An approach to building the local case for MDCs

The following article may be of interest to local commissioners and policy makers interested in implementing MDC-based pathways in their areas.

Context:

Interest continues to grow in the development of Multidisciplinary Diagnostic Centres (MDC) as an approach to improving outcomes for patients presenting with non-specific but concerning symptoms. In line with Recommendation 21 of Achieving World Class Cancer Outcomes, the ACE Programme has been trialling and evaluating MDC-based pathways to improve the knowledge base on this subject.

With the ACE MDCs now in their second operational year, interim findings on MDCs were published in May 2018. As anticipated, final conclusions will be released from winter 18/19 through a series of research papers, prior to the evaluation’s completion in March 2019.

In addition to the five established ACE MDC projects, many Cancer Alliances across England are developing plans to implement similar approaches within their local areas, often with investment via national cancer transformation funding.

The Challenge:

Interim programme conclusions have been very positive, and clinical consensus within ACE projects points to the MDC as a useful rapid diagnostic pathway for complex patients with non-specific symptoms that do not meet current thresholds for urgent referral. Interestingly, the value of the MDC is seen as being wider than cancer alone, with the pathway supporting patients through to diagnostic resolution for cancer and non-cancer disease in a fast and planned way. Importantly though, the evidence-base for this work is still being developed and gaps in our knowledge remain.

The challenge faced by local planners and commissioners is how to accurately plan and implement a MDC pathway before the MDC’s value and potential has been determined, whilst still meeting time-limited funding requirements.

Ongoing National Cancer Diagnosis Audit (NCDA) analysis has improved evidence on the disparity in the diagnostic pathway between patients with non-specific symptoms and those with ‘alarm’ symptoms of a particular cancer. Using the MDC referral criteria to allocate patients to either ‘vague’ or ‘alarm’ groups, comparisons showed those presenting with non-specific symptoms:

- had higher proportions of patients having 3+ consultations with their GP before referral (21% vs. 32% ‘vague’)
- experienced longer times from presentation to diagnosis (median: 38 days vs. 47 days ‘vague’)
- had higher proportions of patients diagnosed via emergency presentation (16% vs. 34% ‘vague’)
- had higher proportions of patients diagnosed at a late stage (stage 4; 21% vs. 32% ‘vague’)

As a result, the case for change has been improved and the rationale behind the MDC is now stronger. However, as this is a new pathway, operational findings to date from the five MDC projects have been based on comparatively low numbers. It’s therefore important to allow a chance to review and revise initial conclusions at a point when a larger evidence base is available to support programme analyses.

**Setting out an approach:**

Information is available at project and programme level to support decision making on planning MDC-based pathways. Further analyses and evaluation data will also be released at the end of the programme, which could provide local areas with a chance to sense-check their arrangements and to guide final decisions on pathway configuration.

Under these circumstances, a pragmatic approach to MDC planning may be the best way forward, with currently available information being used to determine an overall trajectory for pathway development. Such an approach would effectively be similar to an options appraisal, whereby local areas could identify their strategic objectives and need, before building a picture of the available choices:

**Outcomes for patients with non specific symptoms vs ‘alarm’ symptoms**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Non specific symptoms</th>
<th>Alarm’ symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients diagnosed at a late stage (stage 4)</td>
<td>21%</td>
<td>32%</td>
</tr>
<tr>
<td>Patients diagnosed via emergency presentation</td>
<td>16%</td>
<td>34%</td>
</tr>
<tr>
<td>Patients had 3 or more GP consultations before referral’</td>
<td>21%</td>
<td>32%</td>
</tr>
<tr>
<td>Median number of days from presentation to diagnosis</td>
<td>38</td>
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*The ACE Programme: National Cancer Diagnosis Audit Analysis (September 2018)*
To support the above process, it will be helpful to consider the following key questions:

Q: What objectives are being addressed by implementing a MDC-based pathway?

What local, regional and/or national objectives is the MDC intended to contribute to and are these objectives achievable and realistic within the project timescales? Planning footprints may map across to CCG, STP and/or Cancer Alliance areas and it will be helpful to consider proposals in this context.

ACE clinicians see the MDC as a general rapid diagnostic pathway for complex patients with non-specific symptoms, with benefit to both cancer and non-cancer diagnoses. However, given that our understanding of MDC value and impact is still formative, it’s important to think about what the MDC is committing to deliver, and what would happen if this wasn’t achieved within the project’s lifetime.
Q: What need is the MDC primarily addressing and how broad should the pathway be?

Although each of the ACE MDC projects have been set up to reflect local arrangements, they all share a core set of referral criteria covering a range of non-specific symptoms. **It will be necessary to consider the referral criteria to be applied to individual MDCs to effectively address local need and agreed objectives.** Work planned at a national level by NHS England’s cancer team to develop a position statement and guidelines for non-specific symptoms may also be informative to local decision making.

Local population demographics, and decisions regarding eligibility for referral and referral routes, will impact on pathway volumes; whilst smaller numbers may be more manageable, they may also undermine the sustainability of the MDC pathway. **Discussions about referral eligibility, pathway scope, catchment range, and the consequent impact on capacity and demand are essential.** Current MDC projects demonstrate the potential flexibility relating to these pathway elements:

- Referral criteria for most of the ACE projects are based on a core set of symptoms, but with a few additional criteria as determined locally. Most do not include an age restriction but it may be possible to set a minimum age threshold for the majority of referrals
- Some projects have limited referral to participating GP practices, whereas Leeds, London and Airedale have extended referral to also include areas of acute medicine / A&E
- As projects continue to develop their local business cases, some are considering the use of MDC approaches in other referral pathways to utilise available diagnostic capacity and to maximise available resources.

Developing a sense of scale will be vital in estimating pathway activity. Work is currently underway to develop a supporting methodology, but available data from the MDC projects may also be helpful in the meantime.

Q: What type of approach would be most appropriate locally?

This will largely be driven by local strategic objectives, healthcare infrastructure and arrangements regarding diagnostic capacity and staffing, particularly regarding topics like the use of diagnostic imaging, the sequencing and speed of tests and reporting, and local accessibility to specialist diagnostic and treatment facilities.

The MDC design principles outline the varying approaches being trialled within ACE and will act as a description of the potential available options and systems flexibility. Importantly, all five MDC projects are in agreement on the core characteristics of the MDC, which are present and highly valued in all sites, irrespective of their local approach. A summary of these is available [here](#) and further detailed qualitative analysis on MDC arrangements will be available in autumn ‘18.

Again, planned work by NHS England’s national cancer team to identify the core requirements of a MDC-based pathway will help to inform local development and ensure that proposals are consistent with any identified elements.
Q: What information is available to support MDC planning and how can it be used effectively?

At present, the following information is available through the ACE Programme to support MDC planning and to provide evidence to inform the development of local options:

- MDC interim report – May 2018
- Clinical perspectives on MDCs – challenges & benefits
- What is the MDC?
- MDC design principles
- Early project learning leaflet
- MDC core data items & metrics list
- MDC patient experience survey report
- MDC catchment area & referral data
- MDC interim report – May 2018
- MDC design principles
- MDC core data items & metrics list
- MDC catchment area & referral data

Further information and resource materials are planned for the coming months, including qualitative and quantitative analyses on key clinical areas of the MDC pathway, and information on associated pathway costs and benefits.

Q: What is the preferred option (cost and benefit)?

By using the above information to develop a preferred option, commissioners and policy makers may be able to decide if the current proposal offers an improvement on current local arrangements and whether implementation risk is acceptable. This could be considered in a variety of ways; for example:

- Would the introduction of a planned referral route for patients presenting with non-specific symptoms have any positive impact on use of emergency routes to diagnosis and the additional costs associated with unplanned care?
- Would a more rapid pathway for non-specific symptoms positively affect the volume of primary care consultations, or performance relating to cancer waiting time standards?
- Would the implementation of a MDC pathway improve patient experience of care and associated clinical outcomes for this patient cohort?
- Would judgements on sustainability and cost/benefit be affected by extending the MDC approach to other associated pathways?

By assessing the potential impact of specific aspects of the MDC pathway, it may be possible to develop a composite view on local proposals, and whether they represent an improvement on current arrangements.

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