All four networks have a clearly stated focus on reducing inequalities and all now have one dedicated reducing inequalities staff member on their team. It is beyond the scope of this evaluation to determine what specific outcomes have been achieved in reducing inequalities and more study would be required to reach reliable conclusions in this respect.

Indications are that good progress on reducing inequalities has been made in Northern and Central regional cancer networks. These regions are urged to continue their efforts.

Interviewees didn't rate Midland and Southern regional cancer network's reducing inequality efforts as highly and so greater efforts will be required in these regions. We acknowledge both these networks have recently recruited new reducing inequalities staff members.

If specific reducing inequalities funding is going to continue beyond 2010/11 consideration could be given to developing a variable model to target this funding toward the areas of greatest need and undertaking a more focused evaluation of the value and outcomes of the reducing inequalities activities each regional cancer network has undertaken, given that it is nearly 50% of the annual vote health budget for each network.

4.9.3 Evidence and discussion

Each of the regional cancer networks now has a dedicated reducing inequalities staff member as shown in Table 21.

Table 21 – Staff members dedicated to reducing inequalities

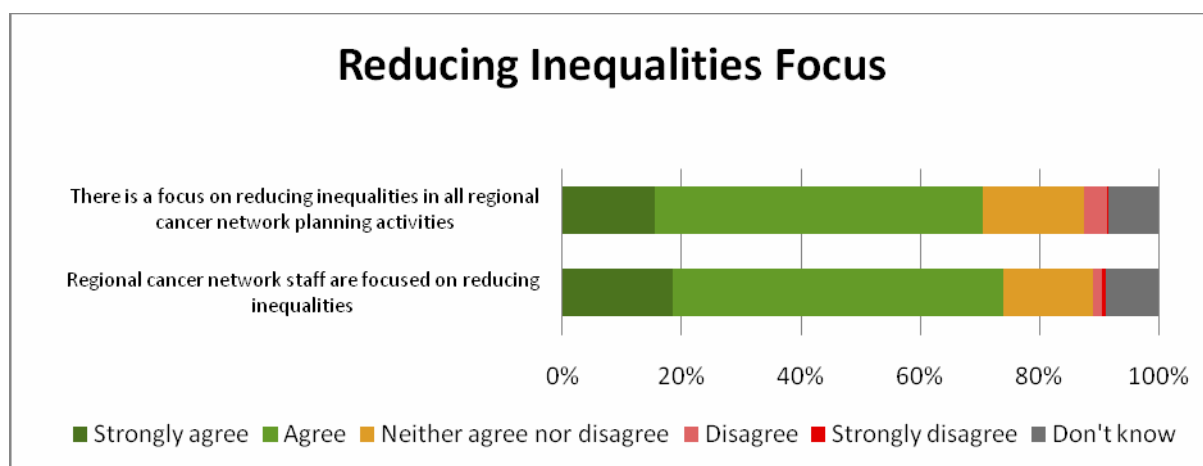
Northern	Midland	Central	Southern
1 FTE Appointed June 2008	1 FTE 1 st appointment April 2008, resigned Oct 2009 0.2 FTE casual from April 2009 –July 2010 2 nd appointment June 2010	1 FTE Appointed July 2008 0.2 FTE Pacific Appointed Jan 2009	1 FTE Appointed June 2009 Resigned April 2010 New appointment July 2010

Many of the activities / projects outlined in section 0 reflect a reducing inequalities focus by the regional cancer networks. As detailed in Table 7, each of the regional cancer networks has received \$875,000 between 2007/08 and the 2010/11 financial years for reducing inequalities initiatives. All regional cancer networks were given equal amounts of reducing inequalities funding despite the differences in the ethnic mix of their populations. It is beyond the scope of this evaluation to provide a detailed assessment of the way in which this funding has been spent or any outcomes achieved. If dedicated reducing inequalities funding is to continue past 2010/11 we recommend a more focused evaluation of the value and outcomes of the activities each regional cancer network has undertaken to date in this respect, given that it is nearly 50% of the annual vote health budget for each network.

Interview findings showed signs that some regional cancer network stakeholders (including some members of the regional stakeholder collaborative groups) still don't have a good understanding of the issue of inequalities in health or the importance of partnership with Māori at all levels of cancer control. Some still see inequalities as something that Māori themselves somehow create and hence not something that members of the regional cancer network have collective responsibility for. This is a fundamental risk to the concept of collaboration within a network. As discussed in section 4.3, collaboration and hence commitment to and ownership of the regional cancer network, can only come about when all collaborating parties can stand in one another's shoes. One of the regional cancer network managers talked about addressing inequalities first needing people with open minds and no preconceptions, leaders who are comfortable to ask, trust, respect and responsiveness. There can be no 'them and us' in a collaborative network.

All network managers talked about their commitment to addressing inequalities and how all potential network initiatives now have an 'inequalities lens' passed over them to determine which are most likely to have a positive impact on reducing inequalities, how they 'matrix inequalities' through all their initiatives and how they are identifying issues and gaps that lead to inequalities on a project basis. Figure 14 shows over 70% of respondents on average agree that there is a focus on reducing inequalities by staff and in planning. All networks scored very similar results.

Figure 14 – Reducing inequalities focus of regional cancer networks



The reducing inequalities focus of the networks was overall the second most common mentioned success (after improving relationships, bringing people together) when people were asked to outline the greatest success of the networks to date in the open ended question in the survey. Successful approaches for reducing inequalities were mentioned particularly by stakeholders in the Northern and Central regions. It was not mentioned at all in the Midland region where respondents saw clinical projects as the areas that the regional cancer network was most successful in.

“[The greatest strength is] the employment of inequalities staff who have the cultural networks and ability to liaise with key stakeholders, coordinate and facilitate hui.”

“Recognising that when things are 'right for Māori patients' they will probably be right for all. In other words getting out of a medical model of health and having to recognise the health determinants with the patient at the centre.”

“I believe that the regional cancer network greatest success to date is the goodwill shown to develop a Iwi/Māori pathway that is underpinned by Iwi/Māori values, concepts, beliefs and principles.”

“The Central Cancer Network has put inequalities as a priority and enabled the voice of Māori to be heard and to develop a means to address disparities. It has encouraged collaboration within providers and provided forums to open up dialogue between services.”

Whilst all networks report a focus on inequalities they all acknowledge there is much more that needs to be done. One of the clinical directors said: *“It currently half works – I still don’t think our network addresses reducing inequalities with as much vigour as we could do particularly when it comes to individual projects.”* One of the regional cancer network managers expressed the challenges this way: *“We have Māori representation on our governance group and at work group level but I feel we get very little advice on how to improve Māori outcomes. There is lots of advice that we should work on improving Māori welfare but it goes a bit quiet when we ask for practical input.”*

Reducing inequalities needs to be more than a concept, a lens, or a matrix – it must result in a different way of working, a different way of thinking and it must produce results or outcomes. Inequalities are not easily reduced and will take many years of concerted action. The tumour stream pathway, particularly at the interface between primary and secondary care, is seen as one of the areas where the networks can have the greatest impact on inequalities. This is also mentioned in section 10.3.

“There is still a long way to go – we need to consciously make sure Māori involvement and the inequalities concept is not just token.”

“Things have gone well but we haven’t got a clear pathway forward yet to make a clear difference in terms of Māori cancer.”

“The network has put Māori on the radar – but we need more than ticking the box – whanau ora is an overarching umbrella – that is what networks should be.”

4.10 Evaluation

4.10.1 Introduction

Monitoring and evaluation activities need to be an integral part of any new project or programme – we need to know whether the investment we are making in new initiatives is making a positive difference, creating change, and leading to outcomes. This applies to regional cancer networks themselves as a relatively new concept as well as to individual projects and programmes undertaken by the regional cancer networks.

4.10.2 Conclusions

There has been little or no monitoring and evaluation either of the performance of regional cancer network themselves or of their various work streams, although KPIs for intermediate outcomes are being developed. There is significant room for improvement in this area.

We would urge the regional cancer networks to think about establishing a mechanism to evaluate one another’s projects – this would keep costs down, up-skill staff and build stronger linkages between the four networks.

The survey conducted for this evaluation provides a good baseline of data – the networks could repeat the same survey in two years time to measure what progress has been made over that time.

4.10.3 Evidence and discussion

To date there have been little or no monitoring or evaluation activities undertaken by the regional cancer networks on the extent to which recommendations from their reports have been implemented at local level. For this reason we didn’t include any specific questions about monitoring and evaluation in the survey and the only interview participants who were asked about monitoring and evaluation were the four regional cancer network managers and the Ministry cancer control team. Comments and suggestions made by the managers have been clustered and listed below :

What is the position with monitoring and evaluation in your regional cancer network?

- *"We haven't done much evaluation but need to."*
- *"We didn't have time to plan and do set up properly and certainly we haven't had time to stop and evaluate."*
- *"It is happening but informally."*

What monitoring or evaluation activities has your regional cancer network undertaken?

- *"We have done a survey monkey exercise and developed set KPIs."*
- *"We are developing KPIs and have quality objectives to report on."*
- *"Our governance group did self evaluation with the team."*
- *"The team keeps a list of learnings that they then refer to in other projects."*
- *"We are doing survey monkey to help design what they do – what's going well – what do you want."*
- *"Reviewing and debriefing on projects."*
- *"There is open sharing between the four networks – documents and sharing at national level and have started to monitor the results of some of our projects. "*

What ideas do you have for monitoring and evaluation activities?

- *"Monitoring and evaluation of regional cancer network performance should do nationally rather than separately four times over."*
- *"We don't need a policeman model – we need to be working with integrity to a common end point."*
- *"Process evaluation as well as outcome evaluations are needed."*
- *"Need to measure 6 to 12 monthly to avoid variances in monitoring."*
- *"Continuous improvement – sharing between networks."*
- *"Need to review network functions quite regularly to ensure they are still needed and still appropriately focused - constantly check course and re-steer the ship."*
- *"Evaluation should be about constantly learning as you go."*

The Ministry team noted that the regional cancer networks are about innovation and implementation and this provides opportunities to observe what's working and what's not working. They suggested regional cancer networks explore opportunities for self evaluation.

The managers told us that monitoring and evaluation is currently on agenda for discussion nationally.

5 Active involvement of cancer sector stakeholders

5.1 Introduction

As discussed in many places already in the report, stakeholder engagement is the cornerstone of regional cancer networks. Cancer control stakeholders cover the broad continuum from prevention through to palliative care and research and include government and non government organisations, consumer groups and those representing the special needs of Māori, Pacific and other ethnic groups. Cancer control also spans the public, private and voluntary sectors.

The CFA states that regional cancer networks need to:

Bring together all constituent organisations, professionals and interest groups involved with cancer, and provide a formal governance structure that:

- *Involves patients, their families / whanau and the public,*
- *Ensures input of all DHB and NGO cancer service providers across the region, including PHOs,*
- *Includes identified Māori leadership and a framework to ensure participation of Māori.*

Many issues and problems in cancer management arise from misunderstandings in the role the various stakeholders play in their respective parts of the patient journey and the different issues experienced by different groups i.e. Māori and other ethnicities and different geographic areas. Bringing the collective voice of the various stakeholders and district/local areas to a collective forum brings everyone's reality into consideration. The challenge for the regional cancer networks has been to ensure each local district and each stakeholder group is fairly and adequately represented at the regional level and, where relevant, on regional cancer network working groups and projects and that there are ways for the wider sector to link in.

5.2 Conclusions

All regional cancer networks have made extensive and commendable efforts to engage with their wide variety of stakeholders (including consumers, NGOs, clinicians, DHBs) and stakeholders are generally satisfied with these arrangements.

The area that requires the greatest attention is the engagement of the primary care sector. This was found to be one of the most significant barriers to progress for the networks (section 9) and likewise one of the greatest opportunities for improvement (section 10.3).

The Northern Cancer Network appears to have made the greatest gains in Māori engagement and Māori leadership and the other three networks are urged to leverage off the gains the Northern Cancer Network has made in this area. All regional cancer networks are urged to collaborate on the development of a consistent Māori framework nationally.

Establishing mechanisms for engagement of other ethnic groups is another area for future focus.

It is much more difficult for the Central Cancer Network and the Southern Cancer Network to achieve the same degree of stakeholder engagement from the same budget and the same level of staffing as the other two networks because they have more DHBs and larger geographical regions.

5.3 Evidence and discussion

All those interviewed are committed to and see the value of stakeholder engagement in cancer control and most would like to see increased stakeholder engagement in the future. Increasing the involvement of stakeholders was the second most commonly mentioned issue by the 97 respondents who completed the open-ended question about opportunities for improvement in the survey.

One of the lead CEOs said he felt the successful engagement with stakeholders is the greatest success of the regional cancer networks. This is reinforced by the fact that bringing people together / improving relationships was mentioned most often as the key success of the regional cancer networks in the open ended question in the survey, where key successes included:

“It has encouraged collaboration within providers and provided forums to open up dialogue between services.”

“Having a platform where all stakeholders meet on a regular basis and discuss current cancer problems.”

“This historically disparate group is gradually coming together with a sense of cohesion and focus that will have a definite impact.”

All those responding to the online survey were asked about their satisfaction with their level of awareness and involvement with the regional cancer networks. The vast majority of people who answered that question expressed satisfaction suggesting that the regional cancer networks are doing a good job with engaging the wider sector. Those who were less than satisfied tended to want additional or more relevant information about the activities of the network, and were slightly higher represented in the Southern region. Only a very few stated that they wanted more specific involvement and there was no consistency with the type of role that they came from.

However, despite the widespread support, stakeholder engagement in regional cancer networks has presented challenges. It has been particularly difficult for those regional cancer networks that have more DHBs and larger geographic regions (Southern Cancer Network and the Central Cancer Network). Not only have these regional cancer networks got more stakeholders to engage but the geographic distances make meeting face to face more difficult, more time consuming and more costly. Both regions utilise teleconferencing and videoconferencing but acknowledge that developing the collaborative spirit and the resulting sense of commitment to and ownership in the network is much harder when stakeholders can't engage with one another in person.

Figure 15 outlines responses to questions asked of all respondents about the involvement of network stakeholders in the regional cancer networks. 297 people answered these questions.

Between 20% and 45% of respondents didn't feel well enough informed to answer each question. This is understandable given that consumers for example may not know about how actively

clinicians are contributing. We present the data both including and excluding those who don't know but the numbers outlined in the text are excluding the don't know responses (those shown in Figure 16).

The most frequently mentioned areas for improving stakeholder engagement identified in the qualitative interviews and the quantitative survey and discussed in the following sub sections are:

- Supporting and fostering the development of multi disciplinary local cancer networks that have the commitment of all stakeholders and provide a regional/district link for the regional cancer networks
- Engagement of the primary care sector
- More active participation of Māori
- The development of more clinical champions
- Greater buy-in at DHB level
- Pacific representation in particular pacific consumers and carers.

Other opportunities for improving stakeholder engagement mentioned by interviewees were:

- National training for network representatives
- Linkages with the private sector
- Strengthening and broadening palliative care involvement
- More engagement of and collaboration with public health - maybe public medicine specialists taking up clinical director positions.

Figure 15 – Involvement of stakeholders in regional cancer networks

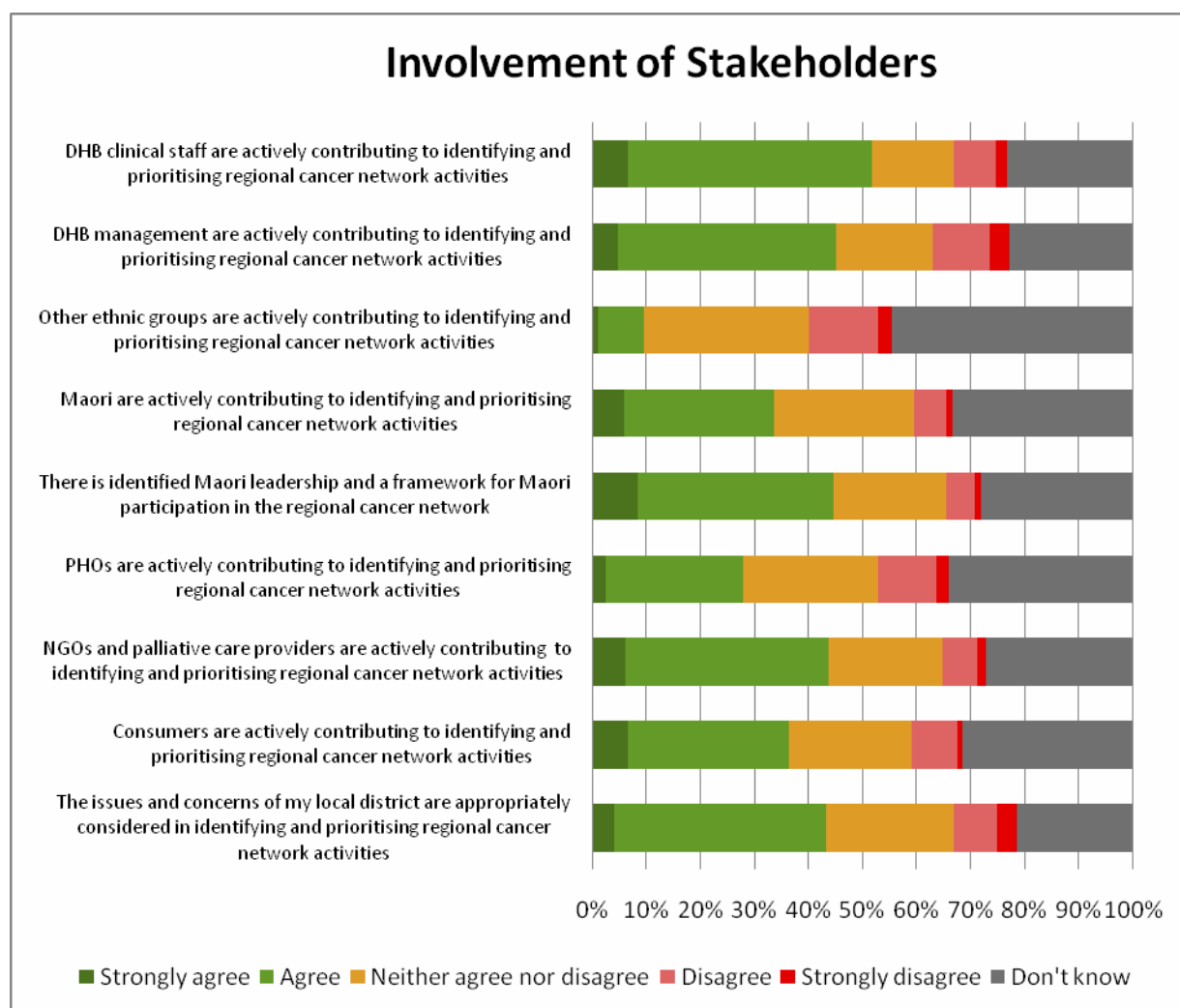
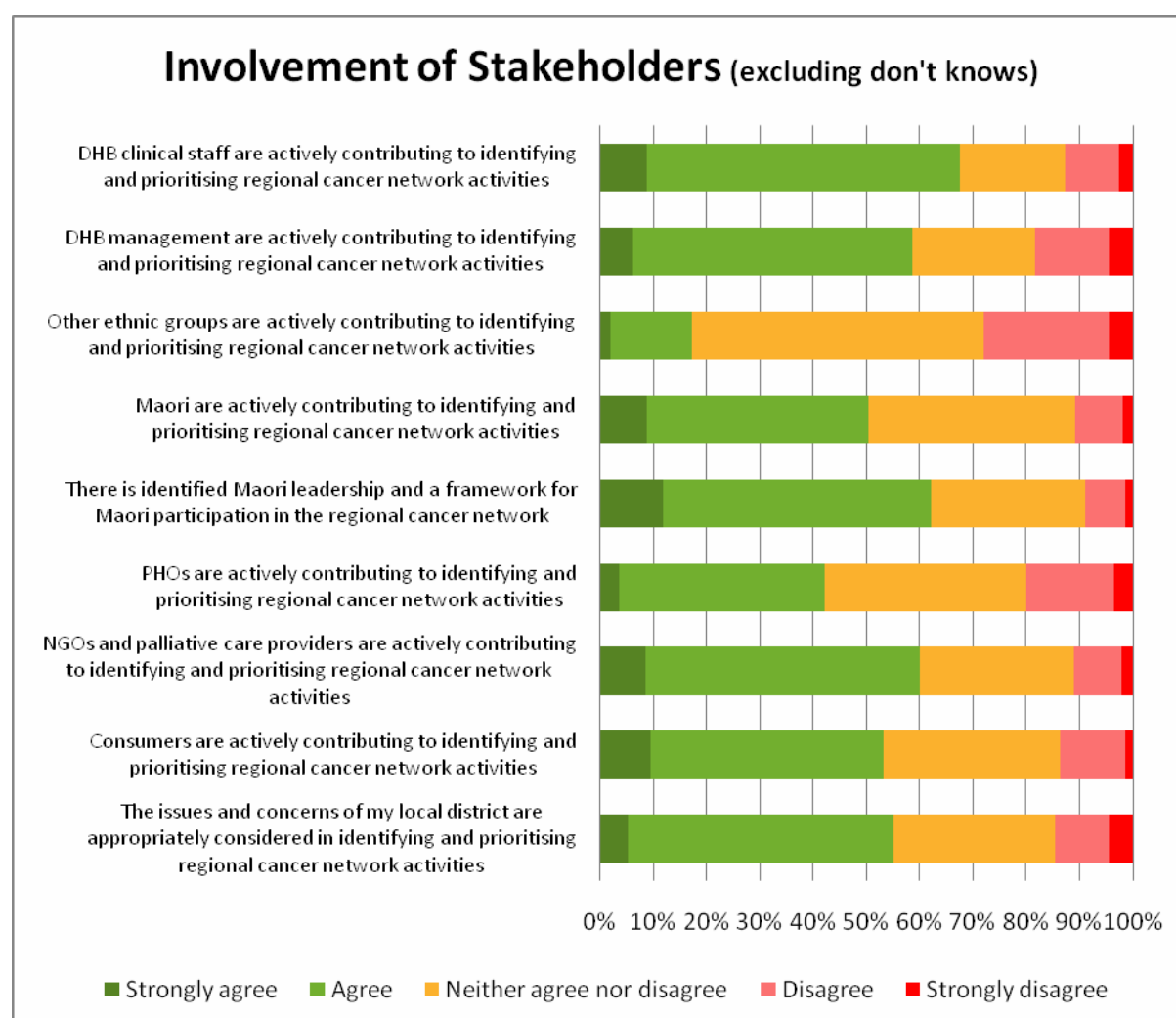


Figure 16 – Involvement of stakeholders in regional cancer networks (excluding don't knows)



5.4 Local DHB district representation

It is interesting to note that over 20% of respondents on average across the four regional cancer networks did not know if the issues for their local area were being appropriately considered in identifying and prioritising regional cancer network activity. Even when excluding these don't knows, only slightly more than half of cancer stakeholders on average across the four networks agree that local issues are being adequately considered, although the result is higher in Midland and is similarly high for Bay of Plenty and Lakes respondents as well as Waikato respondents.

The leaders of the Central Cancer Network and the Southern Cancer Network talked about the particular challenges they face with their vast geographical areas, a larger number of DHB districts (eight for Central Cancer Network) and hence a proportionally larger number of stakeholders. Linking multiple stakeholders across these broad geographical regions is clearly a more difficult job than in the other two regions that have a smaller number of DHB districts and smaller geographical areas.

To a greater or lesser extent the regional cancer networks have all structured their regional stakeholder collaborative groups to include representation from each of the stakeholder groupings

and from each of their constituent DHB districts. The district representation on the regional stakeholder collaborative group of each network is outlined in Table 22. All regional cancer network stakeholder collaborative groups have representation from all their constituent DHBs and the district representation appears to be fairly evenly spread amongst the local districts except in the Midland Cancer Network where the Waikato region has five times more representatives than either Lakes or Bay of Plenty, although many of the Waikato representatives are linked into wider Midland collaborative forums and are the Midland representative on the regional cancer network.

Table 22 – District / local representation as at May 2010

	Northern	Midland	Central	Southern
District representation at regional stakeholder collaborative group level⁵⁷	Northland – 3 (2 DHB and Chairperson) Auckland – 5 (3 DHB, 2 PHO) Waitemata – 3 (2 DHB, 1 hospice) Counties Manukau – 3 (2 DHB, 1 PHO) Other roles not district specific	Waikato - 10 Lakes - 2 ⁵⁸ Bay of Plenty - 2 Regional (network staff and NGO) - 3	Taranaki – 1 (Māori) plus 1 vacant Tairāwhiti – 1 (DHB) Hawkes Bay – 1 (DHB) Whanganui – 1 (PHO) Midcentral – 1 (DHB Chairperson) Wairarapa – 1 (DHB) Hutt Valley – 1 (DHB) Capital and Coast – 1 (DHB)	Nelson Marlborough – 1 (primary care) Canterbury – 4 (DHB) West Coast – 1 (primary care) South Canterbury – 2 (1 DHB, 1 Māori) Southern – 4 (3 DHB, 1 GP)
Local cancer networks	Northland Counties Manukau Waitemata (re-formed from June 2010) Are facilitated locally and were established prior to the network.	Lakes Cancer and Palliative Care Forum jointly formulated between Lakes and regional network, since April 2010 ⁵⁹ BOP Technical Advisory Group – Cancer Control since Oct 2007	Taranaki Tairāwhiti Hawkes Bay MidCentral Wanganui Wairarapa Hutt Valley / Capital and Coast Formation facilitated by regional network All formed between Feb 2008 and June 2009	Nelson Marlborough Canterbury South Canterbury West Coast Otago Southland ⁶⁰ Formation facilitated by regional network with the exception of West Coast who had formed their own grouping. All formed by Feb 2009
Links of main stakeholder collaboration group members to local cancer networks	Reps from CMDHB, NDHB and WDHB are also in the local cancer networks	MCN Executive Group members on the: Lakes Cancer and Palliative Care Forum BOP Technical Advisory Group – cancer control Waikato Palliative Care Network	All district representatives on the Governance Group link to their respective LCN. LCNs now nominate replacement district reps for the Governance Group.	17 of the 19 SCN Steering Group members sit on the LCNs. Two of the SCN Steering Group members chair LCNs.

⁵⁷ Consumer, NGO and hospice representatives (and 1 Pacific rep from the Central Cancer Network) not been included in this table unless specified – in some instances these representatives are not also wearing a specific local DHB district hat

⁵⁸ Plus 1 in an advisory role

⁵⁹ Prior Lakes Cancer Control Stakeholder workshop; Lakes Clinical Advisory Group – EOL and Lakes Palliative Care Service Provider group since 2008

⁶⁰ Although still called Otago Southland this LCN covers the new Southern DHB region

Underpinning both the Central Cancer Network and the Southern Cancer Network there are 13 LCNs, one in each of their constituent DHBs. By LCN we mean a network mirroring the cross continuum, cross sector representation that occurs in the regional cancer network stakeholder collaborative group. In most instances the regional cancer network has worked with these DHBs to facilitate the establishment of the LCNs as an extension of the governance structure of the regional cancer network. Each of the LCNs is represented on the regional cancer network stakeholder collaborative group. Three of the four DHBs in the Northern Cancer Network have LCNs but these are locally facilitated. Lakes DHBs within the Midland Cancer Network has recently set up such a cross sector local group⁶¹ and Bay of Plenty has a technical advisory group which is facilitated by Bay of Plenty funding and planning and provides clinical advice on strategic planning.

All agree that the LCNs have a vital function in enabling the regional cancer network to link to their constituent DHB districts.

“Local cancer networks are getting stakeholder interaction and contributing to collaboration across sectors.”

“From the perspective of the LCN, bringing together the various community and DHB stakeholders and consumers is an accomplishment. Their combined input and developing trust improves the experience for the consumer.”

Common themes reported were:

- LCNs have been particularly valuable for providing some balance between the six DHBs with regional cancer centre and the 14 ‘feeder’ DHBs
- The LCNs are at various stages of development and some LCNs are more organised and more effective than others
- The LCNs provide a vital link between the regional cancer network and funding and planning management in each of the DHBs
- The presence of LCNs enables the regional cancer network to be a conduit for feeding national and regional cancer control matters down to the local/district level and for bringing local/district cancer control issues together at a regional level and where necessary elevating these to a national level
- The LCNs need to be seen as part of the collaborative network for change i.e. part of the collective ‘we’ rather than feeling they are being told what to do by the regional cancer network; an issue that was mentioned by several people in the open ended questions of the on-line survey.

5.5 DHB clinical staff

The current Minister of Health has signalled his interest in establishing clinical networks as a vehicle for linking particular areas of the health sector together. Increasingly the focus of the regional cancer networks is becoming more clinical. This is likely to be due in part to this move towards

⁶¹ Previously there was the Lakes Cancer Control Stakeholder group facilitated by the Lakes DHB and the Midland Cancer Network and the Lakes Cancer Control and Palliative Care/End of Life Advisory groups which were facilitated by Lakes DHB funding and planning team, often with the regional cancer network in attendance.

clinical networks and a corresponding expectation at senior levels of DHBs that the regional cancer networks will become more clinical; and also influenced by the success of the regional cancer network tumour stream activities.

There appears to be good buy-in from DHB clinicians when their involvement is focused on a particular initiative rather than generic cancer control matters: *“Clinicians do not want, or need, more meetings or more bureaucracy.”* This approach of targeting clinical involvement via specific projects and activities is reportedly an attempt to minimise the workload on clinicians and the time they are taken away from the frontline. The challenge of increasing the clinical focus is managing the expectations of the non clinical stakeholders, some of whom believe there is already too much of a focus on treatment at the expense of prevention.

Overall nearly 70% of the survey respondents (excluding the don't knows) agreed or strongly agreed to the statement 'clinical staff are actively contributing to identifying and prioritising regional cancer network activities'. Northern Cancer Network and Midland Cancer Network rated higher than the Central Cancer Network and the Southern Cancer Network. Interestingly this lower ranking corresponds to the two regions with the most DHBs, the biggest geographic regions and each having two regional cancer centres – all factors which make clinical engagement more challenging.

Further development of clinical involvement was one of the three main areas suggested for further development of the networks. It is seen as important that the regional cancer network clinical directors integrate with the non-regional cancer centre DHBs in their region as much as possible. There are opportunities for the development of more clinical champions. The success of the tumour stream initiatives under the regional cancer networks has reportedly resulted in an increased demand for some of the regional cancer networks to take on more clinical improvement activities and the demand is now often exceeding the network management team capacity. Further tumour stream development is seen as a key vehicle for identifying and fostering more clinical champions.

5.6 DHB funding and planning and operational management (including regional cancer centres)

Overall an average of 60% of respondents across the four networks (excluding the don't knows) felt DHB management is actively contributing to identifying and prioritising regional cancer network activities. Once again the Central Cancer Network and the Southern Cancer Network scored slightly lower than the Northern Cancer Network or the Midland Cancer Network and once again we suspect this is because of the complexities of the Central Cancer Network and the Southern Cancer Network that the other two regional cancer networks don't have.

In general, interviewees felt linkages with operational management were more effective than with funding and planning management within DHBs. One of the common challenges cited by all regional cancer network managers is the variability and complexity of networking collectively with 20 funding and planning teams. Restructuring, turnover of staff, tight fiscal constraints and the demands of local priorities were all seen as barriers to effective engagement with funding and planning teams. Some interviewees suggested that engagement of DHB funding and planning teams is easier where the DHB has a LCN, particularly the more effective and more active LCNs.

The six regional cancer centres create another level of DHB engagement for the regional cancer networks. The regional cancer centres provide regional cancer services for radiation and medical oncology and are thus a significant stakeholder interest. This in itself brings a risk that the interests of the regional cancer centres start to dominate the work of the regional cancer networks if their input and involvement is not balanced against other stakeholder interests. The Midland Cancer Network and the Central Cancer Network are physically located within, and directly report to DHBs that are also 'regional cancer centre DHBs' thus potentially exacerbating the risk of regional cancer centre capture – whether real or perceived.

Regional cancer centres have little or no influence or involvement with cancer diagnosis or surgery particularly at the 14 DHBs that don't have a regional cancer centre (albeit that many have outreach services in other DHBs). Hence the DHB operational linkages for the regional cancer networks should be focused on these 14 DHBs, particularly as all indications are that where the gains can be made are the journey from primary care through FSA, various diagnostic modalities (CT etc), to secondary care at DHB level and surgery – all before the patient gets anywhere near a regional cancer centre.

The Regional Oncology Operational Group (ROOG) in the northern region is an additional DHB stakeholder group for the Northern Cancer Network and the Chairperson of ROOG is a member of the Northern Cancer Collaborative.

5.7 Māori engagement

One of the two overarching goals of the Cancer Control Strategy is to reduce inequalities in the cancer sector. This section should be read in conjunction with section 4.9.

Meaningful engagement with Māori at all levels of the regional cancer network is of particular importance and is specifically identified in the CFA. All regional cancer networks are committed to Māori participation but evidence collected from multiple sources for this evaluation indicates that the extent and effectiveness varies between regional cancer networks.

We asked two questions pertaining to Māori involvement in regional cancer networks (refer Figure 16). There appears to be some difference between 'having a framework' and 'active engagement'. All regional cancer networks except the Southern Cancer Network (where the results were about even) scored higher with respect to having an identified Māori leadership framework for participation than they did in terms of how well Māori are actively contributing to the work of the regional cancer network. This would suggest that stakeholders perceive that the structures are in place but more needs to be done to ensure the active engagement and participation of Māori. Table 23 outlines arrangements for Māori participation in each network.

Table 23 – Māori involvement in regional cancer networks

	Northern	Midland	Central⁶²	Southern
Governance / steering group	1 representative being the Chairperson of the Māori Leadership Group	1 Midland representative from Waikato DHB – who is Tumu Whakarae Midland GM Māori Health rep	1 representative – Cancer Nurse from a Māori provider 1 Vacancy	3 representatives – 1 from Canterbury DHB Māori Health Services, 1 consumer and 1 from CEO Māori primary health provider
Māori participation framework	Terms of Reference for Maori Leadership Group	MCN Māori Governance links document 2008		Will be developed by the Māori leadership group
Māori leadership group	Yes, since Oct 2008 ⁶³	GM Māori Health rep links to existing Midland collaborative structures /forums DHB/other Māori governance structures since 2007 ⁶⁴	Māori leadership group in the process of being formed (regional hui held in March 2010)	Māori leadership group in process of being formed
Link between governance and Māori leadership group	Chairperson of Māori leadership group is on Northern Cancer Collaborative	Tumu Whakarae	-	Will be developed by the Māori leadership group
Māori participation on regional network groups	Māori representative on each tumour stream Regional care coordinators forum Consumer Reference Group	Māori make up 50% of consumer / carer reference group Te Puna Oranga (Waikato DHB Māori Health Services) rep on AYA work group, non-surgical treatment work group, palliative care work group, supportive care work group Te Arawa Cancer Support network rep on supportive care work group Māori consumer rep on Supportive Care Work Group Māori consumer on Breast cancer work group	Māori participation on the following groups: Regional palliative care network Care coordinators group Consumer representatives group DHB Cancer Managers group	Māori rep on: Oncology Research group Kaitiaki on AYA group and Canterbury Palliative care group South Island Cancer Nurse Network
Other Māori participation	On LCNs	On LCNs Māori health providers and DHB Māori health services link in to LCNs	On LCNs	On LCNs

⁶² This information is reflective of the situation in May 2010. Spread of membership changes due to nominations for districts representation coming from the local cancer networks. Primarily chosen for region (and then a mix of sector representation)

⁶³ The group is an open forum who meets bi-monthly and draws membership from: Kaumatua and Kuia; Consumers; Te Tai Tokerau, Ngati Whatua and Tainui MaPO; General Managers Māori from the Northern DHBs; Māori Providers; PHO – Tamaki, Te Kupenga o Hoturoa, Waiora and ProCare; DHB cancer nursing services; Palliative care and Hospice services

⁶⁴ Refer to MCN Māori governance and participation framework. Tumu Whakarae BOP – Māori Health Runanga Lakes Te Nohanga; Kotahitanga o Tuwharetoa; Te Roopu Hauroa o Te Arawa Waikato- Iwi Māori Council

The manager of the Northern Cancer Network identified Māori participation as one of that network's main successes, and that claim is supported by the results of the survey where the Northern Cancer Network are well ahead of the other three networks in this area. It is apparent from the interviews that Māori involvement at all levels of this regional cancer network is seen as of utmost importance and from the outset there has been a strong commitment to partnership with Māori based on the Treaty. This is reinforced by a review of Māori participation in the Northern Cancer Network conducted earlier in 2010⁶⁵ which found that:

Strategies that have been considered most effective to date are the Māori Leadership Group (including opportunities for input into the Network's strategy document), the orientation of the Inequalities Project Manager role towards Māori engagement (though there are risks as the Māori engagement focus is not formalised), outreach to Māori stakeholders including regular information dissemination, and mechanisms that enable consistent Māori input into workstreams or projects to the extent that Māori processes and analysis are integrated and there is a clear focus on addressing ethnic inequalities. Most importantly, Māori stakeholders and Network Management consider Māori engagement to be mutually beneficial.

The Northern Cancer Network has a Māori leadership group and the chairperson of the Māori leadership group is the representative on the Northern Cancer Collaborative.

Whilst Māori are actively contributing to identifying and prioritising activities in the Northern Cancer Network, the Māori representative sees a great deal still needing to be done before the network can make a real difference for Māori cancer. The Northern Cancer Network review found that there needed to be a more formal Māori participation framework developed that:

Clearly articulates the meaning of Māori engagement from the Network's perspective and encompasses the Network as a whole. The framework should identify the aims of Māori engagement (what it is that Māori engagement seeks to achieve), the range of Māori stakeholders (in broad terms) with which the Network may seek to engage, key domains for engagement, and practical engagement projects that may be implemented. In combination, these factors will provide a sound basis for goal setting and enable the incorporation of indicators into the framework. These indicators should allow the Network to gauge its success in engaging Northern Māori stakeholders over time in terms of outputs linked to Māori cancer control outcomes. Such a framework will not only be relevant to the Northern Cancer Network, but could equally be applied to the other regional cancer networks and provide a basis for the systematic implementation of Māori engagement actions. There is potential for collaboration between the networks to support development of a framework and thereby enabling other regional networks to leverage off the experience of the Northern Cancer Network.

Findings arising from interviews with all the regional cancer network Māori representatives and others indicate that Māori involvement at all levels of regional cancer network activity is variable but improving.

"At times it felt as though Māori were being politely listened to."

⁶⁵ Ratima, M and Edwards, W. A review of the Northern Cancer Network's Māori engagement processes. 2010

“Being at the table doesn’t cut it as the only solution for Māori – very few on our governance group really understand Māori issues but others don’t get the need for Māori input. It still feels like tokenism – we are not there yet with things Māori.”

“I am not confident the interests of Māori are being addressed in all the network groups.”

“Some [network stakeholder] organisations still don’t know how to deal with Māori.”

Opportunities for further development of Māori engagement in the regional cancer networks were mentioned by Māori and non-Māori. The main areas for improvement were:

- Improved understanding and engagement from non-Māori stakeholders – several respondents suggested regional cancer network stakeholders attending Tiriti o Waitangi training or spending a weekend on a marae making Māori leadership hui more accessible to working people (ie hold them in the evenings or weekends)
- More kaupapa Māori services - ‘better, sooner, more convenient’
- Increased opportunities for Māori ownership and leadership in terms of cancer and palliative care
- Increasing the number of Māori representatives on the regional stakeholder collaborative group, particularly Māori consumers and carers
- More Māori network staff, support for Māori on regional stakeholder collaborative groups and linking Māori into other networks

Māori participation needs to be more than a name(s) on a piece of paper, or a Māori representative on a regional cancer network group – it needs to be a relationship of true partnership, of collaboration. As noted in section 4.4 it is particularly important that Māori are present at meetings where planning and decisions that will impact on Māori are occurring. If, for example, there is only one Māori representative on the group and that person is unable to regularly attend then Māori participation is a concept rather than a reality. It is one thing for the regional cancer networks to include Māori on their regional stakeholder collaborative group, but much more challenging to ensure Māori are actively engaged at all levels, particularly on the LCNs, tumour stream groups or palliative care.

All regional cancer networks would probably agree they have a way to go before they can say there is effective engagement with Māori but all regional cancer networks appear to be working on improvements in this respect.

5.8 Other ethnic groups

All regional cancer networks scored very low in engagement with other ethnic groups. The Central Cancer Network has two Pacific representatives on their Governance Group and the Northern Cancer Network and Midland Cancer Network have a vacancy for a Pacific representative. The Northern Cancer Network has reached agreement about a mechanism for Pacific involvement in the network with their DHB Pacific GMs. Apart from this there is no involvement from other ethnic groups evident at any level in any of the regional cancer networks, apart from in the Central Cancer Network where Pacific issues are being considered in a specific Pacific communities stock-take report and implementation plan and where a 0.2 Pacific inequalities position was established in January 2009.

5.9 Primary care

Stakeholder engagement from the primary care sector was seen by all regional cancer networks as one of the areas they are struggling with the most and hence not surprisingly the survey results were low in all regions. Maximising opportunities for managing cancer at a primary level more effectively in the future is seen as key and managing the interface between primary and secondary care is central to this.

The Southern Cancer Network had a slightly higher result than the other networks and this may be due to three of their Steering Group members coming from the primary care sector and one of the Māori representatives also involved in the primary care sector.

Table 24 – Primary care sector involvement in regional cancer networks

	Northern	Midland	Central ⁶⁶	Southern
Governance / steering group	2	Vacant	2	3 (plus Māori rep is involved in primary care)
Primary care sector representation on other regional network groups	4 PHO reps on Māori Leadership Group 1 GP on bowel tumour stream 3 PHO reps attend CNS / care-co-ordination work group	2 primary care reps on Midland Palliative care work group primary care rep attends CNS / care-co-ordination work group	Primary care involvement in: Regional care co-ordinators forum Regional palliative care network Cancer Control Indicators Report Advisory Group	1 GP on Regional Lung Cancer Working Group
Other participation of primary care sector	On NDHB and CMDHB LCNs 5 PHO partners in HRC funded Lung Cancer Research project including 2 from the Midland region.	Significant primary care involvement in Midland palliative care planning workshops Primary care involvement on LCN Primary care involvement in early detection lung cancer initiative	On LCNs Prostate early detection project Involvement in tumour stream mapping work	Canterbury LCN (GP, Urban PHO rep, Rural PHO rep) Canterbury Palliative Care Network (GP, PHO, primary care rep, Urban PHO rep, Rural PHO rep) Otago/Southland LCN has 1 PHO rep. South Canterbury LCN has 1 Māori rep who is Māori health provider plus 1 GP ⁶⁷ Nelson Marlborough LCN has 4 PHO reps, actively seeking a GP rep West Coast LCN has 1 PHO rep

Indications are that engagement with and commitment by the primary care sector is a national and international issue for health networks. Table 24 summarises the involvement of the primary care sector in each regional cancer network. As we noted in section 4.3 in order to build a sense of

⁶⁶ This information is reflective of the situation in May 2010. Spread of membership changes due to nominations for districts representation coming from the local cancer networks. Primarily chosen for region (and then a mix of sector representation)

⁶⁷ SC no longer has a PHO. This has been assumed by the DHB and DHB is represented by DHB COO, plus three others representatives

commitment to and ownership of the regional cancer network it is important that stakeholder representatives see their involvement as meaningful and for primary care providers this means seeing what benefit their involvement will have for the primary care sector. To date much of the regional cancer network work has focused on DHB service provision and this may be leading to some scepticism from the primary care sector as to whether the regional cancer networks are serious about making improvements in their sector or at the interface between primary and secondary care.

Exploring opportunities to engage more meaningfully with primary care providers and for improvements at the primary care level was one of the areas for improvement mentioned most frequently by all stakeholder groups from all regional cancer networks. Indications from the interviews are that the current model of primary care had led to a fragmented and competitive primary care sector and networks have struggled to know how to get meaningful primary care representation. Individual primary care providers are usually part of small community practices and hence rarely have time to contribute to activities such as regional cancer networks. Moves to establish new alliances of PHOs may make it easier for regional cancer networks to engage with primary care. This being said it is evident that the primary care representatives on the regional cancer networks appear to be involved not out of a sense of duty to represent their sector but because they have a personal commitment to exploring all opportunities for improving the connection between primary and secondary care for cancer patients and for improving cancer outcomes for their communities.

5.10 NGOs / palliative care providers

Each network had about 60% of people agreeing or strongly agreeing that NGOs and palliative care providers are involved (when excluding the don't know responses). Table 25 shows how NGOs and palliative care providers are involved in network activity.

Table 25 – NGO / palliative care involvement in regional cancer networks

	Northern	Midland	Central ⁶⁸	Southern
Governance / steering group	2 NGO 1 Palliative care	1 NGO	1 NGO	1 NGO 1 Hospice
Links between governance and NGO / palliative care groups	Chairperson of NGO Forum and chairperson of Auckland Metro Hospice network are on Northern Cancer Collaborative	A MCN Executive member links with Midland Palliative Care Work Group MCN Executive NGO member chairs Supportive Care Work Group		2 SCN Steering group members sit on national and district level palliative care groups with 1 SCN Steering Group member chairing a district group.
NGO group	NGO Forum ⁶⁹			

⁶⁸ This information is reflective of the situation in May 2010. Spread of membership changes due to nominations for districts representation coming from the local cancer networks. Primarily chosen for region (and then a mix of sector representation)

⁶⁹ An informal grouping of six main cancer NGOs who meet six monthly or as needed.

	Northern	Midland	Central ⁷⁰	Southern
Palliative care group	Local Palliative care Networks/Groups are independent of the Network	Midland Palliative Care Work Group includes all hospices, since Dec 2007 Palliative care NGOs linked to MCN Supportive Care and CNS/care coordination Work Groups	Regional palliative care network since before CCN started	Canterbury palliative care network since May 2009 Southland Palliative Care since June 2010. Regional Palliative care network to be established in 2010
NGO / palliative care representation on other regional network groups	Cancer Society representation on travel and accommodation advisory group and Regional Care Coordinators forum BCAC members are on Consumer Reference Group Palliative care representation on Māori Leadership group	Cancer Society, True Colours, Child Cancer Foundation rep's on AYACS work group. Hospices link in as required Cancer Society, PHO, Aroha mai on CNS/care coordination Work Group Cancer Society, Health Journeys, Midland Palliative Care Hospice rep, Leukaemia and Blood Foundation reps on Midland Supportive Care Work Group Waikato Breast Cancer Trust on Breast Cancer Work Group NGOs on Midland Palliative Care Work Group and 2 PHO reps Waikato Palliative Care group includes Hospice NGO, 2 PHOs and Māori Trust provider NGO / palliative care reps on Midland Palliative Care Nurses Education and LCP Facilitators Work Groups since 2008	Representation on the following groups: Care coordinators group	Cancer Society rep on upper and lower SI colorectal advisory groups Canteen rep on AYA group Cancer Society rep on Oncology Research group Cancer Society representation on Travel and accommodation advisory group
Other participation	NGO / palliative care reps on LCNs	NGO / palliative care reps on LCNs Significant NGO and Primary care involvement in Midland palliative care planning workshops	NGO / palliative care reps on LCNs Participation in tumour stream mapping district meetings	NGO / palliative care reps on LCNs – district palliative care groups in 2 regions meet directly prior to the LCN meeting Working with the Cancer Society as the key partner to develop the Cancer Services Directory for South Island

⁷⁰ This information is reflective of the situation in May 2010. Spread of membership changes due to nominations for districts representation coming from the local cancer networks. Primarily chosen for region (and then a mix of sector representation)

The non Government and palliative care/hospice sectors appear to be easier for the regional cancer networks to engage with than the primary care sector. This may be because neither NGOs nor hospices have a history of competition and the hospices have reportedly got a good history of sharing and supporting one another.

The benefits and challenges of regional cancer network engagement as perceived by the NGOs and hospices include:

- NGOs are patient focused and can speak independently as they are not government funded and have a broad picture of current issues
- The regional cancer network brings hospices in out of the cold. They find that DHBs often forget there are service providers outside DHBs and interaction used to stop at the DHB borders. Without a doubt if it wasn't for the regional cancer networks, hospices would still be out in the cold trying to engage 'with the big boys'
- There are numerous NGOs working wholly or in part in cancer control. It is difficult to network between all these NGOs and hence the regional cancer network NGO representative needs to focus on linking with the main cancer NGOs
- NGOs are represented at the regional cancer network table but not really involved in decision making
- The NGO representatives appear to feel they haven't seen a revolution resulting from the regional cancer networks but they definitely feel engaged and better informed.

Some of the regional cancer network leaders talked about the challenges of managing the different expectations, differing priorities and measures of success and different levels of understanding between the government and non government sectors, whilst also acknowledging the value that NGOs bring to the table. On the one hand the government sector often feels that the NGOs don't understand how the public health system works, the relationships and the accountabilities. On the other hand there is a feeling from some NGOs that the government sector doesn't have a good understanding of what the NGOs are doing in cancer control.

The regional cancer network management feel NGO/palliative care involvement has been valuable in building linkages and that NGO stakeholders provide a reality check to ensure the regional cancer networks ask 'have we got it right – are we addressing the right things?'

5.11 Consumers

All four regional cancer networks now have at least one consumer representative on their regional stakeholder collaborative group and all four have some means of linking consumers into a wider network of consumers regionally. Table 26 shows how consumers are involved in regional cancer network activity. The Northern Cancer Network and the Midland Cancer Network have formal consumer reference groups and the Central Cancer Network and the Southern Cancer Network have virtual groups whereby the consumer representatives from throughout the region are linked together by tele- or videoconferencing and because of the geographic size of these regions the consumers are brought together less frequently.

The Northern Cancer Network had higher numbers of people strongly agreeing or agreeing that consumers were actively involved. The Northern network has had a consumer group for longer than any of the other networks, as outlined in Table 26 and this result may be a reflection of this.

We interviewed a consumer representative from all four regional cancer networks and all felt motivated and engaged in the network. Whilst there is consumer representation on the regional stakeholder collaborative group, relevant consumer representation hasn't yet been achieved on all regional cancer network project groups for example the tumour stream groups and further work is needed to achieve this.

One of the main issues for the consumer representatives is how to get adequately reimbursed for their time. Some consumer representatives talked of difficulties in finding a suitable mechanism for paying them. One cited an example of one of the PHOs paying consumer representatives \$300 + GST for attendance at meetings whereas some regional cancer network consumer representatives have been given petrol vouchers in lieu of payment while others have had to be signed up as employees and had secondary tax deducted. It was beyond the scope of this evaluation to explore this issue further or to ascertain whether payment for consumer representatives is working well in some of the regional cancer networks.

Table 26 – Consumer involvement in regional cancer networks

	Northern	Midland	Central	Southern
Governance / steering group	2	2 since June 2010 Prior 1	1 since Jun 2007 (agreement now for 2 reps, ensuring at least one is Māori or Pacific)	1 consumer 1 consumer / Kaitiaki (employee of CDHB)
Consumer participation framework	Yes	Yes	Yes	yes
Consumer reference group	Consumer reference group since Nov 2008	Consumer / carer reference group since Sept 2009 First formal meeting Mar 2010	Virtual consumer reference group made up of LCN consumer reps since Jul 2009 (bi-monthly teleconference meetings) 6 monthly face to face meetings / forum in Nov 2009 and July 2010	All SI cancer control consumer reps are brought together every six months
Link between governance and consumer group	Chairperson of consumer group is on Northern Cancer Collaborative	Chairperson and deputy of consumer and carer work group members of MCN Executive Group	Consumer Rep on Governance Group currently chairs the consumer group	n/a
Consumer representation on regional network groups	1 on colorectal group Lung tumour stream work group activities overviewed by consumer group as required	Canteen consumer rep on AYACS work group Consumer rep on supportive care work group and breast cancer stream work group	2 on lung group 1 on colorectal group 1 on head and neck group 1 on medical imaging guidelines group 1 on MDM advisory group	Canteen consumer rep on AYA group Consumer rep TBC on Oncology research group
Other consumer participation	On some LCNs Input into various projects accessed via Consumer Reference Group meetings or via email as needed	Focus groups for patient mapping. Face to face interviews. Consumer involvement in information resource development. “patient story” bowel cancer media campaign and Rotorua early detection lung cancer initiative.	On LCNs Focus groups for patient mapping	On LCNs Focus groups for patient mapping Face to face interviews

6 Network activities

6.1 Introduction

This section of the report provides a high level overview of some of the key activities that the regional cancer networks have undertaken by network and describes stakeholder feedback on the impact of these activities to date and their opinion on which have been most successful.

It is important to note that it is beyond the scope of this evaluation to provide a detailed account or evaluation of any or all particular projects given the vast number of varied activities carried out by the networks. This section also does not cover activity outlined in the previous section, for example communication, planning and prioritisation and evaluation activity. It also does not discuss Māori and consumer participation activities discussed in section 5.

Cancer stakeholders were asked to rate the impact that each key regional network project activity⁷¹ had had on the cancer sector (from significant positive to significant negative impact) but were also given the option of “don’t know” and “too early to say” as many of the regional cancer network activities (network groups and/or projects) have only been operating for a short time and it would be unrealistic to expect that any significant impact had been made in such a short period of time.

The ‘don’t know’ responses have been removed from the charts so that only those who felt able to respond about an area are included in the analysis. It is interesting to note that each activity had between 25-80% of people responding saying they did not know about the impact of that activity, indicating that there is further work to be done in communicating both the activities and successes of the network to cancer stakeholders.

Appendix E shows the charts including the ‘don’t know’ responses.

6.2 Conclusions

There is a widely dispersed range of activities being undertaken by the regional cancer networks including tumour stream quality improvement activity, guideline development and dissemination, public education campaigns and development of service directories. Much of this activity has been implemented over the last 12 months and the momentum has been growing as networks have become more firmly established.

Each network has taken a slightly different approach to the way in which they focus their activities although there appears to be a convergence of activity across the four networks in recent times, reflecting both the requirements of the National Cancer Control Programme and the increased sharing of information across the networks about what is working.

It is clear that the tumour stream activity is perceived as having the greatest positive impact across the four networks, along with other clinically focussed activity in each network.

⁷¹ From a list agreed to by each Network Manager

LCNs are also seen as being beneficial as are Central Cancer Network's indicators report and Southern Cancer Network's oncology education network.

6.3 Requirements relating to regional cancer network activities

The current CFA (refer Appendix C) requires the regional cancer networks to:

- *Maintain a core infrastructure and operations*
- *Investigate and address systemic causes of cancer inequalities*
- *Obtain cancer data analysis capacity*
- *Submit a regional strategic cancer control plan.*

The CFA contains a mix of activity and outcome wording but does include some specific service requirements that relate to activities such as:

- *Develop region wide, tumour specific and service improvement multidisciplinary groups and workstreams*
- *Develop patient pathways*
- *Provide specific cancer control expertise to support service planning, identify existing gaps in cancer services, identify barriers to performance*
- *Support a range of quality improvement initiatives and promote the use of quality improvement tools*
- *Undertake, sponsor or facilitate work programmes to improve multidisciplinary management of specific tumours, the improvement of cancer services and the development of the cancer workforce.*

The reducing inequalities service description was included in section 4.9.1 while the data analysis service requirement includes the need to :

Collaborate with other Networks to provide, contract for, or otherwise obtain, data analysis capacity that interrogates existing sources of clinical, service delivery, epidemiological, demographic, workforce, and financial data, thereby allowing the regional Network to:

- Improve understanding of the local and regional cancer burden and inequalities, including at an individual DHB level;*
- Provide evidence-based advice to funders and planners on prioritisation;*
- Target priority areas for service improvement; and*
- Establish baselines for performance indicators and outcome measures.*

The 2009/10 Cancer Control Programme Work Plan also required the following activity from regional cancer networks:

- Establishment of multidisciplinary lung cancer and bowel cancer work groups by June 2010
- Facilitate lung and colorectal quality improvement initiatives
- Collection of data relating to lung and colorectal cancer waiting times and cases presented at multidisciplinary meetings.

The 2010/11 National Cancer Programme Work Plan requires regional cancer networks to monitor wait times from primary care referral to first treatment for lung and colorectal cancers, increase the

percentage of suspected lung cancer patients who meet the two-week standard from GP referral to FSA respiratory, increase the percentage of lung and colorectal cancer patients presented at multidisciplinary meetings and develop a bowel cancer patient management framework.

Each regional cancer network has also developed a strategic plan from which an annual plan of activities is determined via the prioritisation process outlined in section 4.5.

6.4 Northern Cancer Network

A summary of the key activities of the Northern Cancer Network is outlined in Table 27.

Table 27 – Summary of Northern Cancer Network activities

Tumour stream groups	<p><u>Lung</u> Used previous regional lung cancer clinical audit to identify initial areas for improvement. Established multidisciplinary group to implement a variety of improvements to the patient pathway Created a database for lung cancer care, reporting of lung KPIs increasing nursing coordination and/or CNS roles.</p> <p><u>Colorectal</u> Established colorectal multidisciplinary group Using clinical data to analyse high impact areas then facilitating a variety of improvements, including implementation of regional prioritisation criteria for colonoscopy, development of KPIs, exploring the role of CT colonography in the diagnostic pathway</p> <p>Baseline information on several key indicators collected and reported for lung and colorectal cancer</p>
Project / service groups	<p>Travel and accommodation project group set up Travel and accommodation needs analysis report completed in May 2010</p> <p>Key performance indicator project group set up Draft key performance indicators developed (in progress)</p> <p>Radiotherapy strategic review report completed in May 2010. Phase 2 implementation in progress</p> <p>Established Regional Cancer Care Coordinators forum and have scoped approach for development of a regional care coordination framework</p> <p>Set up Māori community support access project group Māori cancer co-ordination referral project (in progress)</p>
Other key activities	<p>HRC Lung cancer research project (in progress, commenced June 2009) Recognition of the early symptoms of lung cancer campaign (commenced May 2010) Development of a regional service directory (in progress) Enhancing MDM functioning project (in progress) Equity of access paper prepared to inform Radiation Therapy Strategic Plan Review of NCN Māori Engagement process Sponsored and assisted with arranging Revolution of Cancer Care conference 2009 Reports prepared on Radiation Therapy Intervention rates for Breast, Lung and Head and Neck Cancer Six sigma review of endoscopy capacity at CMDHB HEAT analysis for bowel cancer (in progress)</p>

The Northern Cancer Network focused initially on lung cancer and has set up a variety of projects relating to lung tumour stream activity, including obtaining significant additional Health Research Council of New Zealand funding for a lung cancer research project that focuses on inequalities. The focus is now also on undertaking similar quality improvement work for colorectal cancer.

Other projects have included a travel and accommodation review, assisting with the radiotherapy strategic review report, and a variety of reducing inequalities initiatives including a Māori cancer co-ordination referral project and a campaign to focus on the early symptoms of lung cancer focusing on Māori and Pacific people (as well as setting up the Māori Leadership Group).

As with all the other networks, the Northern Cancer Network is also working on key performance indicators, enhancing multidisciplinary functioning and is involved in setting up service directories.

Figure 17 shows the responses from the small number of people from the Northern Cancer Network who felt able to answer this question. Each question had between 15 and 31 people who answered (excluding the don't knows) and so the results should be interpreted with caution. The number of responses is shown in brackets at the end of each activity. Not surprisingly, the more recent activities were less well known (as evidenced by less people able to comment on the impact they had had).

The tumour stream projects were thought to be providing the most significant impact to date, particularly the lung project where nearly 60% of the 28 people who knew about the impact of the lung tumour steering group thought that it had had significant positive impact and most of the rest saying that it had had some positive impact. This is reinforced by several of the respondents citing the lung tumour stream activity as being the network's greatest success to date in the open ended question asking about network successes, including the lead CEO, Clinical Director, Network Manager and several other members of the Northern Cancer Collaborative.

The Northern Cancer Network has taken a different approach to tumour stream activities than the other networks and instead of undertaking patient mapping and developing reports, they have based their approach more on initially using clinical data to identify bottlenecks. They then focus on improvements in high impact change in line with the approach taken to meet cancer wait times by the National Health Service in the UK. High impact change areas are focussed around referral, diagnosis, treatment planning and follow up. Regional multidisciplinary tumour steering groups were established early in this process to review the data and agree improvement priorities, timeliness standards and key indicators. These are identified for optimal transit through the patient pathway and changes are implemented (e.g. they developed a standardised MDM form (in the process of becoming electronic) which is used in presentation, data collection and referrals and a diagnostic algorithm to shorten time to diagnosis for lung cancer), and then monitoring of the key points/measures is undertaken to look for improvements. It is understood that other networks are now looking to follow this approach.

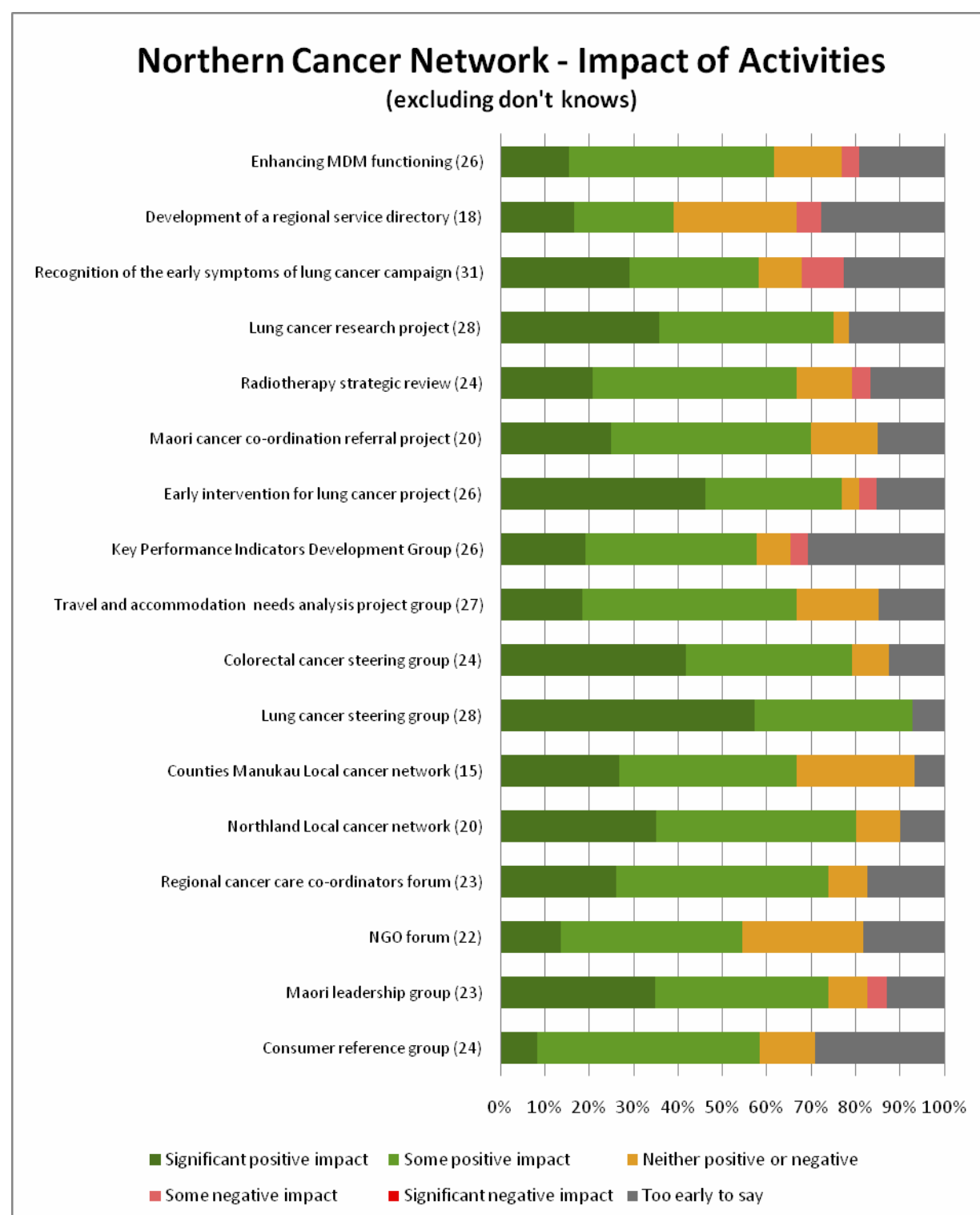
A particular success noted by the Network Manager was the fact that all DHBs in the northern region had agreed to specific timeliness targets for lung cancer and signed up to these in the 2010/11 DAP process.

The other lung cancer projects (HRC funded research project and early intervention for lung cancer project) were also seen as having a positive impact and were especially seen as being positive for Māori by the Māori representative interviewed.

The only project that was thought by more than one person to have any negative impact was the early detection of lung cancer campaign where several people noted that while the motivation

behind the idea was sound it had the potential to undermine the sectors' efforts to reduce smoking and they may have caused confusion for the wider public and politicians, and they queried the role of the network in developing campaigns for the public.

Figure 17 – Impact of Northern Cancer Network activities



6.5 Midland Cancer Network

Table 28 summarises the activities of the Midland Cancer Network.

Table 28 – Summary of Midland Cancer Network activities

Tumour stream groups	<p>Establishment of <u>breast</u> working group Breast cancer patient mapping and audit of waiting times report and action plan produced in May 2008</p> <p>Establishment of <u>lung</u> working group Lung patient mapping and audit of waiting times and action plan (draft report completed)</p> <p>Establishment of <u>colorectal</u> working group Colorectal patient mapping and audit of waiting times (in progress)</p> <p>Baseline information on several key indicators collected and reported for lung and colorectal cancer</p>
Project / service groups	<p>Implementation of Midland Non Surgical Cancer Treatment Service Plan (2004) (ongoing) Establishment of BOP Resident Medical Oncology / Haematology service in 2008 Developing Midland Radiotherapy Services Plan and Midland Medical Oncology Services Plan (in progress)</p> <p>Establishment of AYA work group Establishment of AYACS – CNS in Sept 2007 and development of regional service delivery model. AYACS report and service plan produced in Nov 2008</p> <p>Continuity of care and care coordination framework developed 2008. Assisted with business cases for breast, AYA, colorectal, gynae-onc, generic, genitourinary CNS and MDT coordinator roles between 2007-2009</p> <p>Contributed to development of a regional cancer centre post radiation-oncology dental service 2009</p> <p>Establishment of regional palliative care work group Specialist palliative care framework for generalist nursing and carer education developed in Sept 2009 Midland Liverpool Care Pathway implementation (in progress) Midland and local Palliative Care Strategic Planning (in progress) Assisted with specialist medical palliative care Taupo outreach service</p> <p>Development of supportive care work group Development of supportive care directory (in progress)</p> <p>Establishment of cancer research and audit work group</p>
Other key activities undertaken by network management team	<p>Software requirements specification for cancer care coordination completed 2008 MCN information system requirements and options validation initiative completed and findings report 2009 Psycho-social assessment tool pilot project and report completed in Aug 2009 Lean thinking projects to improve timeliness and access to services for stereotactic biopsy, colposcopy, lung (x2) and colorectal between 2008 and 2009 PET-CT service improvement initiative (2009-10) Audit of Māori breast cancer waiting times (draft report completed) Review of Lung and Bowel Cancer Elective Pathways initiative (2009-10 draft report completed) Improvement project to improve chemotherapy ambulatory pathway 2010 (in progress) Improvement project to improve radiology diagnostics for lung cancer 2010 (in progress) MCN information system project feasibility study of the Somerset Cancer Registry (in progress) MDM project (scope developed) Early Detection of Lung Cancer initiative (in progress) Development of regional cancer control continuum indicators report (in progress) NZ RCN development of lung and bowel cancer indicators (in progress)</p>

The Midland Cancer Network grew out of the Midland non-surgical cancer treatment planning group and has continued to take on a variety of non-surgical planning and implementation projects including implementing the 2004 Midland non-surgical cancer treatment service plan and more recently updating the medical oncology and radiotherapy service plans as well as implementing a medical oncology / haematology service in Bay of Plenty. The network has also contributed to the development of a regional cancer centre post-oncology radiation dental service.

Their initial tumour stream focus was on breast cancer patient pathway mapping but the more recent focus has been on the lung and colorectal tumour stream mapping and quality improvement projects, in line with national priorities. The Midland Cancer Network has received additional funding from the Cancer Service Development Fund for a variety of lung and colorectal improvement projects and to investigate a new data system (Somerset registry) for the region.

The Midland Cancer Network appears to also be more significantly involved than other networks in palliative care activity in part due to the fact that the Network Manager is also responsible for additional funding for palliative care co-ordination⁷².

Other work programmes specific to this region have included AYA service implementation (which received additional Ministry funding), assisting with business cases for CNS and MDT coordinator roles and a PET-CT service improvement initiative.

Figure 18 shows responses from the small number of people who felt able to answer questions about the Midland cancer networks activities. Between 17 and 35 people answered each question (excluding the don't knows). The majority of those who responded to the questions believed that most of the Midland Cancer Network's activities had had at least some positive impact with many projects, particularly the clinically oriented activities such as establishment of a BOP medical oncology / haematology service (mentioned by both the Network Manager and Clinical Director as a key success), developing Midland radiotherapy and medical oncology services plan and LCP implementation having significant positive impact on cancer services in the region.

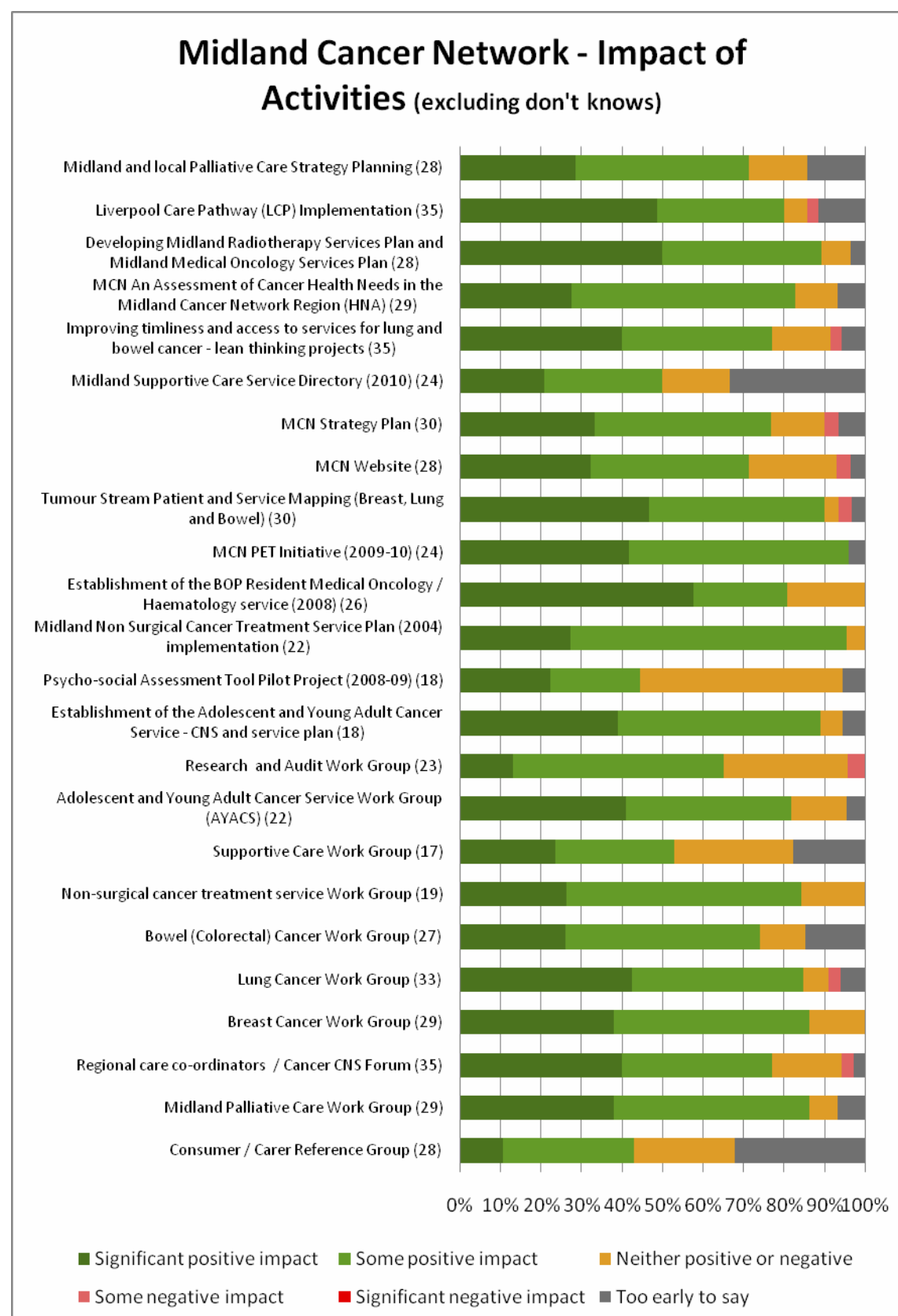
Patient mapping activity and lean thinking projects, the PET –CT initiative, the AYA work group and implementation plan and the lung tumour stream work group were also considered to have had a significant positive impact by over 40% of respondents. These same activities are the ones mentioned as being the most successful by respondents in the open ended questions and/or discussions. The Network Manager and Clinical Director also mentioned the introduction of more tumour specific clinical nurse specialists / care coordinators as being an important success of the network and both the Chairperson of the Executive Group and the Clinical Director see a key success as the palliative care access across the region with most patients now able to access palliative care directly or via their GP.

Key clinicians involved in the lung tumour stream work noted that whilst good progress has been made, the first stage of this work (pathway mapping) took 18 months and was *“the relatively easy*

⁷² The Manager of Midland Cancer Network advises that other reasons for this include: a request by NGOs, clinicians, and DHBs for the Midland Cancer Network to focus on palliative care; palliative care being prioritised by two of the Midland DHBs, a regional response to national development of specialist palliative care service specifications and gap analysis i.e. regional specialist medical staff, education and request to assist with facilitating a regional response to the end of life care programme; it was identified and prioritised within the Midland Cancer Network Strategic Plan.

phase.” They see the real challenge as tackling the issue of waiting lists and access to diagnostic tests. No activity was mentioned by more than one person as having a negative impact.

Figure 18 – Impact of Midland Cancer Network activities



6.6 Central Cancer Network

The activities of the Central Cancer Network are summarised in Table 29.

Table 29 – Summary of Central Cancer Network activities

Tumour stream groups	<p>Establishment of lung steering group Lung report produced in April 2009 Meetings held at DHB level to promote findings of lung report</p> <p>Establishment of head and neck steering group Head and neck dental forum held Aug 2010</p> <p>Establishment of colorectal steering group Bowel report produced in Aug 2010</p> <p>Regional MDM development project for lung and bowel MDMs</p> <p>Baseline information on several key indicators collected and reported for lung and colorectal cancer</p>
Project / service groups	<p>Development of 7 local cancer networks</p> <p>Facilitation of regional palliative care group Not for resuscitation guidelines produced in July 2008</p> <p>Prostate early detection project – training for GPs undertaken in 2008 (completed)</p> <p>Regional palliative care medical specialist model completed 2009</p> <p>Establishment of multidisciplinary framework steering group Multidisciplinary meeting framework and implementation plan produced in Jan 2009 (implementation in progress)</p> <p>Establishment of medical imaging guidelines advisory group Medical imaging guidelines produced in Dec 2009 (implementation plan in progress)</p> <p>Establishment of cancer centre collaboration work groups Cancer Centre Collaboration project activities across Radiation Oncology, Medical Oncology and Gynae-oncology (ongoing)</p> <p>Establishment of cancer managers group</p> <p>Establishment of social workers group</p> <p>Establishment of regional care co-ordinators group</p>
Other key activities undertaken by network management team	<p>Local funding for reducing inequalities (in 2008/09 3 pilots received funding, in 2009/10 each LCN received funding)</p> <p>Pacific communities stock-take report and implementation plan produced in Dec 2009</p> <p>6 monthly Cancer Control Indicators Report produced in Feb 2010</p> <p>Demystifying cancer toolkit produced in April 2010</p> <p>Care Coordination Resources Review Guide (in progress)</p> <p>Scoping a project to support integration of Health Promotion planning (in progress)</p> <p>Cervical screening services project (in progress)</p> <p>Service Directories project (in progress)</p> <p>Implementation of PET funding (in progress)</p> <p>Clinical trials project (in progress)</p>

The Central Cancer Network, with its two regional cancer centres and eight DHBs has had to take a slightly different approach to the other more northern networks given its broader constituency. It has focused on the development of eight local cancer networks and developing tools and resources that these local networks can use. For example, the Central Cancer Network has devolved some of its reducing inequalities funding to each of the eight LCNs for them to use in their own areas. The Central Cancer Network has also developed a demystifying cancer toolkit for use by LCNs in their own regions.

Its initial tumour focus was on lung and head and neck, with a more recent focus on colorectal cancer. Patient mapping has been undertaken and a report produced which is being promoted through each of the eight DHB areas to facilitate implementation. Other focuses have been on developing and promoting clinical guidelines (not for resuscitation and medical imaging guidelines), cancer centre collaboration projects (between the two regional cancer centres), developing a six-monthly indicators report, implementation of PET funding and palliative care. Unlike other networks, the Central Cancer Network has also put a focus on Pacific inequalities and undertaking activity in the health promotion and screening end of the continuum.

Figure 19 shows responses from Central Cancer Network stakeholders who felt able to answer the question. Between 17 and 54 people answered each question.

Again, the more clinically focused projects are thought by stakeholders to be having the most positive impact on the cancer sector. In the Central Cancer Network region this includes the medical imaging guidelines, the work of the multi-disciplinary framework project group and the lung cancer work stream.

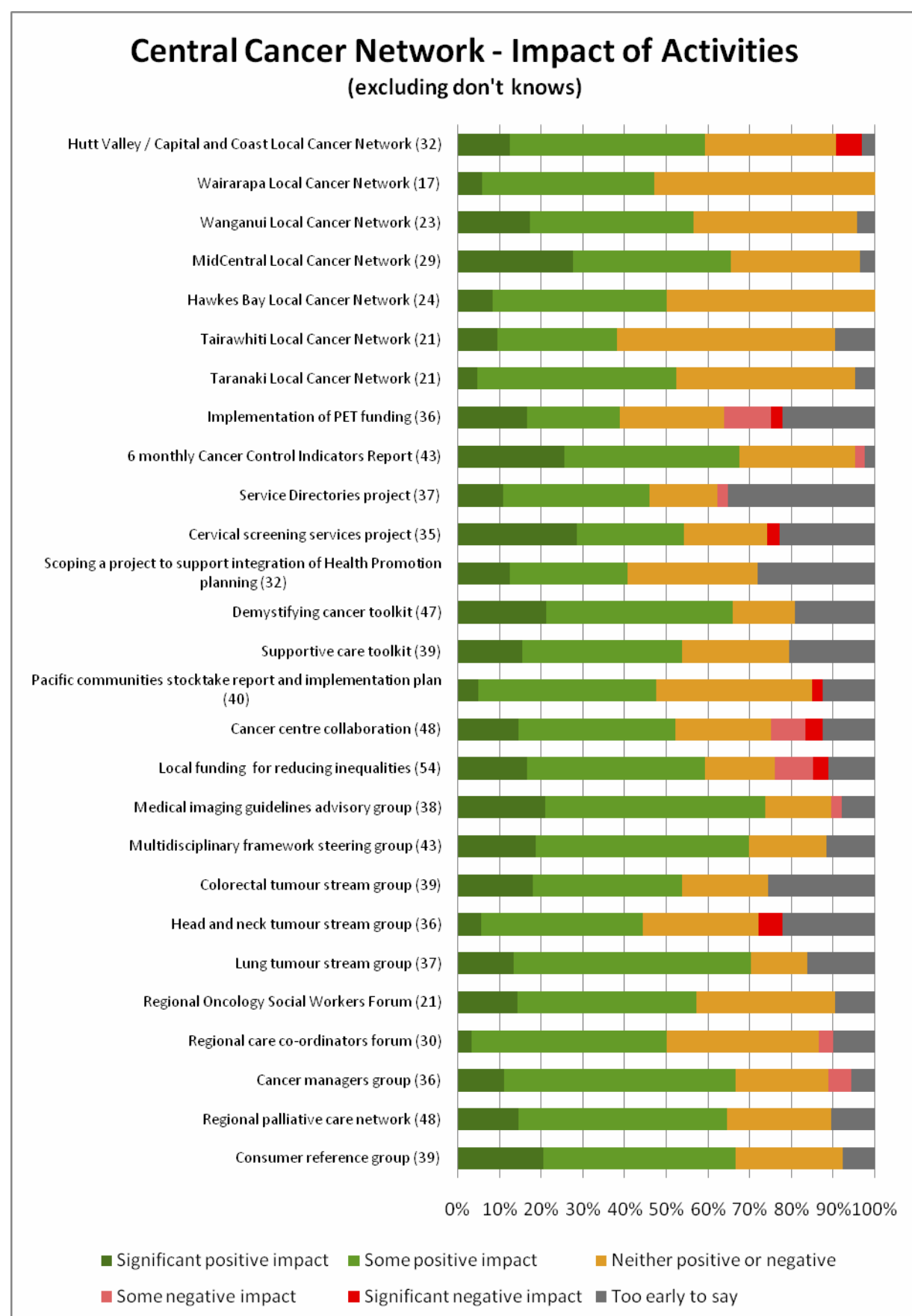
The six-monthly indicators report and the demystifying cancer toolkit were also thought to have had a positive impact.

These same activities are also those mentioned by respondents in the open-ended question or in discussions about the success of the Central Cancer Network. In addition, the primary care and NGO representatives see key successes as establishing the LCNs, which the primary care representative expanded by talking about the successes that arose from the Central Cancer Network transferring some funding to each LCN to support locally led collaborative projects, and the development of the toolkits because these then enable the LCNs to use the toolkits to develop local initiatives.

Interestingly the consumer reference group was thought to be having more of an impact in this region than the others, although this may be because more consumers from the Central Cancer Network responded to the survey than from other regions. The cancer managers group and the regional palliative care network were also thought to be contributing positively to the region.

Several projects were thought to be having a negative impact by 4 or 5 people. These included the reducing inequalities funding, the cancer centre collaboration project and implementation of PET funding, although it is unclear why this was the case as these people did not elaborate on the reasons for this, other than one person commenting on different agendas and expectations on the cancer centre collaboration project and reporting PET scanning indicators that were different to the Ministry for the PET project.

Figure 19 – Impact of Central Cancer Network activities



6.7 Southern Cancer Network

Table 30 summarises the network activities of the Southern Cancer Network.

Table 30 – Summary of Southern Cancer Network activities

Tumour stream groups	<p><u>Lung</u></p> <p>Establishment of regional lung group</p> <p>Regional Lung cancer Patient Mapping report -Canterbury, Nelson Marlborough, South Canterbury and West Coast produced in Dec 2009</p> <p>Regional Lung cancer Patient Mapping report – Otago Southland produced in June 2010</p> <p>Regional Lung key performance indicators developed and agreed by the South Island Lung Working Group</p> <p><u>Colorectal</u></p> <p>Establishment of colorectal advisory group</p> <p>Audit of DHB access to colonoscopy services report completed in Jan 2010</p> <p>Report on comparison of delay in colorectal cancer diagnosis and treatment across three South Island DHBs in February 2010</p> <p>Colorectal patient mapping and audit of waiting times (in progress)</p> <p>Baseline information on several key indicators collected and reported for lung and colorectal cancer</p>
Project / service groups	<p>Establishment of cancer nurses education group</p> <p>Establishment of AYA group</p> <p>Establishment of 5 local cancer networks</p> <p>Establishment of Canterbury palliative care network</p> <p>Establishment of cancer research group</p> <p>Cancer Service Stocktake in March 2009</p> <p>MOU for Sharing of Public Radiation Oncology Capacity between Christchurch and Dunedin Cancer Centres signed by all South Island CEOs in June 2010</p> <p>A process for responding to the new PET Scan Funding developed for the South Island in collaboration with Canterbury DHB. SI PET variance committee established and supported</p> <p>Development of a South Island cancer services directory in collaboration with the Cancer Society (in progress)</p> <p>Travel and accommodation project report in June 2010</p>
Other key activities undertaken by network management team	<p>Report on the process of ethnicity data collection at the two South Island Cancer Centres produced in Jan 2010</p> <p>Draft report on responsiveness of primary care to Māori and Pacific produced in Feb 2010</p> <p>SI cancer database development project (in progress)</p> <p>Standardised reporting of histopathology specimens (in progress)</p> <p>South Island Clinical Cancer Information System Report 1 June 2010</p> <p>South Island Linear Accelerator Capacity Review (project being scoped)</p> <p>Patient stories (project scoped)</p> <p>Funding LCNs for reducing inequalities (project scoped)</p> <p>NZ RCN development of lung and bowel cancer indicators (in progress)</p>

The Southern Cancer Network has only been undertaking significant project activity in the last year as their regional stakeholder collaborative group was not established until April 2009. The initial focus has been on lung cancer patient mapping and more recently colorectal patient mapping and review of diagnosis and treatment waiting times.

The Southern Cancer Network also undertook an audit of DHB access to colonoscopy services as an independent group, undertook a travel and accommodation review, facilitated a MOU between the two regional cancer centres for sharing capacity and is progressing a project to standardise histopathology reporting.

The network has also undertaken a range of reports in the areas of inequalities and has other projects planned or in progress in this area.

The Southern Cancer Network has specific Cancer Service Development Fund funding to scope the development of a South Island Cancer Registry project.

Unlike other networks the Southern Cancer Network also facilitates an education programme for oncology nurses.

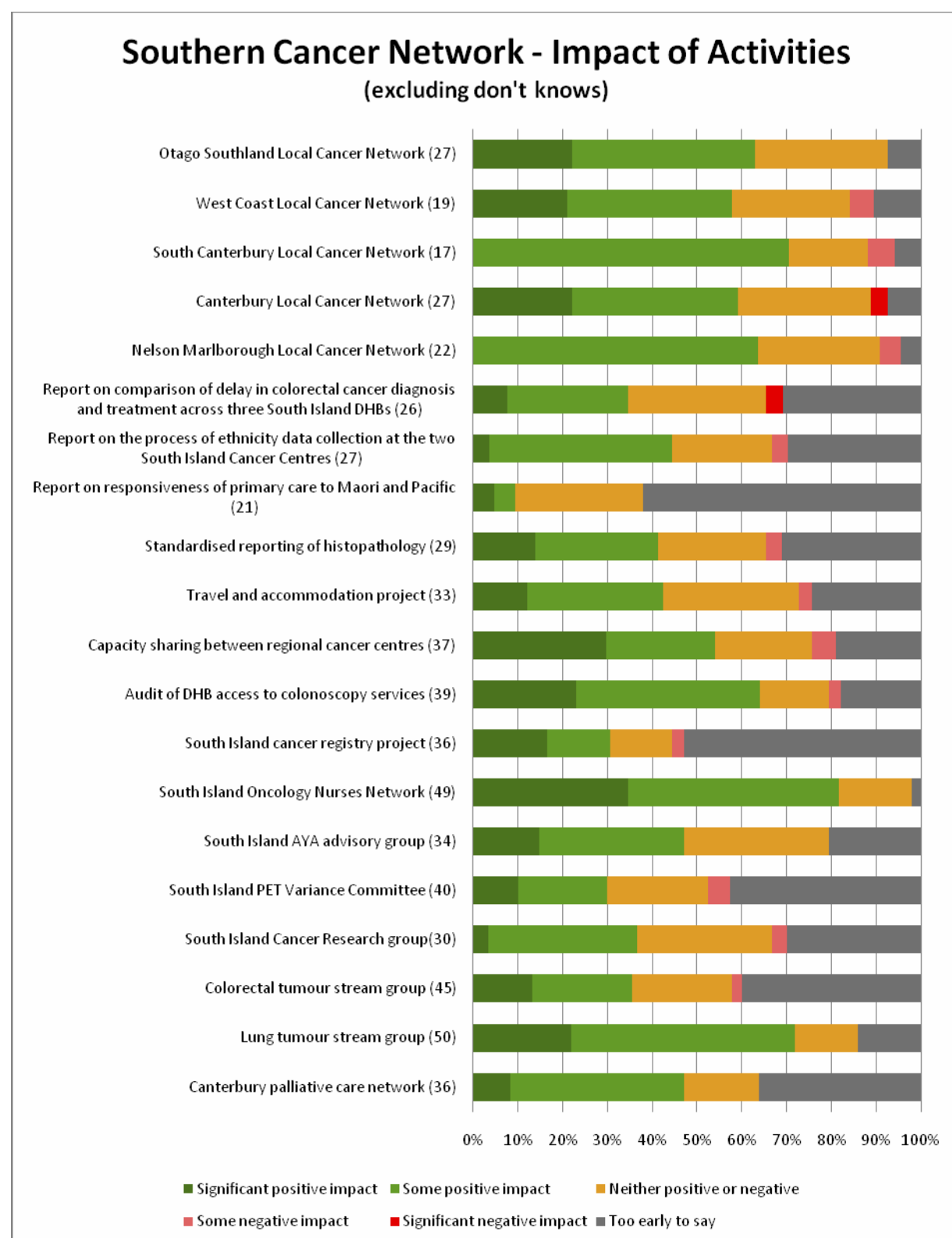
Figure 20 shows the responses from the Southern Cancer Network stakeholders who felt able to answer this question. Between 17 and 49 people answered each question.

In the Southern region, the lung cancer tumour stream patient mapping work, the audit of DHB access to colonoscopy services and the oncology nurses' education network and the local cancer networks were seen to be having the most impact to date, and this was reinforced in interviews.

Mapping the patient journey was the most often mentioned success in the open ended question of the survey amongst Southern Cancer Network respondents and was highlighted by the Chairperson of the Steering group, the Network Manager and the Clinical Directors as a key success. Facilitating the capacity sharing agreement was also seen as a success by this group.

Many people felt that it was too early to say for many of the Southern Cancer Network activities, given that this network was late establishing and many of the groups and activities have only just been established.

Figure 20 – Impact of Southern Cancer Network activities



Part C

7 Network outcomes

What outcomes have the networks achieved and how valuable are these to the cancer sector?

7.1 Evaluation criteria

The following outcomes were chosen to be measured as part of this evaluation, drawn from the immediate and intermediate outcomes in the programme logic (see section 3.3). Immediate outcomes are those that are expected to be achieved first with intermediate and subsequently ultimate outcomes taking longer to achieve.

Immediate outcomes:

- Stakeholders are better informed about cancer control
- Cancer stakeholders are more aware of cancer inequalities
- Increased use of quality improvement tools and methodologies
- Increased focus on the patient experience
- Increased access to information about cancer services for cancer providers
- Agencies and organisations providing cancer care have increased opportunities for information sharing
- Cancer stakeholders have more opportunities to identify and prioritise initiatives across the region
- Enhanced collaborative service planning across the region occurs.

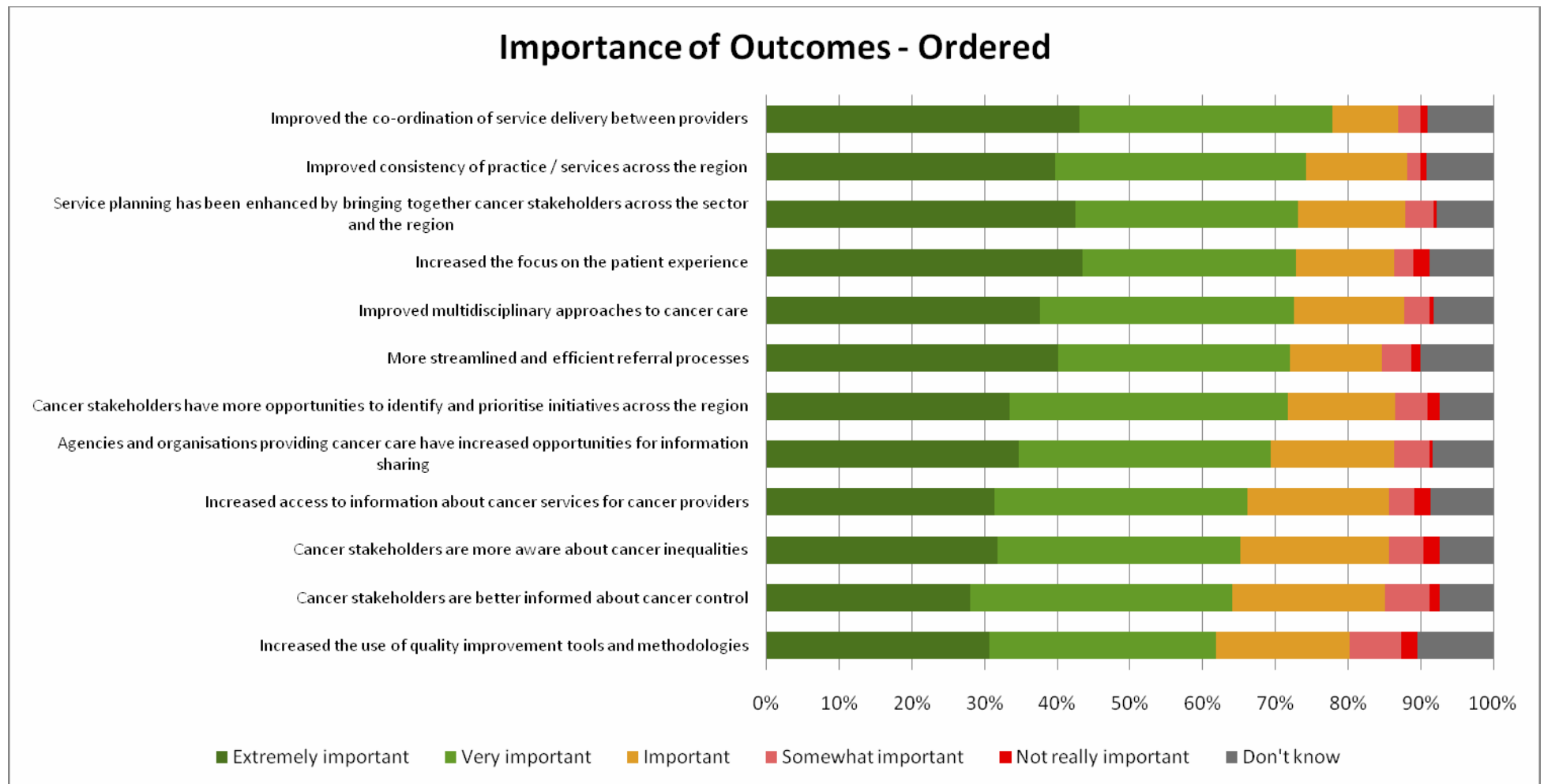
Intermediate outcomes:

- Improvements to patient flows – more streamlined and efficient referral processes
- Improved multidisciplinary approaches to care
- Improved co-ordination of service delivery between service providers
- Improved consistency of practice / services across the region.

Cancer stakeholders who took part in the evaluation were asked to assess the importance of the regional cancer network working towards these outcomes. The 224 people who answered the question confirmed that the outcomes chosen to assess the networks are all important outcomes for networks to be working towards.

Figure 21 shows how the outcomes were collectively ranked, in decreasing order of importance, by respondents who rated them as extremely important or very important. Interestingly respondents rated the intermediate outcomes most important.

Figure 21 – Importance of outcomes



7.2 Conclusions

All regional cancer networks appear to be making good progress towards achieving the immediate and intermediate outcomes from the programme logic model. Raising awareness of cancer inequalities was seen as the area the regional cancer networks have had the greatest impact on, with over a quarter saying the network had significantly impacted on this outcome. Māori representatives from each network were particularly unified in their view that the focus on inequalities wouldn't have occurred without the networks.

Other outcomes respondents believe the networks have been successful in achieving are:

- Bringing people together and developing relationships
- Increased opportunities for sharing information
- Increased opportunities to identify and prioritise initiatives
- Enhanced service planning by bringing together stakeholders
- Cancer stakeholders being better informed about cancer control and cancer inequalities
- Improved co-ordination between service providers
- Service development initiatives and removing service blockages arising from the tumour stream work
- Improved multidisciplinary approaches
- Bridging the gap between national policy and local implementation.

The network's focus on improved patient experiences appears to be a particular success and many interviewees see this as a significant point of difference between the regional cancer networks and the DHBs.

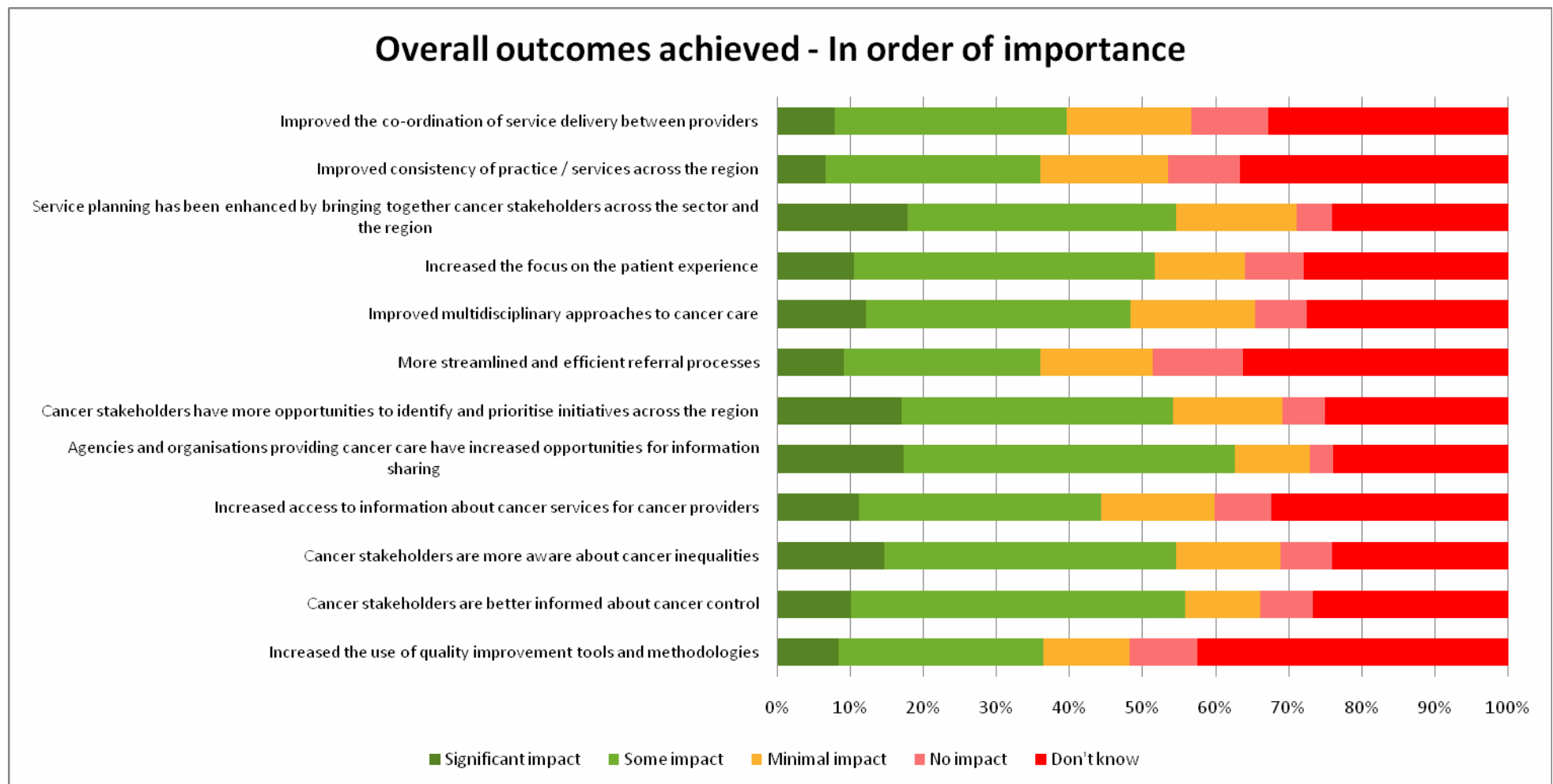
Stakeholders also believe the networks will lead to a reduction in the impact of cancer. However, there is only a tenuous link between the regional cancer network model and the ultimate outcome of reducing the incidence of cancer. The networks and the Ministry may wish to consider removing the ultimate outcome of reducing the incidence of cancer and formally adding the outcome of improved patient experience.

7.3 Immediate and intermediate outcomes

The outcomes ranked as having had the greatest impact to date are the immediate outcomes – precisely the ones we would expect to be achieved first. Hence the outcomes the regional cancer networks have had the greatest impact on to date are the necessary first steps to lead towards the outcomes rated as more important over time.

Respondents were asked to rate what impact they think their regional cancer network has had on each of the immediate and intermediate outcomes. The results are shown in Figure 22.

Figure 22 – Achievement of outcomes



Bringing people together and developing relationships was the most often mentioned success of the regional cancer networks as identified in the open ended question in the survey about network successes. This is reinforced by the fact that ‘increased opportunities for sharing information’, ‘increased opportunities to identify and prioritise initiatives’ and ‘enhanced service planning by bringing together stakeholders’ were the outcomes identified in the survey as being the ones that the networks had had the most significant impact on to date. All regional cancer networks are seen as working closely with their constituent DHBs to cut across traditional boundaries for service planning, for example driving for consistency and commonalities between DHB DAPs. As one DHB representative of a regional cancer network collaborative group said: *“The regional cancer network brings together clinicians and management together with a single focus – without the network we would have fragmentation and duplication and waste – surely we do not want this again.”*

The regional cancer networks have also had a positive impact on cancer stakeholders being better informed about cancer control and cancer inequalities. Raising awareness of cancer inequalities was the outcome seen as having been most significantly impacted by the regional cancer network, with over a quarter saying the network had significantly impacted on this outcome.

Increasing the focus on the patient experience was also seen as a key outcome by respondents. Many interviewees see this as a significant point of difference between the regional cancer networks and the DHBs – whereas the DHB funding and planning teams are primarily focused on funding and the DHB operational teams are primarily focused on meeting their contracted volumes and managing the business, the regional cancer network can focus outcomes for the patient - their experience and their journey through the system. *“I think [regional cancer networks] are crucial to maximise the efficient and effective resource and start putting the patient and their family first.”*

Other positive outcomes of network activity included:

- Improved co-ordination between service providers; in particular facilitating better relationships and increased co-operation between DHBs with regard to cancer service provision and increased collaboration between the two regional cancer centres in each of the Central Cancer Network and Southern Cancer Network regions: *“The regional cancer network is a short term change agent. It helps us to look through other’s eyes and become less territorial.”*
- Service development initiatives and removing service blockages arising from the tumour stream work
- Improved multidisciplinary approaches: *“These wouldn’t have been promulgated as fast without networks.”*

Several people talked about the important role regional cancer networks play in bridging the gap between national policy and local implementation, noting that most change is too hard to achieve from a national (top down) level but the regional cancer network can take national thinking out to district level and in reverse provide a conduit for the local voice and issues to get upwards. This is seen as leading to greater consistency and alignment.

Most of the community stakeholders (Māori, Pacific, NGOs and consumers) see that these outcomes would not have been achieved without the network(s). Previously they saw themselves as a voice on the outside with little or no involvement and little or no information. Whilst the need for changes and new developments may have been seen prior to the establishment of the regional cancer

networks, they saw no impetus and no resources allocated to make the change. Māori representatives from each network were particularly unified in their view that the focus on inequalities wouldn't have occurred without the networks.

The DHB stakeholders are a little more mixed in this regard. Some see the networks as the reason change has happened and are clear it wouldn't have been achieved without the networks, while others think that given time the same change may have occurred without the network albeit probably taking longer. The network leaders are generally of the view that the collaboration happening via the regional cancer networks would not have occurred without the involvement of the network and that some change could have happened but again not as quickly or as strongly without the networks. The primary care sector don't seem to have had sufficient involvement with the networks or been exposed to the network initiatives to make a judgement one way or the other.

A small number of respondents thought that some of the developments being led by the regional cancer networks were already being done by DHBs and that attributing the impact regional cancer networks have had in areas such as service improvement is difficult. These sentiments will be reflective of the 'no impact' or 'minimal impact' responses shown in Figure 22.

7.4 Ultimate outcomes

The logic model includes four long term or ultimate outcomes for the regional cancer networks:

- Reduced inequalities
- A reduction in the impact of cancer
- A reduction in the incidence of cancer
- Improved patient experiences.

The first three reflect the overarching goals of the Cancer Control Strategy. The fourth ultimate outcome has arisen from the regional cancer networks' own documentation and is not yet reflected in national documentation. Survey respondents and interviewees were aligned in their views that the work of the regional cancer networks will ultimately lead to reduction in inequalities, the impact of cancer and improved patient experiences (refer Figure 23).

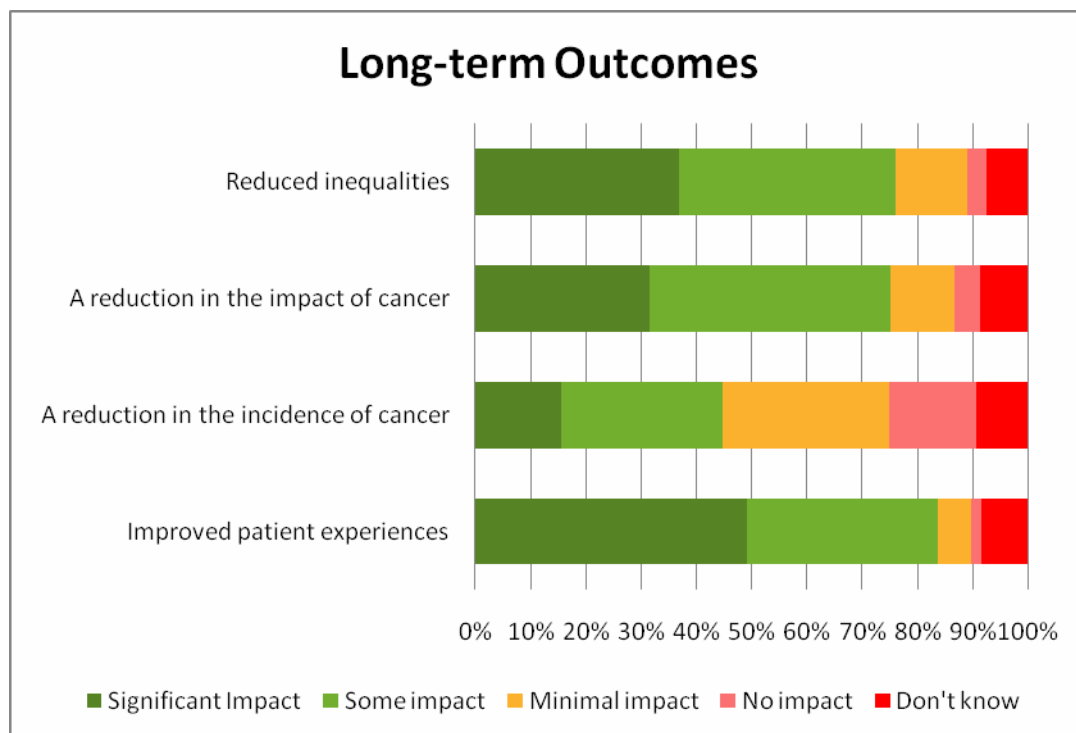
Multiple interviewees from all regions and all regional stakeholder collaborative groups commented on the goal of reducing the incidence of cancer. They appear united in their view that there is only a tenuous link between the work of the regional cancer networks and a reduction in the incidence of cancer and some felt this may be an unrealistic ultimate outcome for the networks. Reducing the incidence of cancer is seen as something the regional cancer networks would require significantly increased resources to achieve as well as a different focus and way of working. Factors impacting on the incidence of cancer are broader social issues for example immunisation rates, socioeconomic, and lifestyle factors, and outside direct influence of the regional cancer networks. Reducing the incidence of cancer is seen more as a national and local public health promotion exercise and thus the domain of other agencies, and regional cancer networks are seen as having a lesser focus at the prevention end of the cancer continuum. Consequently this ultimate or long term outcome scored significantly lower than the others in the survey results.

As discussed in detail elsewhere in this report it is important for the regional cancer networks to be clear of their purpose and prioritise their work programme on the areas where they can have

greatest impact. Most interviewees believe it is important for the regional cancer networks to retain an overview of the whole cancer continuum but almost all felt the regional cancer networks need to focus on the areas where they can have the greatest impact: effective diagnosis and treatment; support, rehabilitation and palliative care; effective planning, coordination and integration of resources and activity. If decisions are made in the future for the regional cancer networks to focus more on prevention, screening and early detection it will be important to clarify how they would interface with agencies and service providers who are already doing work in these areas and agree where they can best add value.

The responses to the question about achieving long term outcomes are shown in Figure 23.

Figure 23 – Impact on long-term outcomes



The results were fairly similar for all networks across these four questions, with Northern respondents being more optimistic than all other regions on all questions.

8 Network value

8.1 Introduction

The crux of this evaluation is to ascertain whether the regional cancer networks are adding value to the cancer control sector and whether the value will increase over time. It is not easy to measure value for many of the core regional cancer network functions. The core network roles of collaboration, facilitation, information sharing, and developing relationships all take time and resources and all are difficult to quantify in terms of return on investment. The value of individual initiatives, projects or programmes would be easier to measure but with all networks doing different activities in different ways it would then be difficult to compare or contrast such results.

The scope of this evaluation included determining the value or impact of the networks themselves, as opposed to their activities. Ascertaining value versus cost needs an understanding of both the costs of running the regional cancer networks and the benefits or outcomes of the work the regional cancer networks have been doing.

8.2 Conclusions

This section alone validates the existence of the regional cancer networks. The majority of survey respondents (who felt able to comment on this point) and interviewees (including all four lead CEOs and network chairpersons) believe the regional cancer networks are already returning value for money and there is an almost unanimous view from all quarters that the value will increase over time.

This result should provide strong evidence for continuing to fund the regional cancer networks and should send a clear signal to stakeholders of the value of their collective and collaborative participation.

A more focused evaluation of the impact of one of the activities all regional cancer networks are doing, for example the lung tumour stream work, would be required to determine the value of specific network initiatives.

8.3 Evidence and discussion

We asked all respondents what value they think the regional cancer networks are having now and what value they think the networks will have in the future. To validate the quantitative result those interviewed were asked about their perception of value in more detail. All four lead CEOs and the chairpersons of the four regional stakeholder collaborative groups acknowledge that the regional cancer networks are still in their formative years but all believe the regional cancer networks have tipped the scales between costs and benefits and are already adding value. These views were reiterated consistently by interviewees from across all sector groups. Most acknowledge that it is early days and that in the past three to four years networks have been establishing themselves and building their linkages and that any new development will have a negative value during its start up phase. Several interviewees noted that it took five years before the UK cancer networks were seen

as producing real gains: *“The challenge is to not get into an anxiety attack and demand short term solutions.”*

The almost unanimous view is that the cost benefit ratio will improve over the next one to three years, providing that the regional cancer networks focus their activities on the areas where they can add the greatest value: *“They are not there yet but are going through another growth spurt.”*

Figure 24 and 25 compare and contrast the results for the two survey questions:

1. In your opinion, what is the current balance between the benefits/outcomes of this regional cancer network compared with the costs required to run it?
2. What do you see this balance being over time with continued regional cancer network activity?

Approximately 25% of respondents didn’t feel well enough informed to answer these questions. We present the data both including and excluding those who don’t know but the numbers outlined in the following text are excluding the don’t know responses (those shown in Figure 25).

Figure 24 – Value comparison

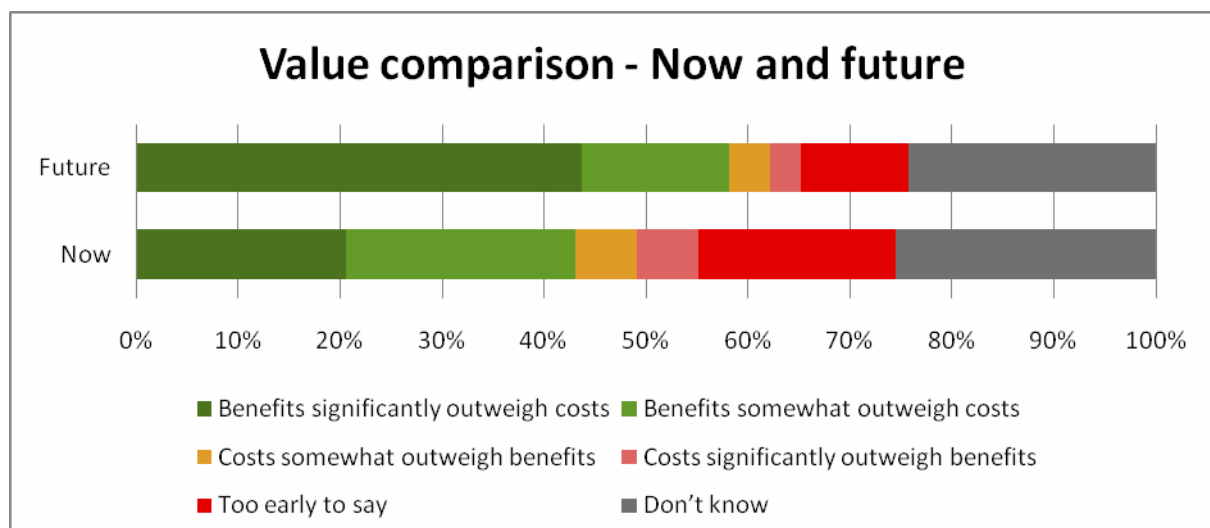
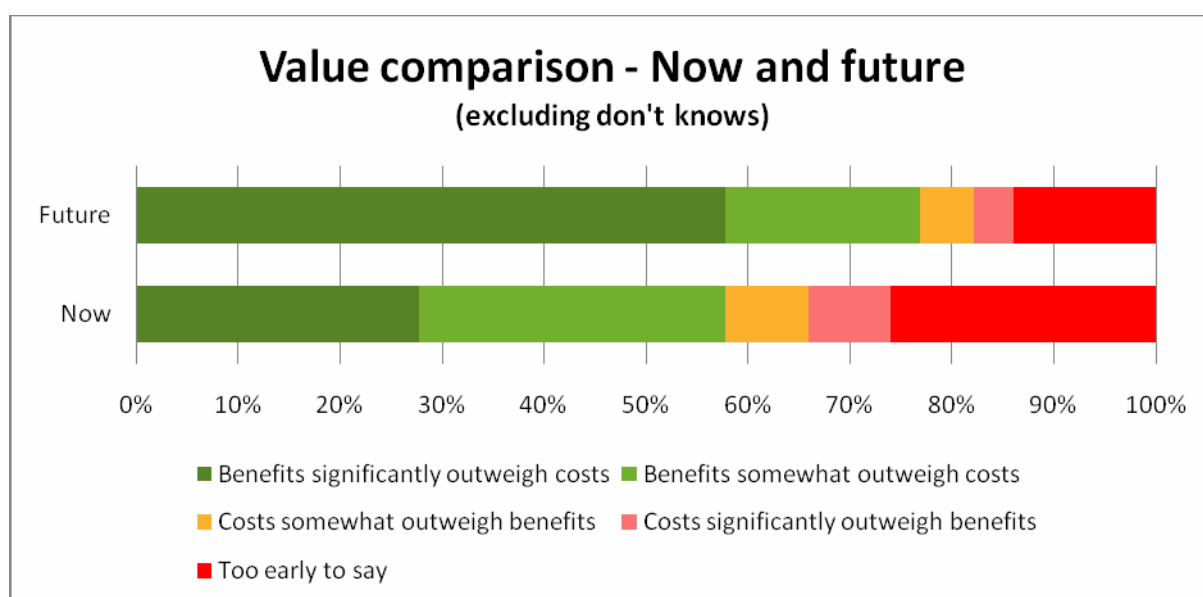


Figure 25 – Value comparison (excluding don't knows)



The results are quite consistent for all regional cancer networks with an average of 60% of all respondents across the four networks believing that currently the benefits significantly or somewhat outweigh costs and this result increases to nearly 80% for the value over time (again when excluding the don't knows). This result is reinforced by the fact that more on-line survey respondents across all networks made spontaneous comments about the value of continuing the networks than those who commented on the lack of value in the “any other comments” open ended question.

*“A great initiative, made me feel inclusive and my opinions felt valued.
Collaboration of services is needed to perform effectively. We do need to be
connected. RCN has done this.”*

*“I believe we have an excellent network driven by committed, knowledgeable
inspiring people. It would be a tragedy to lose this service and driver of
excellence in cancer health care.”*

*“I believe it is important to continue with the networks, we are a small country
and need to keep in touch with best practice and each other.”*

Particular activities where respondents feel the regional cancer networks are adding value are: improved patient services; more coordinated support services; greater stakeholder ownership; focus on tumour stream mapping; inequalities work; multidisciplinary frameworks; streamlining processes for patients; regional planning; common regional protocols and reduced duplication of effort in service provision.

Whilst the quantitative, and the majority of the qualitative results, were positive about the value of the regional cancer networks, some had doubts about their value:

*“Whereas the Cancer Network is probably an excellent concept I’m struggling
to see its benefits- and certainly don’t see outcomes that would prove value for
money - at a service provider level.”*

“Great care must be taken that this does not become just another layer of bureaucracy with great goals and aspirations but no ability to implement change or redeploy resources and therefore another white elephant which started as a great idea but failed to achieve anything of substance.”

It was beyond the scope of this evaluation to measure the extent to which specific initiatives are adding value. In section 4.9 we noted a case study evaluation of the network’s reducing inequalities work could be considered. Similarly a more focused evaluation could be considered to determine more specifically the impact of one of the activities all regional cancer networks are doing, for example the lung tumour stream work.

Part D

9 Enablers and barriers

What are the enablers and barriers that have made the difference between successful and disappointing implementation and outcomes?

9.1 Introduction

Networks in health care have become popular in recent times as a mechanism for groups of stakeholders to work collaboratively together. Unlike the traditional management hierarchy most of the health sector are used to, networks require new techniques, new ways of working, mutual respect, trust and a sense of common purpose.

Many participants in this evaluation commented that the regional cancer networks have been largely about reversing or undoing the competitive model of the 1990s that lead to considerable fragmentation, a sense of competition between providers and in many instances an environment of distrust. This history coupled with a new way of working has presented a range of perceived obstacles or barriers. Despite this the four regional cancer networks have made good progress and as discussed in the previous two sections, they have undertaken a wide range of activities, had a positive impact on outcomes and have added value to the sector.

In this section we report on what network stakeholders have told us about the enablers and barriers they have experienced over the past three to four years. Reviewing the enablers and barriers is an effective way of learning what does and doesn't work, what obstacles need to be overcome, and identifying opportunities for future improvements.

9.2 Conclusions

A range of barriers and areas for improvement are articulated throughout the report. Networks are urged to focus on removing all possible barriers in their efforts to become more successful over time.

Specific barriers to implementation and outcomes identified by interviewees were:

- The model and the environment
- Lack of national oversight, national direction or national guiding documents
- Lack of mandate, the lack of authority
- Getting service providers to implement changes arising from the regional cancer network activities without any mandate or any discretionary funding to 'require' them to take action
- Multiple stakeholders and multiple competing priorities
- Difficulties in engaging with the primary care sector
- The paucity of evidence, data and technology at national, regional and local level.

Almost all interviewees mentioned the skills, competencies and attitudes of network personnel (particularly clinical leaders, network managers, network staff members, and regional stakeholder collaborative group chairpersons) as key enablers of success. The Minister of Health's focus on collaborative arrangements throughout the health sector is seen as giving the networks a good mandate to get the parties to the table. The network structure is also seen as an enabler: its ability to bring people together collectively; the independence of the networks; the independent thinking the network can bring to an issue; their ability to connect stakeholders together.

Networks could all do more with increased revenue, with more staff. The dedicated funding of the networks is seen as an enabler but limitations of resources were also seen as a barrier. There are inequities between the four networks when revenue is apportioned against the number of DHB districts they each cover and this will inevitably lead to barriers to those networks with more DHBs or larger geographic regions. There would be merit in introducing a variable funding model to enable all four networks to operate on more of a level playing field.

9.3 Evidence and discussion

The barriers most commonly mentioned by interviewees relate to the model and the environment. The fragmented and constantly changing nature of the health system is seen by interviewees as the source of many of the challenges and barriers to the regional cancer networks. The sector the regional cancer networks interface with is seen as complex with an array of systems, multiple players with competing agendas and competing timeframes. Some respondents perceive a disconnect between the Ministry, the District Health Boards and the regional cancer networks across the cancer continuum and some say this has led to a culture of distrust between key stakeholder groups, different agencies and services. Breaking down these old patterns and ways of working was seen as one of the major barriers and challenges.

Many interviewees perceive there is a lack of national oversight, national direction or national guiding documents and see this as having resulted in the networks taking longer to get themselves established. One of the clinical directors said: *"All four regional cancer networks started with a blank sheet of paper and all had to work it out in their own way."*

The absence of national leadership is also seen as contributing to the fragmentation and difficulties the regional cancer networks are having at effecting change at a regional level. Several of the regional cancer network leaders talked about the lack of any national documentation to guide the establishment, development or activities of the networks, for example national patient management frameworks, guidelines and standards. One clinical director said *"The networks have been asking for national direction since day one – the parent body (Ministry) has been supporting but not driving, not leading and not providing the framework, the guidance that would have been beneficial."* One of the lead CEOs put it succinctly as *"The national parenting has not been as good as it could have been."* These matters will be explored in more detail in section 10.3 as an opportunity for future development.

The most frequently mentioned barrier was the lack of mandate, the lack of authority. The Ministry suggested that the network model itself is a potential barrier, acknowledging that the regional cancer networks can make recommendations but don't have any levers to require implementation other than to influence. By design, networks do not have the traditional single line, top down,

responsibility/accountability. This coupled with confusion over lines of authority and accountability will inevitably lead to confusion over mandate and ownership.

Many respondents talked about the barrier of getting service providers to implement changes arising from the regional cancer network activities without any mandate or any discretionary funding to 'require' them to take action. DHB funding and planning teams were most commonly cited as a barrier to implementation. Indications are that whilst funding and planning representatives participate, to a greater or lesser extent, in network governance, decision making and work programme activities they are seen as providing minimal guidance or continuity between the DHB funding and planning teams and the network. Frequently work is done to plan for new initiatives or changes at the network level only to find DHB funding and planning personnel in one or more DHBs block these from advancing to implementation. One regional cancer network leader said that eight out of every ten network initiatives are blocked by funding and planning in one of more of their DHBs: *"Getting engagement is one thing – getting change as a result is another."* A cancer network clinical director said: *"All we've done is make decisions that have then been put up through the DHB processes to get approved and implemented."* This was reiterated by a DHB representative who noted *"While the multi disciplinary work at regional level is significant, the implementation at local level is much slower."* And another DHB representative said: *"I am uncertain whether some of the failures relate to being under-resourced or the inability [of the network] to readily influence executive DHB decisions or to a lack of staff to introduce operational change."*

As noted in the introduction to this section a networked way of working requires non traditional techniques – whereby a network's mandate arises from a common sense of purpose, collaboration between stakeholders, mutual respect and trust. These are challenging concepts for some network stakeholders to grasp, particularly when in their day to day role they are still operating in a fragmented and to some extent 'competitive and non collaborative' environment.

This search for a mandate is coupled with another frequently mentioned barrier – the fact that the regional cancer network has multiple stakeholders and these multiple stakeholders often have competing priorities. One respondent described this as: *"The network dancing between the various stakeholders and agencies"*.

The networks are all experiencing difficulties in engaging with the primary care sector and this is seen by most as a barrier to the network effectiveness in making change around the interface between primary and secondary care and addressing inequalities and is one of the key opportunities for improvement (refer following section).

Another frequently mentioned barrier is the limitation of resources restricting the scope of the regional cancer network work programme. As identified in section 3, the four regional cancer networks have to date received equal levels of base funding even though the size and complexity of the networks is very different. The more DHB districts a network has the more stakeholders there are to engage with. This coupled with the large geographical area creates a diseconomy of scale requiring increased costs for the same level of output or outcome. Hence while funding limitations are a barrier for all networks it is a significantly greater barrier for the Central Cancer Network and the Southern Cancer Network. The differences between the four regions mean the networks are unlikely to achieve the same outcomes until the annual revenue for the regional cancer networks is distributed more equitably.

Table 31 shows the revenue inequities between the four networks when apportioned against the number of DHB districts they each cover. The tagged reducing inequalities funding has been removed for these comparative purposes.

Table 31 – Revenue apportioned by DHB districts.

	Northern	Midland ⁷³⁷⁴	Central	Southern
Total base revenue per annum	250,000	250,000	250,000	250,000
Number of DHB districts	4	3	8	5
Funding per DHB district	62,500	83,333	31,250	50,000

The final cluster of barriers identified by multiple respondents is evidence, data and technology. A lack of IT support and relevant clinical databases at national, regional and local level is frustrating all networks and appears to be exacerbated by the networks' lack of authority to broker for change on this sort of issue. Data is reportedly poor and laborious to extract from DHB systems and this is handicapping the regional cancer network planning processes. One regional cancer network reported recent improvements in this regard while another noted that their lung cancer MDM has had to resort to a paper based system with a staff member spending a day a week doing data entry. Furthermore, there is no central or easily accessible repository for international evidence to underpin the work of the regional cancer networks.

"There is a lack of accessible and useful data in the IT systems to support planning, monitoring and evaluation by the regional cancer networks."

"There are barriers in evidence – no reliable patient pathway measures – we have the anecdotal word of clinicians but no data to support – through primary/secondary – data is major barrier."

"Data is so poor and laborious to extract that the resultant planning is handicapped"

"Lack of IT support. Lack of clinical databases."

There is one enabler that stands head and shoulders above all others mentioned. He aha te mea nui? He tangata. He tangata. He tangata. What is the most important thing? It is people, it is people, it is people. Almost all interviewees mentioned the skills, competencies and attitudes of network personnel as being the most important enabler. Multiple positive comments were made about clinical leaders, network managers, network staff members, and regional stakeholder collaborative group chairpersons. Particular qualities that were mentioned include: people who can get others engaged and enthused; the ability to persuade and influence; ability to listen to a wide range of

⁷³ Note this budget does not include funding for facilitation of the Waikato Palliative Care Network that the regional cancer network manager is also responsible for

⁷⁴ Accounting internal recharge and outsourced rule changes over the 4 years, overhead charges not included in accounts therefore an estimation has been made

arguments, then when everyone has had a say, to sum it up into a collective view; logical yet creative thinkers; people who enable and support; passion and commitment; people that people respect; leaders and champions; mutual respect, understanding and knowledge – people who have a genuine eagerness to work collaboratively.

Most of the other enablers are the mirror effect of the barriers. The Minister of Health's focus on collaborative arrangements throughout the health sector provides a good mandate to get the parties to the table. The Ministry's stated priority for regional cancer networks to work on lung and bowel tumour streams has reportedly provided a very effective mandate for the networks, has assisted the prioritisation process and focused regional cancer network activities on these areas.

"Lung and bowel work had a mandate from the Ministry/Minister – this made it much easier and took the pressure off doing other things."

"The Ministry's priorities give us a mandate, bring networks together, focuses activity"

The network structure is seen as an enabler: its ability to bring people together collectively; the independence of the networks; the independent thinking the network can bring to an issue; their ability to connect stakeholders together - consumers with CEOs with front line workers - is seen as unique. The network can step outside the silos and can engage with grass roots clinicians to bring about change. The work networks are doing is not necessarily about new ideas but the difference is that they have been the facilitators, the enablers to driving these ideas through to their conclusions.

The dedicated funding of the networks is seen as an enabler as it allows the network to focus on something from beginning to end. Where technology (ie video conferencing) is available it is seen as an enabler. Likewise where evidence is available it is a key enabler in getting clinician buy-in. The health needs analysis work done by the networks provided evidence to underpin their work and hence became another enabler. One of the clinical leaders was adamant that the electronic collection of meaningful data to manage the tumour stream pathways will be the key enabler for the future: *"IT support is needed before any more real progress can be made – this is the same for whole country and the same for all tumour streams."*

10 Learnings

What can we learn:

- *about how the networks can be improved and developed to add further value into the future and*
- *that will inform the development and implementation of other networks in the health sector?*

10.1 Introduction

This section of the report details what the survey and interview respondents see as the way forward for the networks. Opportunities for further development have already been identified in many of the earlier sections of this report. These matters will not be repeated here.

All survey respondents were asked: 'What opportunities for improvement or further gains could the regional cancer network make. What would have to happen for this to occur?' Stakeholders who were sent the email questionnaire were asked the above questions and also:

- How sustainable do you think the regional cancer networks will be in the future in a changing health environment and why?
- What lessons can be learned for the benefit of other clinical/health networks that may be developed in the health sector in New Zealand?

Interviewees were asked about their views on these matters in more detail.

In this section we will present the findings in two different subsections that reflect the two aspects of the evaluation question being answered in this section:

- Opportunities for improvement and further development of the regional cancer networks
- The development and implementation of other health sector networks.

10.2 Conclusions

The establishment of a mechanism to more formally link networks together – nationally and between regions - was the most commonly mentioned opportunity for improving and developing the regional cancer network model to add further value. Interviewees were not suggesting replacing the regional level or creating a top down hierarchy but rather strengthening and further developing existing arrangements. Their suggestions ranged from creating a virtual national network to a national network with regional offices. They felt this would provide greater alignment, connectivity, consistency, cooperation and collaboration between the networks and have the potential to reduce duplication of effort.

The greatest opportunities for improving and developing network activities are seen to be continuing to develop and expand the tumour stream work, further development of MDMs, and improving the interface between primary and secondary cancer services. Indications are that focusing more on the front end of the tumour pathways provides the greatest opportunities for reducing inequalities. Whilst it was outside the scope of this evaluation there appears to be an opportunity for the networks to lead the regional planning process for cancer control. Numerous other opportunities for further development are identified throughout this report.

Key factors identified by interviewees for building successful networks are:

- Allow sufficient time for the network to have a positive influence on outcomes
- Relationships, trust and a sense of collective identity
- Vision, passion and determination
- Inspire, lead and facilitate collaboration
- Communication is a critical mechanism for achieving collaboration
- Identify champions and bring people with you
- Good management and clinical leadership
- Representative governance structures and effective linkages
- Reduce duplication of effort
- Have a clear framework that identifies the network's goals, purpose, decision making processes and mandate
- Focus on a small number of goals
- Trust your stakeholders and empower them to add value
- Explore opportunities for a consistent model for Māori, consumer and primary care stakeholders to input into different networks.

There is considerable consistency between the advice our interviewees gave to those developing other health networks and the criteria for operating a successful network used in this evaluation. Hence we trust that many of the findings discussed throughout this report will be relevant to other networks.

10.3 Opportunities for improvement and further development of the regional cancer networks

A member of one of the Central Cancer Network LCNs summed up the opportunities for the future beautifully: *“Mā to rourou, ma toku rourou ki a ora ai te iw⁷⁵i.*

1. *Letting go of the power and control*
2. *Shared methodologies and ideologies (eg values, ideas, concepts, beliefs, research, and principles)*
3. *Leadership*
4. *More funding focused on outcomes instead of outputs*
5. *Whanau ora clause in contracts that give clear and precise direction of the implementation of a strategic pathway for iwi/Māori.*
6. *Good consultation with manawhenua and tangatawhenua”.*

Stakeholder participation and collaboration remains central to the regional cancer network model and regional cancer networks are urged to continue to develop this area. It is expected that as stakeholders see how they are able to meaningfully participate in planning, prioritisation and decision making and as the networks get ‘runs on the board’ they will increasingly see the value of working collaboratively and hence become more engaged. The areas of stakeholder development mentioned most frequently as opportunities for improvement were: primary care, Māori

⁷⁵ “With your food basket and my food basket, the people will thrive”

engagement, fostering clinical champions and local cancer networks as a mechanism for stakeholder engagement. These suggestions have been incorporated in the relevant parts of sections 0 and 5.

A consistent theme for future development is the need to bring the secondary and primary care sectors closer together, and the opportunities this provides for networks to focus their activities more at the front end of the patient journey to move their focus away from cancer treatment towards a focus on the primary care and diagnosis stages of the pathway. This is seen as a key area where inequalities can be reduced. One respondent suggested that if Māori enjoyed the same good health as non Māori the country would save between \$700 and \$800 million per annum: *“Focusing on kaupapa Māori cancer initiatives in the primary care sector is where the greatest gains can be achieved in reducing inequalities and realising these savings.”*

Identifying primary care providers willing to take a leadership role in cancer control is seen as a key opportunity for engaging with the primary care sector and bridging the gap between primary and secondary care. This has also been discussed in sections 5.2, 5.9 and 9.3. One of the clinical directors sees an opportunity in the community health centres the Government are moving to have established. One primary care representative suggested the regional cancer networks pilot a model whereby an interested GP could become a sub specialist operating as an intermediary between the originating GP and the hospital cancer specialist to increase access and reduce costs by having a small number of GPs seeing all suspected cancer patients before they enter the hospital system. Other suggestions included the regional cancer network funding a regional cancer primary care position to test a range of possible primary care initiatives in cancer management, and the establishment of a regional primary care collaboration forum.

Tumour stream initiatives were also frequently mentioned as an important area for further activity. The interface between primary and secondary care is important to the early diagnosis stage of all tumour streams and the tumour stream work is seen as providing a platform for more active engagement of the primary care sector in the regional cancer network’s activities. The regional cancer network managers suggested that between ten and 12 cancer tumour streams are needed and it would be inefficient for each regional cancer network to work separately on each of these. They propose collectively identifying how many tumour and service-specific work streams are required and allocating responsibility for each of these between the regional cancer networks. Once a tumour stream is worked up in one region it can be shared and ‘regionalised’ by the others.

The further development of MDMs is seen as an important mechanism for improvements and for bringing clinicians together around a common regional table. One clinical leader suggested the regional cancer networks consider opportunities for developing models of integrated care using similar KPIs between different MDTs and then encouraging the adoption of these as national targets. Other opportunities for increased engagement of clinicians have been discussed in section 5.5.

Stakeholders see LCNs as a valuable part of the regional cancer network. Not only do the LCNs facilitate local level engagement of stakeholders but they are seen as an important vehicle for feeding information and suggested developments up to the regional cancer network. There are also good opportunities for the DHB management and the regional cancer networks to give the LCNs a mandate for helping to implement and operationalise regional cancer network initiatives at the local level.

In section 4.5 we have discussed a number of opportunities for improvement in the regional cancer network planning, prioritisation and decision making processes. This is such an important juncture in moving forward that it worth noting the general comments from respondents here:

“It appears the regional cancer networks will consider anything – they need to be careful not to take on too many things – complete what they are doing and get some runs on the board.”

“Regional cancer networks need to focus on finishing what they have started.”

“Don’t grow too quickly – take a phased and staged approach.”

“Give networks time to realise the benefits of the initiatives already underway.”

“Take what is working well and duplicate it.”

“Need good data to show networks are making a difference to get clinicians to believe in them.”

“Regional cancer networks are susceptible – they need to achieve and market some clear successes.”

Respondents have mixed feelings about how sustainable the networks are. This is interesting given the majority felt the networks were already providing value for money and will provide increasing value in years to come. The main reasons given for their uncertainty include: political will; changes to the structure of the health sector in particular if the Government changes the configuration of DHBs or establishes regional funding and planning bodies; fiscal pressures to divert funding to front line services may make regional cancer networks a target if they are seen as just another layer doing project work; a model of LCNs linking directly to a national cancer network may be seen as a more effective model; funding may be scaled back to only cover a manager and a clinical lead i.e. the operational team may be dispensed with. Most of these reservations relate to potential external threats to the regional cancer network model. Respondents had some constructive suggestions of how the networks could maximise their opportunities for long term sustainability including:

- Evolve in such a way as to maintain an active presence in the changing health environment – continue to adapt as the environment changes around them
- For the four networks to become more aligned, more integrated, and therefore more efficient – working together and sharing rather than duplicating effort
- Make sure the network work programme is manageable within the health sector and aligned with other network programmes to minimise the risk of duplication of effort
- Continue to develop inspiring leadership and an effective team
- Continue to build the sense of collaboration – the more stakeholders feel a commitment to and ownership of the network the more sustainable the model will be. This will help ensure networks do not become patch protective and siloed.

“I would like to think that they will be supported to sustainability to ease the way into the future where collaboration and sharing of resources is going to become increasingly important with growth in cancer rates together with

increasing inequalities due to financial pressures, rural disadvantages and increases in a multicultural New Zealand.”

Over a third of interviewees (all of whom were a lead CEO or a member of a regional stakeholder collaborative group) suggested the establishment of a mechanism to more formally link networks together nationally when asked what they saw as the opportunities for improvement or further gains in the networks. Interviewees were not suggesting replacing the regional level or creating a top down hierarchy but rather strengthening and further developing existing arrangements – nationally and between regions.

Currently the four networks regional cancer network managers and clinical directors link together on a regular basis as the New Zealand Regional Cancer Network Forum (refer section 4.4.3 National linkages) but this forum isn't part of the formal cancer management infrastructure (refer Figure 1). The four managers are finding they need to meet more regularly to ensure consistency, reduce duplication, and get more alignment in planning. One manager summed it up as: *“There is a vacuum in national leadership and regional cancer networks need to find a way of getting this, a way of pulling together, of reducing duplication and inefficiencies.”* The Ministry representatives noted that national alignment between the networks has not worked as rapidly as they would like to have seen and they see opportunities for more national leadership for the networks. Indications are that such a move wouldn't have been right at the outset but now that regional development has occurred it is timely to decide how the four regional cancer networks can come together more.

The following is a list of gains that respondents felt could be made with stronger national linkages:

- Cross fertilisation/learning between networks
- More openness, sharing and connectivity
- More national consistency and efficiency whilst recognising regional and local differences: *“Regional cancer networks are where bottom up meets top down”*
- Gluing things together at a national level
- Need some way of reducing fragmentation at a network level: *“We have to get over the idea of needing to do things differently”*
- It would provide more national leadership and more of a mandate to regional cancer networks
- A link between regional and national planning
- National, regional and local all connected
- Work co-operatively to promote the development of a national standards framework including national targets for common cancers
- Develop some common understandings
- Better alignment between national, regional and local work streams
- Reduce duplication of effort for example if each network did two tumour streams and then would have eight done. Regional differences could be accommodated via each network subsequently regionalising the model that others had developed.
- Facilitate national development e.g. national tumour stream work
- Ways of enabling /encouraging innovation whilst learning from one another – nationally and between regions
- Encourage consistency in training and inter-sector learning for example learning about inequalities, ethics, up to date cancer initiatives and evidence

- Provide a formal mechanism for collating and disseminating up to date international literature to network stakeholders and management
- Encourage a sense of collaboration at a national level – as all stakeholders develop a sense of commitment to and ownership of the national framework.

At the heart of this issue is whether the current model is the best one for the future. Different interviewees had different views as to what the national model should be and hence how different this is from the current arrangements. The concepts and terms mentioned were:

- Virtual national network
- Federation of regional networks – not another layer and not national top-down
- National coordination
- National collaboration
- National framework
- National forum
- Taking the current structures and bring them together
- National collective of networks
- National unity of networks
- National office
- National coordination with local ownership
- National network with regional offices

Some interviewees had a vision of a National Cancer Institute with responsibility for national funding and planning of cancer services and the regional cancer networks becoming managed care networks under that umbrella. The National Cancer Institute would have budgetary control and could free up funds for new innovations at regional or local level.

Others went even further in their proposals for the future, suggesting that the regional cancer networks broaden their focus to become regional integrated care networks, recognising that the main chronic diseases are closely linked. This model would bring together planners, thinkers, doers and change makers to organise, facilitate and coordinate in a more generic way.

These ideas were tempered by a few words of caution, most of which came from the leaders of the Southern Cancer Network. As this network is still in the early stages of development it is understandable that they would be cautious about making any changes to the model until their network is fully established:

“Be careful not to complicate a winning formula by trying to suggest there is a national view.”

“Don’t need anything top down.”

“I would hate to see more bureaucratic structures.”

“Don’t restructure now – the baby is not weaned, not grown up yet – reconsider this option in a couple of years time.”

Whilst the further development of mechanisms to link networks together nationally and between networks is seen by many interviewees as an area for development, further work would be required to scope the issues and options for any changes to the current model.

Interviewees were also very keen to see a mechanism developed to facilitate networking between networks - collaboration between all stakeholder groups in all networks. Currently the only links between the four regional cancer networks is via the managers, the clinical directors and the lead CEOs. Interviewees were asked whether they have any mechanisms for networking between regional cancer networks and whether they saw merit in this occurring. Stakeholder representatives were enthusiastic about the prospect of being part of a virtual network with their equivalent representatives on the other regional cancer networks, in particular the chairpersons of the regional stakeholder collaborative group and the Māori and consumer representatives.

Interviewees felt it would increase their effectiveness as stakeholder representatives if they could learn about what is happening for their stakeholder group in other regional cancer networks and to share ideas and experiences with one another. Other benefits suggested include: reducing the risk of the networks developing horizontal silos to replace the vertical silos they are addressing; provide opportunities for shared resources between regional cancer networks; enable stakeholders to share ideas and problems and to learn collectively; to learn about the similarities or differences between the four regional cancer networks and their activities; facilitate sharing between local districts for example Nelson sharing with Northland. The Chairperson of one of the regional stakeholder collaborative groups suggested more inter-network linkages could open up opportunities for someone involved in a particular project going to the other regional cancer networks and presenting their work so they can all learn from one another – so they can all collaborate.

“Stakeholder engagement is like the roots of a tree - the more stakeholder engagement there is and the further those stakeholders can reach out regionally and nationally the more nutrients the trees can get and the stronger the trees grows.”

Such inter-network collaboration could be as simple as sharing minutes of meetings or consumer representatives sharing email addresses so they could communicate with one another, or as ambitious as developing a national consumer collaborative or organising a national conference for all regional cancer network stakeholders. This may be facilitated under the requirement of section 4.1.4 of the CFA (refer Appendix C) that states ‘In collaboration with the Ministry and the other networks, leads an annual national cancer control forum to report back and share knowledge and learnings with the wider cancer community’.

A number of interviewees (particularly clinical interviewees) also talked of opportunities for developing and formalising linkages with international counterparts, particularly with the Australian Cancer Networks. This it was felt would realise untapped potential and share ideas and learnings, enable us to compare ourselves more widely and ensure the New Zealand networks aren’t reinventing a wheel already developed by someone else.

Lastly regional service planning for cancer control is another area providing opportunities for further development for the regional cancer networks. We did not specifically question evaluation participants about their views on the role of regional cancer networks in regional service planning

for cancer control but there appears to be an opportunity for the regional cancer networks to take a lead role in this area.

The Minister of Health is calling for the health sector to work more collaboratively together at a regional level and the Ministry has recently called for DHBs to prepare some regional plans. These regional planning activities have in the past been lead by regional funding and planning entities, by shared service agencies or by one DHB taking a lead role on behalf of other DHBs and service providers in the region.

While the CFA states that each network should develop a Regional Strategic Cancer Control Plan, in reality the strategic plans are for the network's activity, not for the region's cancer control activity. However, the Northern Cancer Network has recently been given responsibility for leading the development of a northern regional cancer control plan and believes this is only possible now that the regional cancer network has proven itself. The Midland Network has also developed a number of regional strategic plans in specific areas such as a Midland radiotherapy services plan and a Midland medical oncology services plan as well as working on a regional palliative care strategic plan.

Clarification is needed as to whether the four regional cancer networks will be seen as the appropriate agency to lead the regional planning process for cancer control or will work alongside a lead DHB or the regional cancer centre(s) in their region to 'promote a collaborative approach to service planning and delivery'. The extent to which this changing national landscape will impact on the regional cancer networks is not yet clear but will undoubtedly help to define the purpose of the regional cancer networks and potentially assist in defining the network's mandate.

The health environment is very conducive to networks going forward. The regional cancer networks need to be ready and able to move and adapt as changes occur in the sector.

10.4 The development and implementation of other health sector networks.

Interviewees were forthcoming with their ideas about lessons that can be learned from their experiences with the regional cancer networks that may help those setting up other health networks. There is considerable consistency in the advice from different quarters.

Timing is everything and setting up a new network takes time – usually more time than is expected. Sufficient time must be allowed for the network to have a positive influence on outcomes. Networks take time to develop because you are bringing together people with different values and different cultures, people who have never worked collaboratively before. If this isn't appreciated there is a risk of unrealistic expectations that the network will: *"Show value in a clear and tidy mathematical equation."*

Communication is a critical mechanism for achieving buy-in and for building a sense of collaboration – a sense of 'we'. Relationships, trust and a sense of collective identity are key and it takes time for different parties to trust one another. Good management and clinical leadership are critical. The relationship between the network chairperson and manager is vital as is the relationship between the manager and the clinical leaders. Network leaders can't drive change under duress or force of personality; they need to inspire, to lead, to facilitate collaboration.

Barriers have to be broken down to build a sense of collaboration. Removing the barriers first is far more effective than trying to push through the barriers in a forcible way. Identify champions – bring people with you – get early runs on the board. Building relationships is labour intensive particularly in the early stages. Vision, passion and determination are required. One of the consumer representatives noted: *“If you don’t have clinicians on board you might as well go home.”* And conversely the advice to other networks from a DHB staff member involved in one of the regional cancer network groups was: *“Let go, be accountable but listen to the people who are affected – reach out, we are all stronger when we are all in this together.”*

Representative governance structures and effective links between network governance and operational arms are important: *“Good working relationships are absolutely key to a successful network.”* Stakeholders from the regional cancer networks recommend linkages and integration between regions and between networks – to get ideas, provide support, share skills, and learn from one another. This would be particularly relevant for the non DHB stakeholder representatives. The Māori interviewees are keen to see a common framework for Māori input into all networks: *“Otherwise Māori will be always attending meetings – having conversations with different groups of people about similar issues.”* This will be the same for consumer and primary care representatives. National or regional networks could potentially share support staff and facilities.

Different networks are needed for different purposes and different parts of the health sector but opportunities could be explored for adopting consistent models. Some networks will most appropriately be national only, others regional only or regional linking together nationally. Yet another model suggested was one region hosting a network on behalf of others. Wherever possible, efforts need to be made to reduce duplication of effort and to fit networks within an existing infrastructure and context, for example under the umbrella of a shared services agency.

Without a clear framework networks will be set up to fail. Networks need to be more than a good idea – they need to be underpinned by strategy. Network functions should be worked out before deciding the form. Our interviewees urge new networks to be clear on the goals, purpose, and decision making processes of the network. The network’s mandate or authority needs to be clarified from the outset. If networks are to be like the regional cancer networks and only have a mandate to influence rather than control, then the skills of the manager become critical.

Networks need dedicated resources and should focus on a small number of key goals rather than spreading themselves too thinly: *“Be clear about what you are trying to achieve – try not to do too much – prioritise and then develop plans around the highest priorities.”* There is a fine line between trying to do too much and doing too little.

Our interviewees see significant advantages in the network being ‘outside’ the system so there are no potential issues around *“biting the hand that feeds you.”* And the non-DHB interviewees advocate for other networks to get away from a purely clinical or medical model but to link all stakeholders, all players, together - get everyone in the room from the outset - trust them and empower them to add value. Collaboration between providers has become important in the new health environment. Networks are not a place for patch protection: *“All parties need to realise that patch protection has to disappear and real teamwork will provide the solution.”*

The final word of advice comes from one of the regional cancer network managers: *“There is no one magic formula for networks.”*

Appendix A – Detail of methodology

Key informant interviews and documentation review

Initial key informant interviews were conducted with key network stakeholders in order to:

1. Introduce the evaluators
2. Provide an opportunity for network staff to input into the evaluation objectives and methodology
3. Allow the evaluators to gain an initial understanding of the scope, role and functioning of the networks
4. Collect key documentation relevant to network structure and activities.

Table 32 – Key informant interviews

Sample	Regional cancer network managers and clinical directors (6) Staff from the Ministry Cancer team (1)
Length of interview	1 - 3 hours per interview
Timing	May 2010
No. of interviews	7

The regional cancer networks and the Ministry were asked at this time to provide copies of relevant documentation relating to the development and on-going functioning of the networks including (but not limited to):

1. All relevant Ministry documentation developed subsequent to the 2007 review
2. All papers pertaining to the Ministry's work in performance and outcome monitoring of regional cancer networks (via DHBs)
3. Key documentation developed by each regional cancer network including (but not limited to) strategic plans, annual reports, work plans, terms of reference, newsletters, key reports and reporting to the Ministry
4. Documentation pertaining to funding arrangements, budgets, reports on expenditure of the networks.

This documentation was reviewed to develop an understanding of the form and functions of each network, the way each has developed over time and the various roles and responsibilities of network stakeholders within the network structure.

Development of programme logic and criteria to assess networks against

Programme evaluations are traditionally based on the programme logic (also known as intervention logic/outcomes model / theory of change) that underpinned the development of the new initiative. A programme logic) is a well accepted and commonly developed tool in an evaluation methodology and is a key plank in an effective evaluation, particularly in complex programmes such as networks. It is used to map the activities, outputs and immediate outcomes of a programme to the ultimate

outcomes. It enables clarity around what the programme is trying to achieve and how it goes about doing so.

No consistent programme logic had been developed for the regional cancer networks so the first stage of this evaluation was to develop a programme logic linking network activity to network outcomes against which to assess network implementation and outcomes against. It was developed in consultation with the network managers and clinical directors, based on information about the way in which regional cancer networks operate included in the Cancer Control Strategy and Action Plan, the Cancer Programme Plan, the CFA variation, and the individual networks' strategic plans as well as some key literature and assessment tools pertaining to evaluating networks⁷⁶. A summary of the programme logic developed can be found in section 3.3 of the report.

Network managers and (separately) network clinical directors met as a group to refine the programme logic and sign off the criteria used to evaluate the networks against.

Criteria used

The criteria chosen to assess the networks against as part of this evaluation were drawn from the inputs, activities and outcomes outlined in the regional cancer network programme logic, confirmed as important in the literature and were agreed to by network managers and clinical directors.

Data collection

Qualitative Interviews

Qualitative interviews were conducted with 37 individuals, or groups of individuals. 19 of these were conducted face to face (in Auckland, Hamilton, Palmerston North, Wellington and Christchurch) and 18 by telephone.

Table 33 – Face to face and telephone interviews completed

	Network Managers and Clinical Directors	Lead CEO	Regional stakeholder collaborative group chairperson	NGO, Māori, consumer, primary care	Chairperson lung group	Other	Total
Northern	2	1 ⁷⁷	1	3	1		8
Midland	2	1	1	4	1		9
Central	3	1	1	4	0*		9
Southern	2	1	1	4	1		9
Other						2 ⁷⁸	2
TOTAL	9	4	4	15	3	2	37

* Chairperson Lung Tumour Stream Group is one of the clinical directors

⁷⁶ . Government Policy on the Development of Clinical Networks. Health Report 20100236. Ministry of Health. 2010
 Innes J, Hughes H (2009). Health Networks Literature Review. Stratum Ltd for Central TAS
 Siggins Millar (2008) Literature Review of Managed Clinical Networks. Developed for Cancer Australia.
 Goodwin N, Peck E, Freeman T, Posaner R (2004) Managing Across Diverse Networks of Care: Lessons from Other Sectors. Final report to the NHS SDO R&D Programme, health Services Management Centre, University of Birmingham
 Williams B (2003) A review of collaborative relationships between government agencies and community organisations. Networks, Collaborations, Coalitions and Partnerships.
 Cancer Service Networks National Demonstration Program (CanNET) Evaluation Tool. Siggins Miller. Australia
 Partnership Self Assessment Tool. Centre for the Advancement of Collaborative Strategies in Health.
 Assessing Strategic Partnerships. Partnership Assessment Tool. Nuffield Institute for Health. UK
 Collaboration Factors Inventory. Wilder Research. Amherst Wilder Foundation. US

⁷⁷ This person is also Chair of CCSG

⁷⁸ Ministry of Health staff as a group, Chair of CTAG

Email Questionnaire

An email questionnaire was developed and sent to 81 people including:

- DHB Funding and Planning staff member from each DHB (20)
- DHB provider arm staff member chosen by each DHB (20)
- Chairperson of the LCNs in each DHB if not already included or other local cancer representative in areas with no LCNs (16)
- Other governance / steering group members if not already included in sample (14)
- Shared service agency staff member (3)

In addition, most of those people interviewed face to face or by telephone (with the exception of the Ministry staff, the lead CEO for each network and the Chairperson of the Cancer Treatment Advisory Group) were also asked to complete a quantitative questionnaire (the same as the email questionnaire) prior to or after the qualitative interview.

All people in the email questionnaire were reminded at least twice about the questionnaire.

In total 114 questionnaire forms were sent out to the core evaluation sample and 64% (73) were completed and returned; 90% from the qualitative sample and 52% from the email sample.

A copy of the email questionnaire can be found below.

Table 34 – Email questionnaire response rate

	DHB Funding and Planning	DHB Operations	Local Cancer Network rep	Shared Service Agency	Other Governance	Other requested to be added⁷⁹	Total
Northern	2/4	1/4	4/4	0/1	1/2 (1 on leave)	2/4 (1 on leave)	10/19
Midland	2/3	2/3	2/3 (1 on leave)	n/a	0/5	1/3	7/17
Central	6/9 (1 declined to participate as too new to job)	3/7	2/4 (1 on leave)	1/1		0/1 (on leave)	12/22
Southern	1/5	2/5	5/5	1/1	4/7	-	13/23
TOTAL	11/21	8/19	13/16		5/14	5/11	42/81

Online survey of the cancer control sector in each region

An on-line survey was conducted using the mailing lists of each of the regional cancer networks. Each person/organisation/agency on a network mailing list was sent a web link to a customised survey specific to their network that had been set-up in SurveyMonkey. Those who had already been interviewed or asked to complete an email questionnaire were not part of the on-line survey. Stakeholders had two weeks to complete the survey and a reminder was sent.

⁷⁹ Each Network Manager suggested several other people who should be included

Table 35 – On-line survey response rate

	NGO / Hospice / Māori / Pacific	Consumer	DHB	Primary Care PHO / GP	Other / skipped question	Total
Northern	8/40 (20%)	4/8 (50%)	25/198 (13%)	2/38 (5%)	3/56	42/340 (12%)
Midland	9/37 (24%)	2/5 (40%)	43/137 (31%)	5/17 (29%)	4/12	63/208 (30%)
Central	31/58 (53%)	10/25 (40%)	44/239 (18%)	5/151 (3%)	6/43	96/517 (19%)
Southern	17/137 (12%)	3/8 (38%)	62/502 (12%)	7/85 (8%)	3/86	92/800 (11%)
TOTAL	65	19	174	19	16	293

Questions

There were three broad questioning methods.

1. A questionnaire, to be filled in electronically or in hard copy, was completed by almost everyone in the face to face and telephone interview samples⁸⁰ and everyone who participated in the email questionnaire sample. The questionnaire contained a range of quantitative questions and multiple areas for respondents to provide free text comments (qualitative). There were four different questionnaires – one for each of the four regional cancer networks and an example is shown later in this appendix.
2. A full interview guide was developed containing a range of additional qualitative questions to explore in more detail with those being interviewed face to face or by telephone. The guide was a flexible document and was used to ensure that areas of importance were covered while at the same time allowing the opportunity to discuss areas of interest as they arose. Face to face and telephone interviews focused primarily on questions pertaining to the regional cancer network the interviewee was involved with. Only a small number of the interviews related to all networks for example the Chairperson of the Cancer Treatment Advisory Group and staff from the Ministry Cancer Team.
3. On-line survey conducted via ‘SurveyMonkey’ (survey template contained later in this appendix). The on-line survey contained the same quantitative questions that were asked of the email respondents and most of the telephone and face to face interviews. In addition a small number of free text qualitative questions were asked in the on-line survey. In line with the two questioning methods above, four different surveys were loaded into SurveyMonkey – one for each of the networks.

⁸⁰ The lead CEO for each network and the Ministry of Health staff and CTAG were not asked to fill in a questionnaire.

Analysis

The qualitative interviews were analysed into key themes based on the objectives of the evaluation.

The quantitative questions in the email and on-line survey were analysed in SurveyMonkey and Excel. As each of the four networks had a different response rate to the survey, in order to not have a bias to those networks with number of responses, the total for each question was calculated as an average of each of the 4 network's responses to the question.

Information is presented as a total for the networks (4 networks averaged).

The open ended questions in the survey were coded by a CCNZ analyst and key themes analysed.

Evaluation of Regional Cancer Networks

Cancer Control New Zealand has been asked by the Minister of Health to evaluate the Regional Cancer Networks and has commissioned Trio Consulting to undertake the evaluation. We are using multiple methods to assess the implementation and operation of the networks and to help network development in the future. This survey is a key component of the evaluation.

You have been selected as an appropriate person to provide feedback on the **Central Regional Cancer Network** and we appreciate you taking the time to give your opinions. We appreciate that not everyone we survey will know about all aspects of network activity and so please feel free to respond “don’t know” for areas that you are not familiar with.

If you have any questions or would like clarification on any aspect of this survey please email Ruth Herbert at ruth@trio-consulting.co.nz

Please fill in your responses to the survey questions electronically, add additional comments as you wish and email the completed survey back to ruth@trio-consulting.co.nz by **Wednesday 23rd June**

If you are unable to respond electronically, you can send the completed hard copy of the survey back to Trio Consulting, PO Box 5158, Lambton Quay, Wellington, 6145.

You need to allow approximately 30 mins to complete this survey.

We will not be naming any respondents in our report but if you are happy for your comments to be identified by your role in the report, please indicate below:

<input type="checkbox"/>	Yes, I am happy to be identified by role in the report
<input type="checkbox"/>	Yes, I am happy for you to use my comments but not identify my role
<input type="checkbox"/>	No, please don't quote my comments at all

Parts of this survey have been based on a number of existing network and partnership assessment tools including:

- Cancer Service Networks National Demonstration Program (CanNET) Evaluation Tool. Siggins Miller. Australia
- Partnership Self Assessment Tool. Centre for the Advancement of Collaborative Strategies in Health.
- Assessing Strategic Partnerships. Partnership Assessment Tool. Nuffield Institute for Health. UK
- Collaboration Factors Inventory. Wilder Research. Amherst Wilder Foundation. US

Identifying Your Role

Which DHB District do you come from?	Please mark one with an 'X'
Taranaki	
Whanganui	
Midcentral	
Wairarapa	
Hutt Valley	
Capital and Coast	
Hawkes Bay	
Tairāwhiti	
Other (please specify)	

Your agency and role	Please mark one with an 'X'	Job title / agency / role
DHB Funding and Planning		
DHB Operations		
Other		

Your role within the regional cancer network	Please mark as many as apply with an 'X'
Member of the Central Cancer Network governance group	
Member of a regional cancer network group (eg tumour stream group, service development group, consumer reference group, project advisory group)	
Member of a local cancer network group	
Actively involved in a regional cancer network project but not on a formal group	
None of the above	

The following areas have been identified as important to the effective functioning of a regional cancer network in New Zealand. Please **rate** the key criteria outlined below in terms of importance by marking each row with an “X”.

Key criteria for a well functioning network	Extremely important	Very Important	Important	Somewhat important	Not really important	Don't know
Clear and unique network purpose						
Commitment to and ownership of network by cancer stakeholders						
Active involvement of cancer stakeholders						
Strong leadership						
Good communication						
Good staffing						
Clear governance, structure and decision making processes						
A reducing inequalities focus						
Monitoring and evaluation mechanisms						
Using evidence based planning						

Please mark one box in each row with an “X” to identify how strongly you agree or disagree with the statements as they relate to the Central Cancer Network. You are welcome to provide additional comments that provide extra information about this dimension and/or help to explain the reasoning behind your responses.

Clear governance, structure, decision making	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
The regional cancer network has a clearly defined governance structure in place						
There are clear linkages between the regional cancer network and DHB planning and funding						
I am clear about the mechanisms for decision making within the regional cancer network						
The regional cancer network has a clearly defined structure that links the various groups in the network						
The governance structure is representative of cancer stakeholders in the region						
I am clear about the roles and responsibilities of regional cancer network group members						
Please add any comments about the governance, structure and decision making of this regional cancer network.						

Commitment to and ownership of regional cancer network	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
Senior level management in my organisation are committed to working collaboratively as part of the regional cancer network						
Cancer stakeholders take collective ownership of the regional cancer network						
Cancer stakeholders accept the benefits of working collaboratively via the regional cancer network						
Please add any comments about the commitment to and ownership of the regional cancer network						

Leadership	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
The regional cancer network's clinical leader(s) has the skills and experience needed to lead the network						
The regional cancer network's manager has the skills and experience needed to lead the network						
The regional cancer network's manager and clinical leaders work together effectively to lead the network						
Regional cancer network leadership successfully communicates the vision of the network						
Regional cancer network leadership inspires and motivates people to create change						
Regional cancer network group members take a leadership role on network activities within their sectors						
Please add any comments about the leadership within this regional cancer network.						

Network staffing	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
The regional cancer network has adequate staff to carry out network activities						
Regional cancer network staff have the influence and credibility required for their role						
Regional cancer network staff have the appropriate skills in project management, change management and facilitation needed to successfully manage network activity						
Regional cancer network staff are focused on reducing inequalities						
Regional cancer network staff are adequately connected to and informed about the wider cancer control sector						
Regional cancer network staff provide appropriate facilitation / secretariat services to network groups						
Please add any comments about the regional cancer network staffing						

Evidence based planning	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
There is on-going strategic planning to identify and prioritise regional cancer network activities						
Planning is based on documented evidence and draws on best practice						
There is a focus on reducing inequalities in all regional cancer network planning activities						
Please add any comments about the way in which the regional cancer network goes about planning						

Network purpose	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
I clearly understand what the regional cancer network's purpose is						
Other cancer stakeholders I know clearly understand the purpose of the regional cancer network						
The regional cancer network has defined, clear and realistic activities set out in an annual plan						
The work the regional cancer network is doing is not being done by others						
The work the regional cancer network is doing would be difficult for any other organisation to accomplish by itself						
Please tell us what you understand the regional cancer network's purpose to be.						

Communication	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
The regional cancer network communicates regularly with cancer stakeholders						
Relevant and useful information is disseminated from (or via) the regional cancer network						
Cancer stakeholders use the regional cancer network to share information						
Regional cancer network group members communicate effectively about network activities to their own sectors						
Please add any comments about the quality of the communication within the regional cancer network						

Active involvement of cancer stakeholders	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
The issues and concerns of my local district are appropriately considered in identifying and prioritising regional cancer network activities						
Consumers are actively contributing to identifying and prioritising regional cancer network activities						
NGOs and palliative care providers are actively contributing to identifying and prioritising regional cancer network activities						
PHOs are actively contributing to identifying and prioritising regional cancer network activities						
There is identified Maori leadership and a framework for Maori participation in the regional cancer network						
Maori are actively contributing to identifying and prioritising regional cancer network activities						
Other ethnic groups are actively contributing to identifying and prioritising regional cancer network activities						
DHB management are actively contributing to identifying and prioritising regional cancer network activities						
DHB clinical staff are actively contributing to identifying and prioritising regional cancer network activities						
Please add any comments about the input of cancer stakeholders.						

The following list outlines the main regional cancer network groups and activities (current or completed) of this regional cancer network. Please mark one box in each row with an “X” to identify the impact the activities of the group or project have had on the region’s cancer sector.

Central Cancer Network Group Achievements	Too early to say	Significant positive impact 5	Some positive impact 4	Neither positive or negative 3	Some negative impact 2	Significant negative impact 1	Don't know
Consumer reference group							
Regional palliative care network							
Cancer managers group							
Regional care co-ordinators forum							
Regional Oncology Social Workers Forum							
Lung tumour stream group							
Head and neck tumour stream group							
Colorectal tumour stream group							
Multidisciplinary framework steering group							
Medical imaging guidelines advisory group							
Local funding for reducing inequalities							
Cancer centre collaboration							
Pacific communities stocktake report and implementation plan							
Supportive care toolkit							
Demystifying cancer toolkit							
Scoping a project to support integration of Health Promotion planning							
Cervical screening services project							
Service Directories project							
6 monthly Cancer Control Indicators Report							
Implementation of PET funding							
Taranaki Local Cancer Network							
Tairāwhiti Local Cancer Network							
Hawkes Bay Local Cancer Network							
MidCentral Local Cancer Network							
Wanganui Local Cancer Network							
Wairarapa Local Cancer Network							
Hutt Valley / Capital and Coast Local Cancer Network							

Network Success and Opportunities for Improvement
--

<p>What would you describe as this regional cancer network's greatest successes to date?</p>

<p>What hasn't worked so well for the regional cancer networks?</p>
--

<p>What opportunities for improvement or further gains could the regional cancer networks make? What would have to occur for this to happen?</p>

The following list describes some potential outcomes achieved by the regional cancer networks. Please mark one box in each row with an “X” to identify the extent to which this **regional cancer network’s (RCN) activity has been responsible** for the following outcomes:

Network Outcomes to date	This RCN has had a significant impact 4	This RCN has had some impact 3	This RCN has had minimal impact 2	This RCN has had no impact 1	Don't know
Cancer stakeholders are better informed about cancer control					
Cancer stakeholders are more aware about cancer inequalities					
Agencies and organisations providing cancer care have increased opportunities for information sharing					
Service planning has been enhanced by bringing together cancer stakeholders across the sector and the region					
Cancer stakeholders have more opportunities to identify and prioritise initiatives across the region					
This regional cancer network has developed improved multidisciplinary approaches to cancer care					
This regional cancer network’s activities have resulted in more streamlined and efficient referral processes					
This regional cancer network has improved the co-ordination of service delivery between providers					
This regional cancer network has improved consistency of practice / services across the region					
This regional cancer network has increased access to information about cancer services for cancer providers					
This regional cancer network has increased the focus on the patient experience					
This regional cancer network has increased the use of quality improvement tools and methodologies					
What other outcomes have resulted from regional cancer network activity (both good or bad)?					

How important is it to you that the regional cancer networks achieve these outcomes? Please mark each row with an “X” to identify how important the achievement of these outcomes by the regional cancer network is to you.

Importance of Network Outcomes	Extremely important	Very important	Important	Somewhat important	Not really important	Don't know
Cancer stakeholders are better informed about cancer control						
Cancer stakeholders are more aware about cancer inequalities						
Agencies and organisations providing cancer care have increased opportunities for information sharing						
Service planning has been enhanced by bringing together cancer stakeholders across the sector and the region						
Cancer stakeholders have more opportunities to identify and prioritise initiatives across the region						
This regional cancer network has developed improved multidisciplinary approaches to cancer care						
This regional cancer network's activities have resulted in more streamlined and efficient referral processes						
This regional cancer network has improved the co-ordination of service delivery between providers						
This regional cancer network has improved consistency of practice / services across the region						
This regional cancer network has increased access to information about cancer services for cancer providers						
This regional cancer network has increased the focus on the patient experience						
This regional cancer network has increased the use of quality improvement tools and methodologies						

The following list describes some potential longer term outcomes that may be achieved by the regional cancer networks. Please mark one box in each row with an “X” to identify the extent to which you think that, over time, continued regional cancer network activity will lead to the following outcomes:

Networks into the Future	RCNs will have a significant impact 4	RCNs will have some impact 3	RCNs will have minimal impact 2	RCNs will have no impact 1	Don't know
Improved patient experiences					
A reduction in the incidence of cancer					
A reduction in the impact of cancer					
Reduced inequalities					
Why do you say this?					

How sustainable do you think the regional cancer networks will be in the future in a changing health environment and why?

What lessons can be learned for the benefit of other clinical/health networks that may be developed in the health sector in New Zealand?

Overall value of the network	Too early to say	Benefits significantly outweigh costs 4	Benefits somewhat outweigh costs 3	Costs somewhat outweigh benefits 2	Costs significantly outweigh benefits 1	Don't know
In your opinion, what is the current balance between the benefits/outcomes of this regional cancer network compared with the costs required to run it?						
What do you see this balance being over time with continued regional cancer network activity?						
Please add any comments about the costs versus the benefits/outcomes of this regional cancer network						

Do you have any other comments to make about regional cancer networks?
--

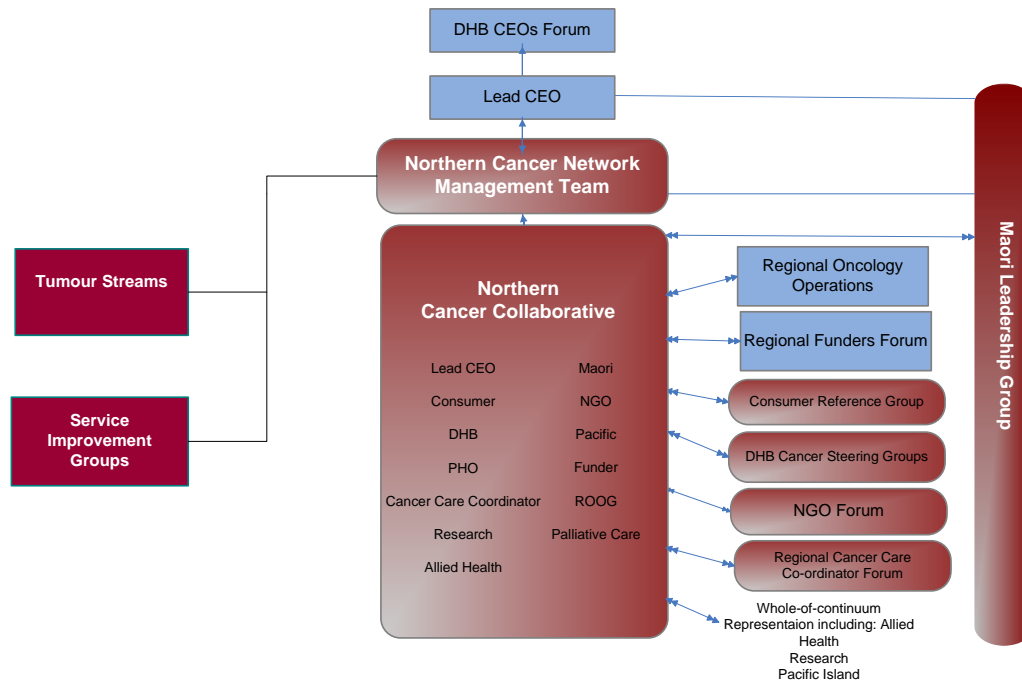
Thank you for your input. We appreciate you taking the time to complete this survey. Please email it back to ruth@trio-consulting.co.nz

Appendix B – Structure of each network

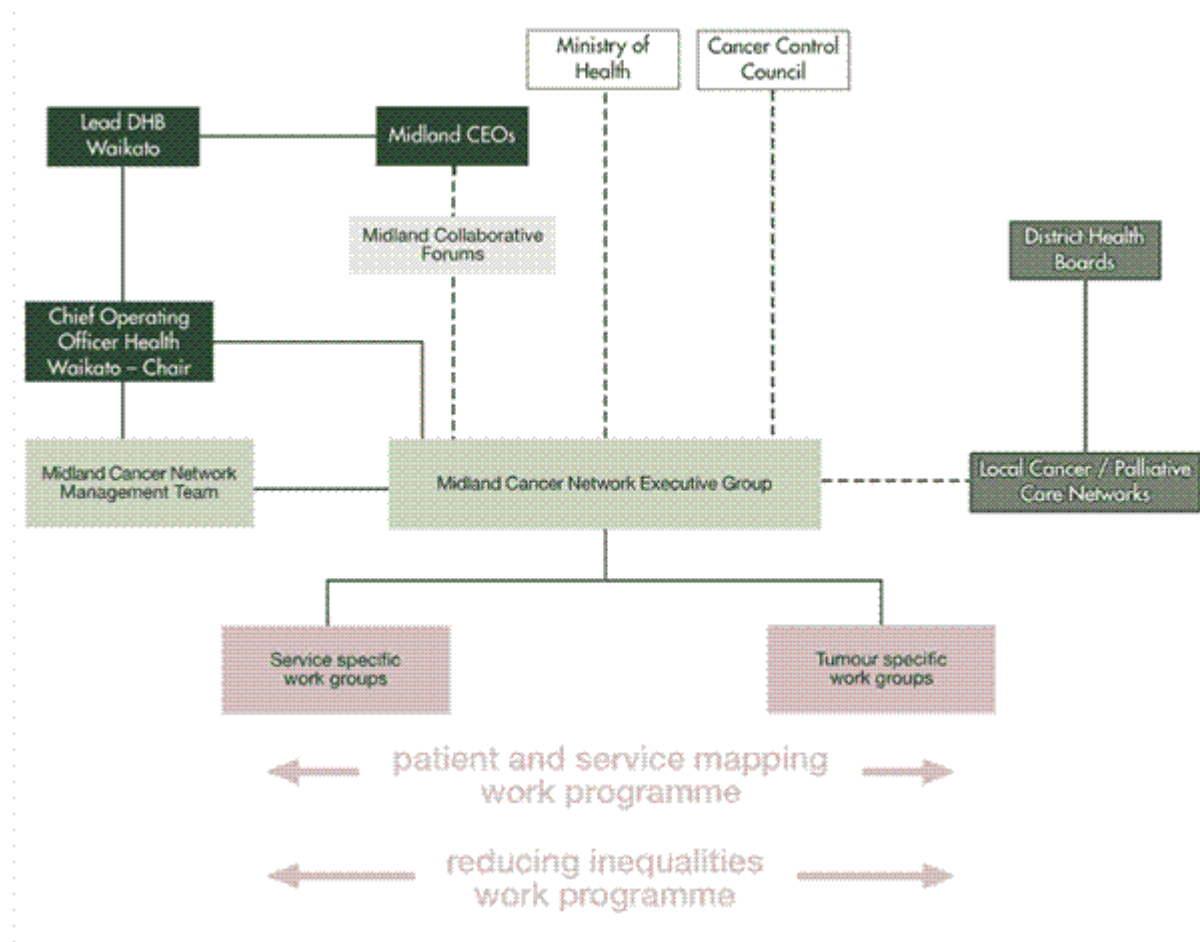
Northern Cancer Network

Northern Cancer Network Organisational Structure

Updated as of November 2009

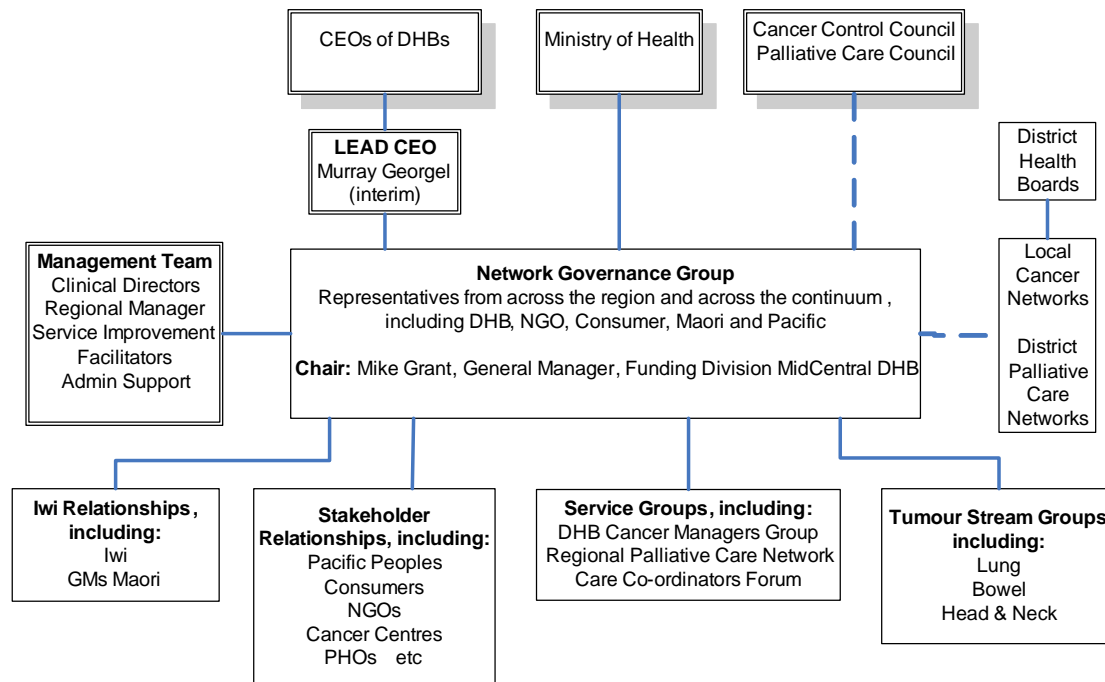


Midland Cancer Network

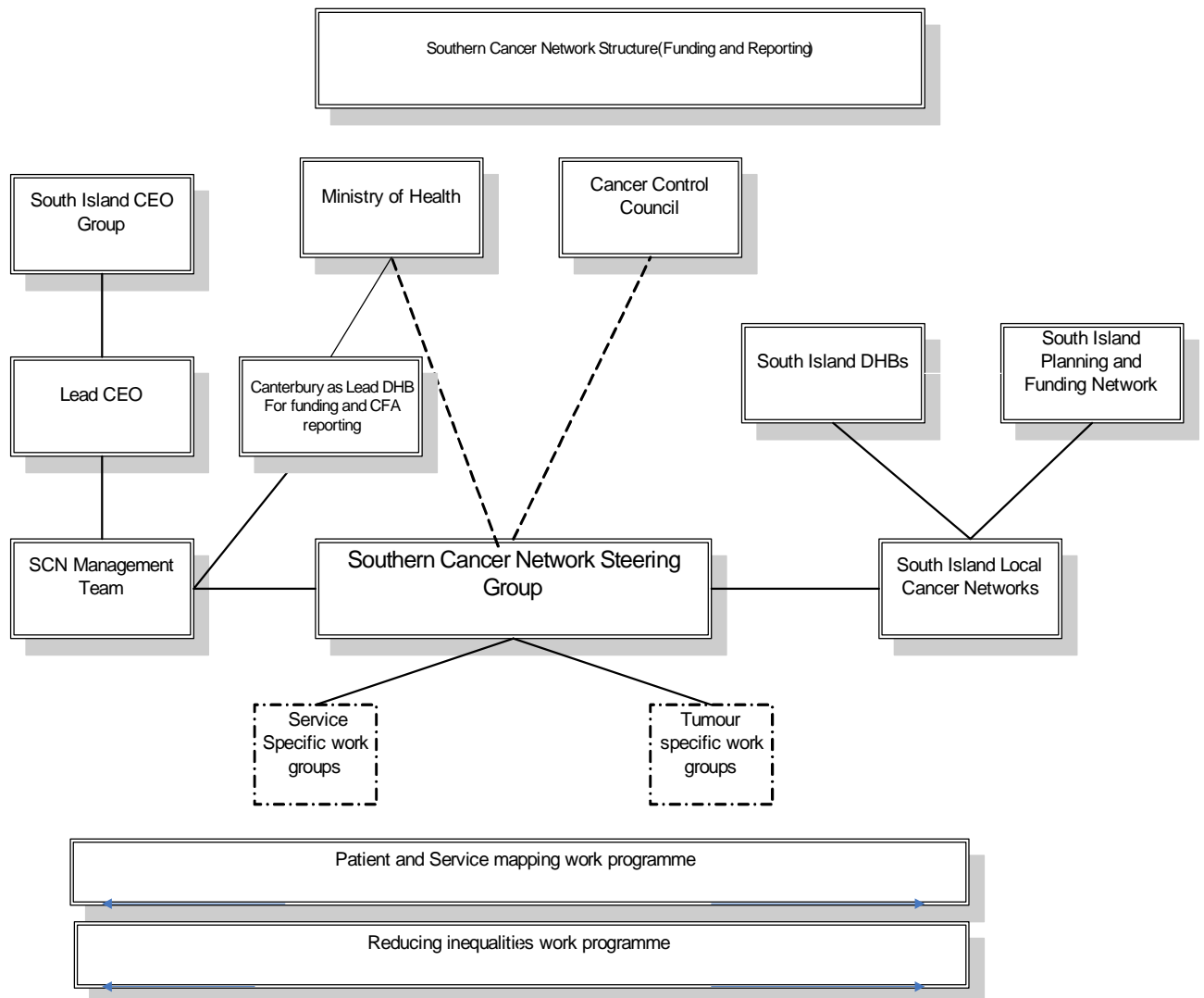


Central Cancer Network

Central Cancer Network (CCN) Structure (Aug 2009)



Southern Cancer Network



Appendix C – Crown funding agreement

Schedule A27: Regional Cancer Networks – Waikato DHB

1. Background

1.1 In 2006/07, four regional cancer networks (“Networks”) were established in New Zealand.

1.2 Networks have a leadership, facilitation and co-ordination role in implementing the Cancer Control Strategy, improving cancer outcomes and reducing inequalities. Networks work across organisational boundaries and promote a collaborative approach to service planning and delivery.

1.3 The structures, scopes and functions of Networks continue to evolve. There will continue to be regional differences due to variations in the configuration of cancer control service providers, and different regional priorities for cancer control activities.

1.4 Waikato District Health Board (“the DHB”), the lead DHB, receives the funding for the Midland regional cancer network (“the Midland Network”) infrastructure and operations on behalf of the populations of the designated DHBs (Waikato, Bay of Plenty and Lakes) and their cancer control stakeholders (including DHB funders and providers, Non Government Organisations (“NGOs”), Māori, professionals and consumers). The populations and cancer stakeholders of Taranaki and Tairāwhiti DHBs also have an interest in the Midland Network.

1.5 The Ministry of Health (“the Ministry”) intends to provide funding to support Networks for a further three years. As well as renewing the \$250,000 per Network for core Network infrastructure and operations, the Ministry will make available an additional:

- \$250,000 per Network per annum (pro rata from 1 January 2008) for Network operations to investigate and address systemic causes of cancer inequalities; and
- \$50,000 per Network per annum (pro rata from 1 January 2008) for the Networks to collaboratively obtain cancer data analysis capacity to support their operations

2. Service Description

2.1 The DHB must, as lead DHB, during the term of this Schedule A27, provide the following services (“the Services”):

2.1.1 Fund the Midland Network to:

- (i) Maintain the Midland Network’s core infrastructure and operations, in accordance with clause 4.1.1 to 4.1.4 of this Schedule;
- (ii) Investigate and address systemic causes of cancer inequalities, especially for Māori, but also for Pacific, rural, lower socio-economic, other minor ethnicity, or other groups with poor cancer outcomes, in accordance with clause 4.1.5 to 4.1.7 of this Schedule; and

- (iii) Obtain cancer data analysis capacity to support the Midland Network's operations, in collaboration with the other Networks, in accordance with clause 4.1.8 of this Schedule.
- (iv) Submit to the Ministry and regional stakeholders, for their approval, a final Regional Strategic Cancer Control Plan, based on the draft Regional Strategic Plan described in Schedule AO of the (Eighth) May 2007 Omnibus Variation to the 2004/05 CFA.

2.1.2 Report to the Ministry, in accordance with clause 6.1 of this Schedule.

3. Term

3.1 This Schedule A27 commences on the date when this Schedule is duly executed by the Parties and, unless terminated earlier in accordance with the Principal Agreement, will expire on 30 June 2011.

4. Service Requirements

4.1 In performing the Services, the DHB must ensure the Midland Network:

Maintains the Midland Network's core infrastructure and operations:

4.1.1 Brings together all constituent organisations, professionals and interest groups involved with cancer, and provides a formal governance structure that:

- (i) Involves patients, their families/whanau, and the public;
- (ii) Ensures input of all DHB and NGO cancer service providers across the region, including Primary Health Organisations ("PHOs");
- (iii) Includes identified Māori leadership and a framework to support participation of Māori;
- (iv) Links to DHB funding and planning;
- (v) Links to national groups, in particular the New Zealand Cancer Treatment Working Party, the joint Ministry/DHB steering group and the other Networks; and
- (vii) Is accountable to constituent DHBs.

4.1.2 Maintains an effective management team with strong clinical and managerial leadership, which:

- (i) Develops region-wide, tumour-specific and service improvement multidisciplinary groups and workstreams, not constrained by organizational or professional boundaries;
- (ii) Develops patient pathways, promoting a focus on the patient journey and improving the experience of care;
- (iii) Provides specific cancer control expertise to support service planning, promoting the efficient and effective use of finite resources to improve cancer outcomes and reduce inequalities;

- (iv) Identifies existing gaps in cancer services, including workforce gaps, and supports providers to reduce duplication in the delivery of cancer services;
- (v) Identifies barriers to performance across provider organisations;
- (vi) Supports a range of quality improvement initiatives across the continuum and promotes the use of quality improvement tools such as clinical guidelines, protocols, patient information process mapping, and capacity or demand analysis;
- (vii) Promotes and facilitates information dissemination and knowledge sharing; and
- (viii) Supports clinical research, audit and outcomes reporting.

4.1.3 Undertakes, sponsors, or facilitates work programmes to improve the multidisciplinary management of specific tumours, the improvement of cancer services, and the development of the cancer workforce.

4.1.4 In collaboration with the Ministry and the other Networks, leads an annual national cancer control forum to report back and share knowledge and learning's with the wider cancer community.

Investigates and addresses systemic causes of cancer inequalities:

4.1.5 Includes resources in the Network management team with a specific focus on inequalities.

4.1.6 Raises awareness of inequalities among cancer service providers and other cancer stakeholders.

4.1.7 Works to better identify the causes of cancer inequalities and address those inequalities, by:

- (i) Promoting the consistent collection of ethnicity data by providers and the inclusion of ethnicity data in routine data reporting;
- (ii) Undertaking, sponsoring or facilitating appreciative enquiry to better understand the inequalities in access apparent through data;
- (iii) Sponsoring or facilitating innovative pilot or demonstration projects to reduce inequalities in service access and/or improve service effectiveness and acceptability for different populations groups. The network may allocate funding to small-scale, one-off projects or initiatives, but is not expected to sustainably support service delivery;
- (iv) Ensuring that information on successful initiatives is widely disseminated and that other providers or stakeholders have the opportunity to learn and benefit from these successful initiatives;
- (v) Promoting system-level changes that can reduce access barriers for population groups, including changes that may be required beyond dedicated cancer services;
- (vi) Providing advice to funders and planners of both DHB and non-DHB services on strategies for reducing inequalities and the highest priorities from an inequalities perspective; and

- (vii) Consulting with and ensuring the participation of Māori and other population groups in service delivery planning as well as at governance levels.

Obtains cancer data analysis capacity to support the Midland Network's operations

4.1.8 Collaborates with other Networks to provide, contract for, or otherwise obtain, data analysis capacity that interrogates existing sources of clinical, service delivery, epidemiological, demographic, workforce, and financial data, thereby allowing the Midland Network to:

- (i) Improve understanding of the local and regional cancer burden and inequalities, including at an individual DHB level;
- (ii) Provide evidence-based advice to funders and planners on prioritisation;
- (iii) Target priority areas for service improvement; and
- (iv) Establish baselines for performance indicators and outcome measures.

5. Funding

5.1 The Ministry will pay the DHB one million, eight hundred thousand dollars (\$1,800,000) (excluding GST) to provide the Services under this Schedule A25 ("Funding"). The Funding will be paid as follows:

1.1.1 In respect of those Services described in clause 2.1.1(ii) and (iii) of this Schedule, one hundred and fifty thousand dollars (\$150,000) (excluding GST) in 2007/08;

1.1.2 In respect of the Services described in clauses 2.1.1 and 2.1.2 of this Schedule:

- (i) Five hundred and fifty thousand dollars (\$550,000) (excluding GST), in 2008/09;
- (ii) Five hundred and fifty thousand dollars (\$550,000) (excluding GST) in 2009/10; and
- (iii) Five hundred fifty thousand dollars (\$550,000) (excluding GST) in 2010/11.

5.2 The DHB agrees that it will only use the Funding for the purposes of performing the Services.

5.3 Where a valid invoice is received 10 working days prior to the payment date, payment will be made according to the table set out below. If an invoice is not received 10 working days prior to the payment date, payment will be made 12 working days after receipt of the invoice. Invoices must be addressed to the National Finance Manager, Sector Capability and Innovation Directorate, of the Ministry.

Date of Receipt of Invoice by Ministry	Date payment will be made	Amount Payable
6 June 2008	20 June 2008	\$150,000
6 December 2008	20 January 2009	\$275,000
6 June 2009	20 June 2009	\$275,000
6 December 2009	20 January 2010	\$275,000
6 June 2010	20 June 2010	\$275,000
6 December 2010	20 January 2011	\$275,000
6 June 2011	20 June 2011	\$275,000

5.4 Notwithstanding this Schedule, in accordance with section 10 of the Public Finance Act 1989 (and any subsequent amendment to it which is of the same effect), both Parties acknowledge that future agreements and payments to the DHB for Services of the type covered by this Schedule beyond the 2008/09 financial year is contingent upon the appropriation of adequate levels of funding under an Act of Parliament for that financial year.

6. Reporting

6.1 In addition to the reports required under the Principal Agreement, the DHB, will provide the following written report(s) to the Ministry:

Report Contents	Date Report Due
Report on progress to stakeholders within the Midland Network.	Quarterly from 20 July 2008
Report on progress to the Ministry.	Six-monthly from 20 July 2008
Report on progress and prioritised annual work programme to the Ministry and stakeholders within the Midland Network.	Annually from 20 July 2008
Regional Strategic Cancer Control Plan developed and endorsed by regional stakeholders and the Ministry.	30 June 2009
Quantitative and qualitative indicators that measure progress in reducing the impact and incidence of cancer and reducing cancer inequalities, as agreed with the Ministry and regional cancer stakeholders, and set out in annual and strategic plans.	Dates to be determined in discussion with the Ministry. High-level framework for indicators to be included in the Regional Strategic Plan.

7. Variation

7.1 Any proposed variation in the Services to be provided by the DHB under this Schedule A27 must be discussed and agreed in writing by the Ministry and the DHB

Appendix D – Objectives and principles of each network

Northern	Midland	Central	Southern
<p>The Network's vision is to improve cancer control through increased regional collaboration. The goals of the Network are adopted from those in the New Zealand Cancer Control Strategy:</p> <ul style="list-style-type: none"> ▪ To reduce the incidence and impact of cancer in the Northern region; and ▪ To reduce inequalities with respect to cancer in the Northern region. <p>To achieve the vision and goals outlined above, the Network's objectives are to support the local delivery of effective, efficient and equitable cancer control services by:</p> <ul style="list-style-type: none"> ▪ Facilitating Cancer Control Strategy and Action Plan planning and implementation ▪ Facilitating regional collaboration to improve patient experiences and outcomes ▪ Supporting quality improvement initiatives designed to achieve the vision ▪ Supporting regional integration across traditional silos 	<p>The network's vision is improved cancer control through increased regional collaboration not constrained by organisational, service or professional boundaries.</p> <p>The network has a leadership, facilitation and coordination role in bringing together and working with stakeholders to:</p> <ul style="list-style-type: none"> • Reduce the incidence and impact of cancer • Reduce inequalities with respect to cancer; and • Improve the experience and outcomes for people with cancer and their family / whānau through the complex pathway of care. 	<p><i>Vision</i></p> <p>The Network's vision is improved cancer prevention and control through increased regional collaboration not constrained by organisational, service or professional boundaries.</p> <p><i>Purpose</i></p> <p>The purpose of the Network is to take a proactive leadership, facilitation, collaborative and coordinated approach across organisational and service boundaries to ensure all providers of cancer prevention and care in the network area work together with the community to:</p> <ul style="list-style-type: none"> ▪ Manage the implementation of the Strategy and Action Plan to: <ul style="list-style-type: none"> ○ reduce the incidence and impact of cancer ○ reduce the inequalities with respect to cancer ▪ Improve the journey of cancer patients and their family/whānau through the complex pathway of care, ensuring equitable, high quality, patient centred, evidence based and multidisciplinary care. 	<p>The SCN, by providing a framework to improve collaboration and co-ordination across cancer control groups and services, is expected to achieve the following key objectives as set out in the CFA:</p> <ul style="list-style-type: none"> ▪ The efficient and effective use of finite resources within and across DHB populations ▪ Reduction in disparities of outcomes and improvement in equity of access ▪ Closing of existing gaps in services and reduction of duplication ▪ Greater co-ordination of service planning and delivery ▪ Promotion of a focus on patient access to, and experience of care ▪ Reduction of barriers to co-ordinated service provision to ensure seamless care across providers ▪ Accountability for performance across provider organisations ▪ Provision of expertise to support planning and development of services ▪ Facilitation of clinical audit and outcomes reporting ▪ Implementation of multidisciplinary teams and clinical guidelines.

Principles for each Network

Northern	Midland	Central	Southern
<ul style="list-style-type: none"> ▪ Support regional integration across traditional silos ▪ Ensure continuum and district wide representation ▪ Ensure open communication and transparency in decision making ▪ Ensure mutual respect, partnership and collaboration ▪ Advocate, and practise, a strong clinician/management partnership in decision making ▪ Reduce duplication within the provision services across the region ▪ Equitable access for the same level of clinical need across the region ▪ Key foci to include: <ul style="list-style-type: none"> ○ quality of care ○ inequalities ○ patient-centred. 	<p>Core principles to guide the network's structure and function include:</p> <ul style="list-style-type: none"> • A person centred approach • Ensuring timely and equitable access to cancer control services • Recognising and respecting cultural diversity • Promoting a seamless patient pathway across the cancer control continuum • Services being of high quality • Being effective and evidenced based • Being sustainable • Ensuring a multidisciplinary team approach • Ensuring a continuous quality improvement approach • Taking a partnership approach with stakeholders, actively engaging health professionals, Māori, Pacific peoples, non-government organisations, consumers, carers and communities • Undertaking service improvement within the context of a planned, co-ordinated, collaborative and integrated approach. 	<p>Have followed principles outlined in the Cancer Control Strategy</p>	<p>Core principles underlie the structure and function of all the cancer networks. These are to:</p> <ul style="list-style-type: none"> ▪ Provide a focus on improving the pathway of care for cancer patients, families and whanau by improving quality, access to and appropriateness of care ▪ Have an organised structure that provides management and leadership to support co-ordination of activities and actions by groups and organisations within the network ▪ Be accountable to their constituent DHBs through regular reporting including performance against agreed output and outcomes measures ▪ Provide collaborative advice to support the existing decision making and accountability framework of DHBs ▪ Provide a framework to support the input and engagement of Māori, Pacific Islanders, other ethnicities, NGOs and consumers ▪ Be multidisciplinary across all providers in cancer care and provide a framework that supports both tumour and generic service multidisciplinary teams ▪ Be evidence based in the approach to advice and work programmes ▪ Provide the focus for implementation of quality assurance programmes, guidelines and protocols ▪ Enable increasing total system efficiency within available resources to the cancer sector ▪ Provide a transparent framework for the lines of advice, decision making and accountability to the DHBs.

Appendix E – Formal regional network groups

Table 36 – Summary of formal regional cancer network groups

	Northern	Midland	Central	Southern
Regional stakeholder collaborative group	Northern Cancer Collaborative since Feb 2008	Midland Cancer Network Executive group since 2006 ⁸¹ Links to Midland DHBs Collaborative Principles and forums since 2007	Central Cancer Network Governance group since May 2007	Southern Cancer Network Steering group since April 2009
Consumer	Consumer reference group since Nov 2008	MCN consumer / carer reference group since Sept 2009	Consumer reference group since July 2009	Consumer reference group to be developed 2010-2011
Māori	Māori leadership group since Oct 2008	Links with existing Midland collaborative Māori forum group through GM Māori Health, Waikato since 2007	Māori leadership group in process of being formed (regional hui held in March 2010)	Māori leadership group in process of being formed
NGO	NGO Forum	⁸²		
Palliative care	⁸³	Midland Palliative Care Work Group since Dec 2007	Regional palliative care network (CCN support since 2007)	Regional Palliative care network to be established in 2010
Local cancer networks	Northland Counties Manukau Waitemata reconvened June 2010. Are facilitated locally and were established prior to the Network	Lakes Cancer and Palliative Care Forum jointly formulated between Lakes and regional network, since April 2010 Prior Lakes Cancer Control Stakeholder workshop; Lakes Clinical Advisory Group – EOL and Lakes Palliative Care Service Provider group since 2008 BOP Technical Advisory Group – Cancer Control since Oct 2007	Taranaki Tairāwhiti Hawkes Bay MidCentral Wanganui Wairarapa Hutt Valley / Capital and Coast Formation facilitated by regional network All formed between Feb 2008 and June 2009	Nelson Marlborough Canterbury South Canterbury West Coast Otago Southland ⁸⁴ Formation facilitated by regional network with the exception of West Coast who had formed their own grouping. All formed by Feb 2009

⁸¹ Developed from Midland Non-surgical treatment services network

⁸² NGOs are represented on relevant work groups – at their request no regional NGO forum was established

⁸³ Palliative care networks in place but not formalised as part of RCN structure

⁸⁴ Although still called Otago Southland this LCN covers the new Southern DHB region

	Northern	Midland	Central	Southern
Other local networks		Waikato Palliative Care Network facilitated by regional cancer network since 2006 ⁸⁵	Local palliative care networks	Canterbury palliative care network since May 2009 2009 Southland Palliative Care since June 2010.
Tumour stream work groups	Lung since Feb 2008 Colorectal since May 2009	Breast since Nov 2008 Lung since July 2009 Colorectal since Oct 2009 Urogenital (being formed)	Lung since Nov 2007 Head and neck since Aug 2008 Colorectal since Jun 2009	South Island Lung Cancer Working Group since Dec 2009 Colorectal Upper and Lower South Island Advisory Groups since Sept 2009 SI Colorectal Cancer Working Group since August 2010
Project / service groups	Regional Oncology Operations Group since 2006 - commenced prior to the Network Regional cancer care co-ordinators forum since Oct 2008 Travel and accommodation needs analysis project group from 2008 to 2010 Key Performance Indicators development group since 2009 Maori community support access project group since Sept 2009	Midland care co-ordinators / CNS work group since Aug 2007 Midland non-surgical cancer treatment services work group established prior to 2006 AYACS work group since March 2008 Research and audit work group since Nov 2009. Professor, School of Medicine chairs Supportive Care work group since Dec 2009 Midland palliative care nurses education work group since 2008 Midland palliative care LCP facilitators work group since 2008	Cancer managers group since 2007 Regional care co-ordinators forum since Aug 2008 Multidisciplinary framework steering group since Mar 2009 Medical imaging guidelines advisory group since Apr 2008 Cancer Control Indicators Report advisory Group since Jan 2010 Cancer Centre Collaboration work groups from Jan 2010 Regional oncology social workers forum since 2008 (CCN support since Apr 2010)	South Island Oncology Research group since Oct 2008 SI Cancer Nurse Network since March 2009 South Island AYA Advisory group since April 2010 South Island Clinical Cancer Information System Advisory Group since July 2010 South Island PET Variance Committee since July 2010

⁸⁵ Note funding for the facilitation of this group comes from sources additional to the regional cancer network funding and is not included in the budgets outlined earlier in this report.

Appendix F – Network Activities – including don't knows

Figure 26 – Impact of activities for Northern Cancer Network

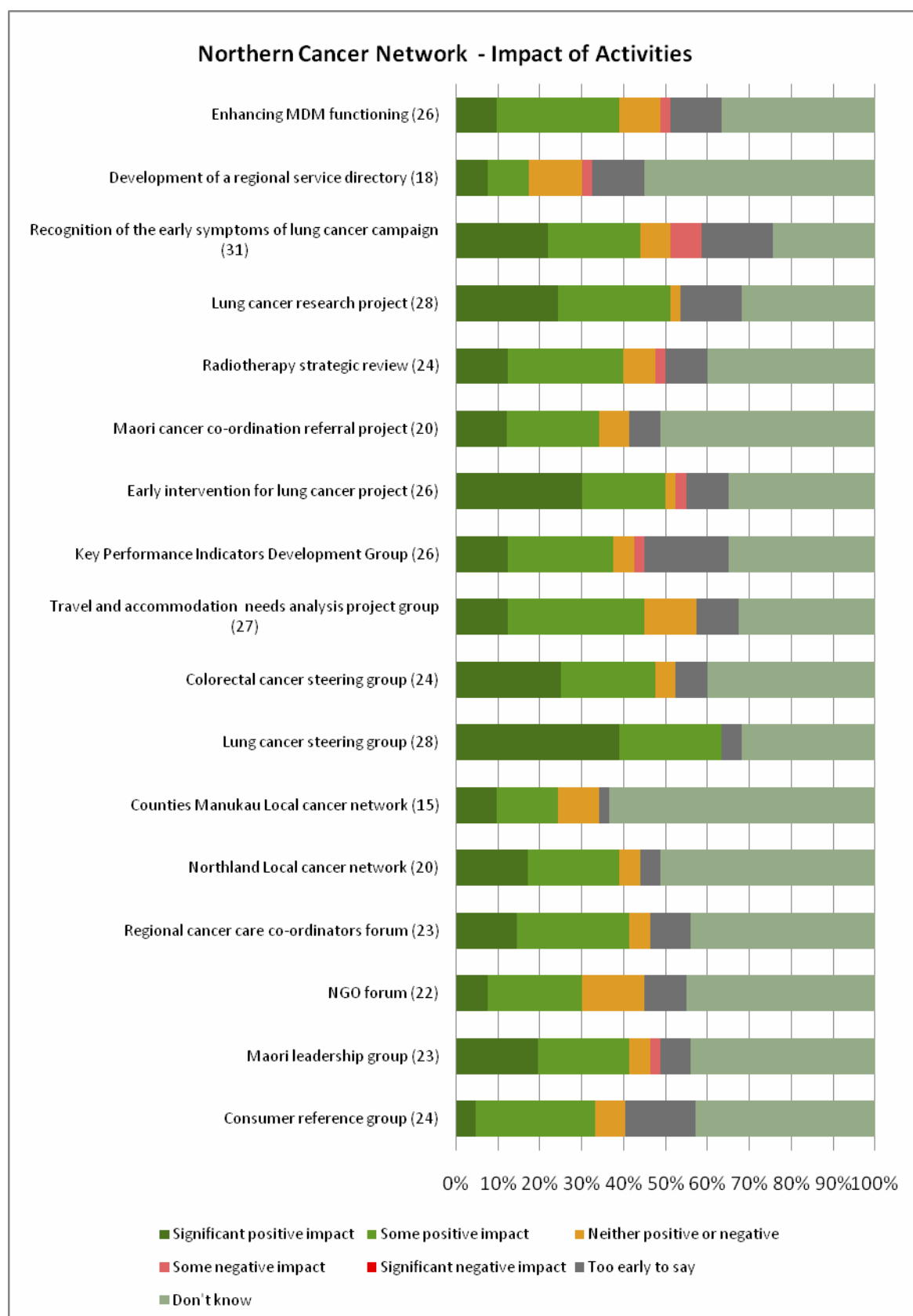


Figure 27 – Impact of activities for Midland Cancer Network

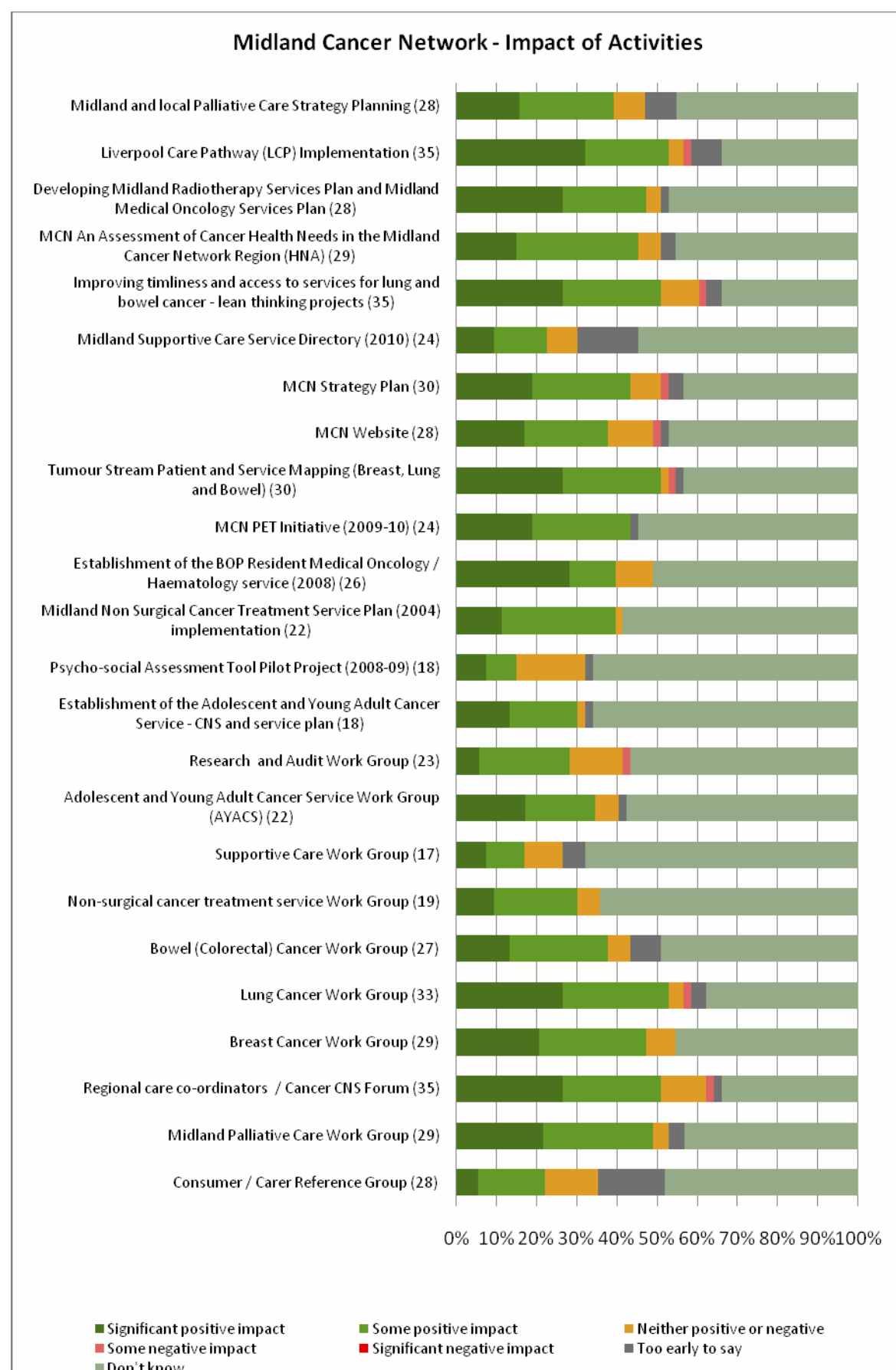


Figure 28 – Impact of activities for Central Cancer Network

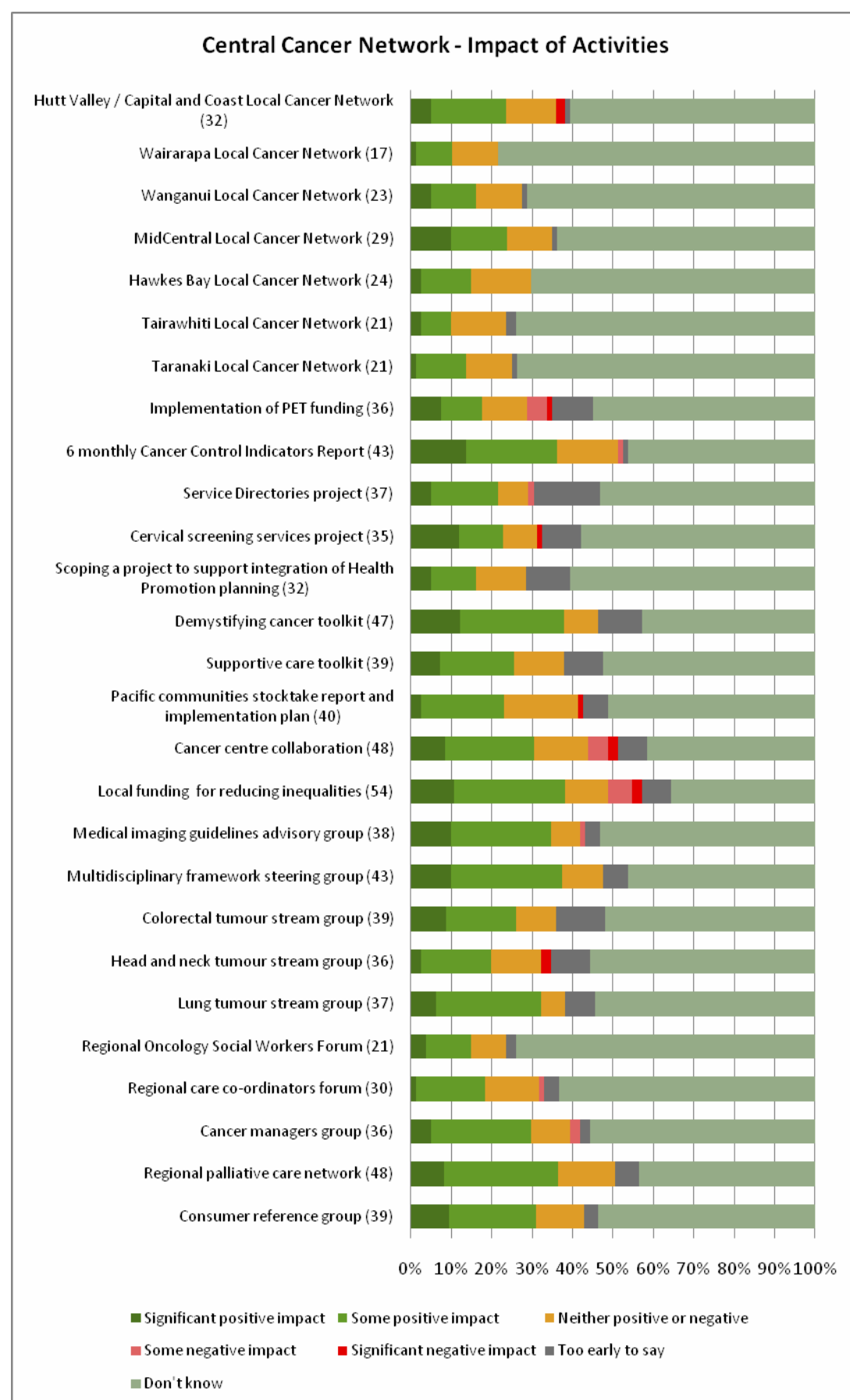


Figure 29 – Impact of activities for Southern Cancer Network

