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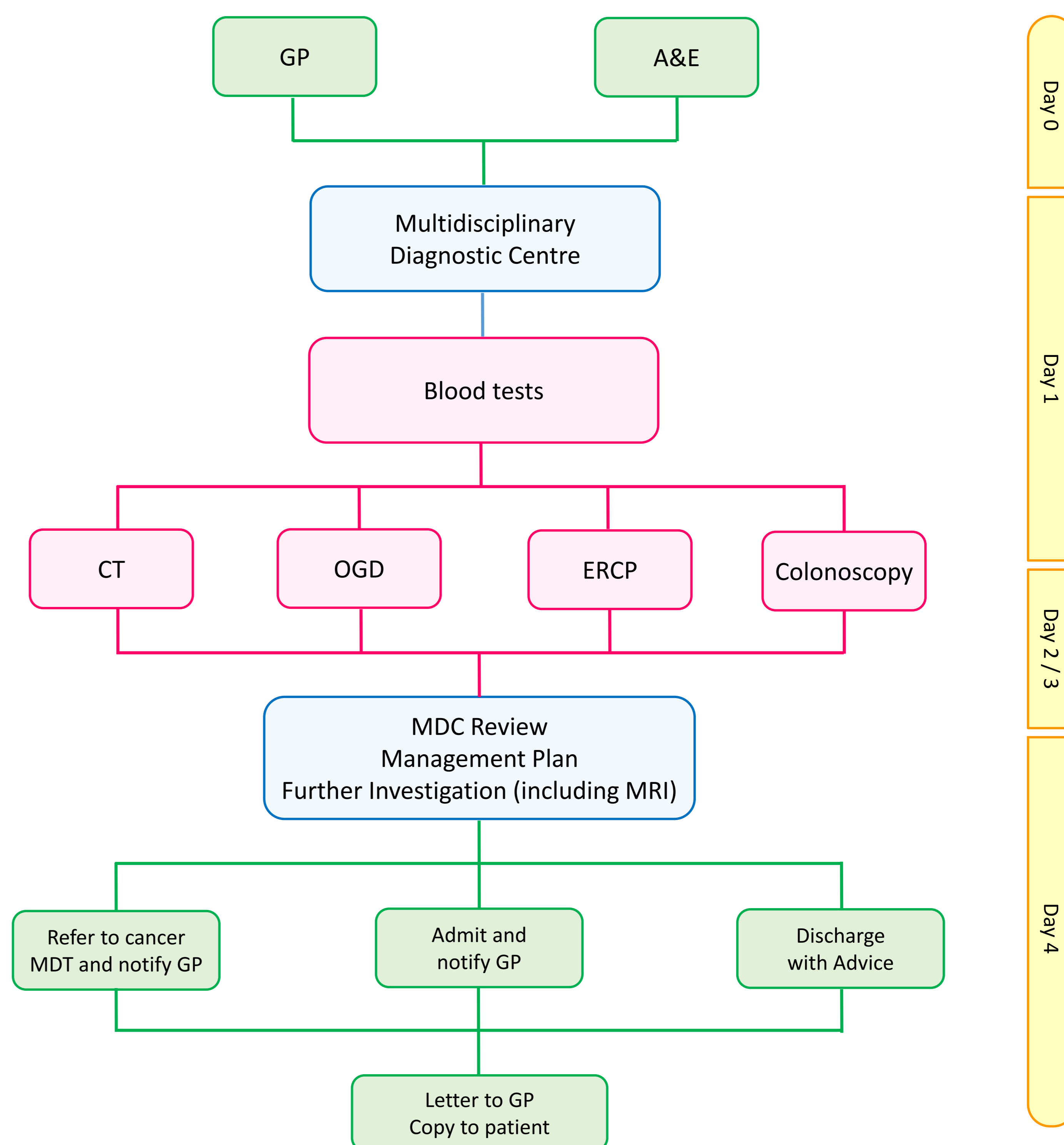
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## Background

Late diagnosis underlies some of the lower cancer survival in UK compared to Europe. Only a small proportion of abdominal complaints presenting in primary care would subsequently be diagnosed as cancer. Within *London Cancer* in 2012 a high proportion of cancers were advanced at diagnosis (Stage 4) – 74% of pancreas, 57% of hepatobiliary and gall bladder, and 35% of oesophagus and stomach. To compound the problem, patients with abdominal cancer are often diagnosed after attending Emergency Departments, where the patient pathway is fragmented, resulting in poorer patient experience and outcomes.

## Method

Building on our engagements with patients, clinicians and charities, two pilot Multidisciplinary Diagnostic Centres (MDCs) have been developed to enable rapid specialist assessment with appropriate diagnostic tests and a management plan within four days. The MDCs will be available for: (a) patients with severe but non-specific worrying symptoms, warranting rapid diagnosis but not qualifying for a '2 Week Wait' (2WW) referral; (b) patients with severe symptoms who may meet 2WW criteria and for whom urgent assessment at hospital currently offers the only clinically appropriate route to timely care. The Model of Improvement is used as the framework to evaluate whether our intervention will deliver better value for our patients and population, allowing rapid diagnosis in an ambulatory setting.



### Multidisciplinary Diagnostic Centre is designed for the following patients:

- should have a serious possibility of cancer
- those who would fit the 2WW criteria but do not need admission, and are too unwell to wait for 2WW
- those who do not fit easily in a 2WW pathway in whom other explanation for their symptoms have been excluded or are very unlikely

## Evaluation

Measurement is integral to the pilot for internal process control and tracking outcome of our intervention. Twenty metrics have been identified. Patient involvement has facilitated the focus on outcomes that matter most to our patients. These outcome measurements align with the national evaluation of the ACE Programme.

### Service Improvement Measures

- Number of times attending general practitioner with symptoms
- Length of time between attending their general practitioner on the first occasion and the first referral to hospital
- Period of time between being first seen by a specialist and a diagnosis being made
- Percentage of patients receiving definitive diagnosis
- Stage of malignancy at diagnosis
- Patient satisfaction score on information provided by MDC

### Health Economic Measures

- Number of inpatient bed days prior to diagnosis at MDT
- Number of (any) A&E attendance prior to diagnosis at MDT
- Number of general practitioner attendance prior to diagnosis at MDT
- Number of investigations per patient
- Cost of investigations per patient

### Balancing Measures

- Number of inpatient admissions from MDC
- Number of cases discussed at MDT
- Number of patients waited longer than 6 weeks for
  - endoscopy – gastroscopy, colonoscopy and flexible sigmoidoscopy
  - Radiology – CT, MRI, non-obstetric ultrasound, barium enema

## Conclusion

Demonstration of positive change in outcomes for our patients and population is essential for the new diagnostic pathway. Prospective data relevant to healthcare teams and patients enable them to take ownership of the change process, encourage cross fertilisation and ultimately wider adoption and diffusion of innovation.

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