

Summary of the implementation of the ACE Programme, Qualitative Evaluation

Wave 2, 2017-18

This document outlines the key findings from the qualitative evaluation carried out by the Policy Research Unit for Cancer Awareness, Screening and Early Diagnosis on behalf of the Accelerate, Co-ordinate, Evaluate (ACE) Programme.

Wave 2 of the Programme worked with 5 projects to test out innovative new ways of quickly investigating and diagnosing patients with non-specific symptoms through the development of Multidisciplinary Diagnostic Centres (MDC). 10 pilot MDC sites were established, 6 of which participated in this qualitative evaluation.



The ACE pilot sites developed MDC-based interventions that were designed to integrate within existing local infrastructures. Whilst each MDC had the overall aim of improving speed to cancer diagnosis, and ultimately survival, there were distinct differences in the mechanisms used to drive change in services, and in the contexts within which these mechanisms were implemented. All sites successfully implemented their chosen MDC model, with strong enabling support from the ACE programme. Sites stated that a transformational style of leadership, strong working relationships and stable project management were key to the smooth implementation of a MDC.



Approach

To evaluate the implementation of MDCs, a realistic evaluation method was used. This theory-driven approach explores the relationship between the outcomes (intended and unintended consequences), mechanisms and contexts of a programme by mapping out and then testing the 'programme theory'. A full description of the evaluation methods used are included within the [full report](#).

Sequential one to one interviews were used with clinicians, service/project managers, commissioners, nurses and other key informants in each project. Potential participants for interviews were identified by the local project lead. All pilot sites had an opportunity to comment on the accuracy of the completed case-studies.



Context – supporting implementation

Being **part of the ACE programme** brought a range of perceived benefits, including additional finance and credibility for the pilot within the host organisation as it was a **national initiative**. Involvement in the wider programme also provided an opportunity to collaborate and share with others.

- Organisations where **staff felt stable and secure** in their roles, and where **the value of the pilot was acknowledged**, appeared to be more effective at implementing change.
- **Significant experience of change management** and a **supportive organisational culture** were needed to successfully implement such a large scale transformational change. All of the ACE pilots stated that they had previously been involved in other related modernisation work. *“we were already seen as credible by the powers that be and as a result supported at an organisational level”*
- The relationship between **primary and secondary care** was described as the most important **relationship** by the majority of pilot sites



Mechanisms – for driving change

Ownership was cited as a key mechanism by the majority of pilots. Ownership involves key stakeholders feeling part of a project, buying in to the vision and taking responsibility for delivering their elements of the pilot. Lack of ownership was cited as a problem, *“I think the main challenges have been the fact that we didn’t have a suitable environment for this project and the fact that we didn’t have full consultant buy in”*

- **Project management** was crucial for all projects. Although none were able to articulate the use of a specific model, pilots with a systematic approach were more effective than those with a more ad hoc approach. Many of the pilot Project Managers were required to deliver on a range of initiatives, often with minimal or no additional support from their Trusts. In the future it would be useful for projects to consider in advance how they will reflect on progress and react to challenges.
- A **transformational** style of **leadership** was evident at most pilot sites. The most common characteristics described in the interviews were leaders communicating an ambitious vision, effective team working and continual learning and improvement
- The most successful pilots, in terms of those closest to being embedded within routine practice, **needed support at both a service delivery level and at a strategic, senior level**. Where sites were often unable to progress, this was due to other organisational pressures.
- All pilots experienced some pressure relating to **securing MDC clinician capacity**. Oxford and Airedale both unexpectedly lost clinicians on a temporary basis. Leeds experienced difficulty in recruiting the range of clinicians needed for the pathway.

- Many also expressed concern about whether they could meet demand for additional diagnostic capacity such as radiology or endoscopy. However, the evaluation found that **diagnostic capacity does not appear to have been under pressure** as a result of implementing the MDC pathway. Projects dealt with this shortage of capacity in different ways. Wythenshawe and Airedale, sought to create additional ad hoc capacity by slotting patients into other clinics. All sites are aware that expansion of the service could have a future effect on diagnostic services.
- All pilots identified the need to **communicate with clinical staff and other stakeholders** and most opted for a steering group to be the platform. Successful communication was based on all parties understanding the purpose of the pilot and their specific role within it.



Emerging roles

The Cancer Workforce Plan (2017) addresses the need for the NHS to ensure sufficient numbers of skilled staff to deliver high quality care. The King's Fund also asserts that improvements in the quality of care come from intentional actions by staff who have the skills to enable change. This was borne out in the experience of MDC pilots who identified **several new workforce requirements in relation to**: patient support, MDC pathway co-ordination, and effective clinical leadership.

- **Patient support.** Patients are supported from the point of referral through to diagnosis; this differs from existing suspected cancer referral routes, which generally see the allocation of a Clinical Nurse Specialist (CNS) from point of diagnosis. This continuity of care is provided by the MDC CNS role or, in Oxford, by the MDC Navigator role. In all instances, these roles are unique to the MDC pathway:
 - **CNS** – The MDC pathway environment is well suited to CNS' who operate at a higher competency level, and the role has the potential to take a significant amount of pressure off clinicians. Projects reported that adequate training was required to enable CNS' to successfully meet these requirements. However, it was also recognised that CNS' were not autonomous practitioners, but rather, worked alongside medical colleagues within robust governance arrangements.
 - **MDC Navigator (Oxford)** – The CNS role in Oxford is provided by pathway navigators with a clinical background (radiographer). The navigator is the first point of contact for patients within secondary care. They check that the patient is eligible for the ACE SCAN pathway, take bloods and book the patient in for their CT scan. The Navigator (radiographer) is also able to perform and report against the CT scan, and provides continuity of care throughout the pathway.
- **MDC pathway co-ordination.** All MDC projects included measures to support patient progress through the pathway. In some instances, this was addressed by the CNS and Navigator roles outlined above. In other projects, complementary roles were introduced to work alongside the CNS / Navigator to improve pathway co-ordination.

- In Greater Manchester, the navigator post is a non-clinical role supporting the CNS that **coordinated all elements of the pathway** to ensure a timely diagnosis. Because Greater Manchester’s approach is based on a “one stop” service, the navigators also physically take the patients to the department(s) where they are to undergo investigations and ensure that they are back at the clinic in order to be given their diagnosis.
- **Administrative support.** Four of the pilot sites also have dedicated administrative support, though the job titles and responsibilities vary. In Leeds this role is similar to that of the well-established cancer MDT coordinator, who has responsibility for the administration of the MDT meetings and tracking patients.
- All projects felt these roles were key to delivering a positive patient experience.
- **MDC lead clinician.** Clinicians delivering MDCs are also required to operate differently than they do for other site-specific cancer pathways. The skill set required to diagnose patients attending a MDC is more generic. In general, the more specialised the clinician is, the more concerned they were about missing something potentially serious, whether it be cancer or non-cancer. MDC lead clinicians will need to spend more time liaising with colleagues in order to achieve a diagnosis for the patient.



Sustainability

All MDC pilot sites reported a good patient experience and all sites wish to continue the pathway in some way moving forward. Generally, projects felt that the MDC offered a faster route to diagnosis for both cancer and non-cancer, and GPs in particular believed the MDC had provided a valuable alternative pathway for patients who do not fit established 2WW routes.

However, many of the pilots thought that MDCs would need to develop further to become fully sustainable, with attention required regarding the following areas:

- Further roll-out of MDCs will require comparable resourcing. Trusts need to plan in detail the resources required to ensure long-term viability. They also need to develop robust back up plans for addressing fundamental problems, such as ongoing staffing and/or capacity issues.
- MDCs require effective teams with a range of skills including; communication, change management, and service improvement and evaluation. If an MDC is solely dependent on one or two highly motivated individuals there is a high risk that innovations are not normalised and are likely to be sustained.
- It may be worthwhile mapping the core clinical competencies required to operate an MDC in order to decide what skillset a clinician should have in order to be most effective. Although there is scope to develop new roles to support the MDC, sufficient forethought must be given to the need of the role and who is best placed to deliver then. A new role may be underused or cause existing roles to become de-skilled. It could also cause care to become fragmented and may increase costs.



Recommendations for a successful implementation:

Any sites wishing to introduce an MDC or similar pathway should:

- Ensure organisational commitment and test receptiveness to change prior to commencing
- Ensure key stakeholders have sufficient time to deliver their responsibilities
- Invest time in developing a robust implementation strategy and maintaining inter/intra organisational relationships
- Creating plans to react to challenges as they emerge
- Think about the most appropriate and cost-effective skill set to deliver the initiative and to start building capacity and skills at the earliest opportunity