Acute Diagnostic Oncology Clinic

Establishing and measuring
the impact of ADOC

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Version 1-0

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Executive Summary

In England, 25% of all cancer patients are diagnosed with their disease as part of attendance at acute medical services such as the emergency department (ED), of these patients 60% will be admitted. Emergency presentation of cancers is associated with a significantly poorer survival rate and worse patient experience.

The purpose of this project was to establish and test the feasibility of:

- Providing a new rapid access out-patient clinic for patients with new suspected cancer.
- Providing General Practitioners (GPs) with an alternative to referring their patients to ED.
- Expediting the diagnosis or exclusion of cancer for patients, who are too ill to wait for a two week referral.

The Acute Diagnostic Oncology Clinic (ADOC) was set up and run as an outpatient clinic for a one year period at Chelsea & Westminster NHS Foundation Trust embedded within the Acute Oncology Service using established ambulatory clinic facilities and services. The Clinic was publicised to and accepted referrals from the 120 GP practices within the surrounding four Clinical Commissioning Groups.

ADOC has shown that the cancer pathway can be improved for patients by identifying a specific patient population, working innovatively, with similar resources but to tighter timeframes to provide:

- Better patient experience
- Faster access to the service
- Faster diagnosis and treatment
- Fewer patient admissions.

Results showed:

- 98% patients were reviewed within 24 hours of GP referral
- 7 day (mean) referral to diagnosis
- 48% of patients seen had a cancer diagnosis
- 16 days (mean) referral to treatment
- 73% of imaging investigations conducted at first appointment
- 67% results back the same day
- Reduced the need for in-patient admissions.

This report presents the findings from data collected for a one year period for clinic performance, patient and GP satisfaction.
1. Overview

The purpose of the project was to test the feasibility of providing a rapid access out-patient clinic for patients with new suspected cancer, who are too ill to wait for a two week referral.

We developed and established the procedures and resources to set up and run the outpatient clinic for a one year period at Chelsea & Westminster NHS Foundation Trust. This report presents the findings from data collected for a one year period for clinic performance, patient and GP satisfaction.

2. Context

In England, 25% of all cancer patients are diagnosed with their disease as part of attendance at acute medical services such as the emergency department (ED), of these patients 60% will be admitted. This route to diagnosis is associated with a significantly poorer survival rate and worse patient experience, as compared to patients diagnosed through elective ‘2-week-wait’ pathways. Furthermore, there is an additional burden on already overstretched acute medical services.1

In England, the NHS recommends that only those with serious emergency care needs should use emergency departments. Cancer should, ideally, be diagnosed after referral to a secondary care outpatient department from a general medical practitioner (GP) or the NHS Cancer Screening Programme. Growth in the number of people using emergency care is leading to mounting costs, increased pressure on resources, disruption to elective healthcare, and poor patient experience. Avoiding unnecessary emergency hospital attendances is therefore a major concern for the NHS.2

The Acute Diagnostic Oncology Clinic was set up in the light of a drive to reduce the emergency presentation of cancers and in response to the findings of an earlier study, Cancer Diagnosis in the Acute Setting (CADIAS), conducted at Chelsea & Westminster Hospital and five other London Foundation Trusts. This study suggested that in up to 50% of patients with an acute new diagnosis of cancer, GPs refer patients to the ED, and in addition patients also present to the ED whilst waiting for planned appointments or tests. Conversations with GP stakeholders confirmed that some GPs use ED as a rapid means of assessment for patients who need to be seen, or have diagnostic tests, sooner than the two week wait referral allows. In this respect ED is seen as a ‘safe’ pathway into secondary care.

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3. Aim and objectives

The aims of the project were to:

- Provide a rapid access clinic for the diagnosis of cancer, for patients who are too ill to wait for a two week referral or when the GP is unsure of the cancer site, and referral path
- Run the Acute Diagnostic Oncology Clinic for a one year period – where patients can be seen within 24 hours of GP referral
- Collect data of clinic performance to assess benefits, clinic feasibility, and patient and GP satisfaction.

The objectives of the project were to:

- Specify clinic resources, booking procedures, referral criteria, pathways and protocols
- Publicise and provide the service to GPs from four local Clinical Commissioning Groups: West London; Wandsworth; Central London; and Hammersmith & Fulham
- Provide a clinic service for up to three patients per day for one year
- Define the roles of clinical nurse specialist (CNS) and consultant within the context of ADOC
- Collect and analyse data to assess the benefits listed above.

The expected benefits of the Clinic were to:

- Reduce new cancer presentations via acute medical services
- Reduce time to diagnosis
- Improve the patient experience
- Reduce the number of investigations per patient
- Provide more support for GPs
- Produce financial savings
- Provide high quality rapid access clinic and support for primary care.
4. The new ADOC pathway

The pathway seeks to expedite the diagnosis or exclusion of cancer for patients:

- with urgent suspected cancer
- who are too unwell to wait for a ‘two week referral’
- who are well enough to attend an outpatient clinic

The pathway was designed to provide GPs with an alternative to referring their patients to ED, but not to compete with or replace the established two week wait pathways.

Patients who meet the clinic criteria are seen within 24 hours of GP referral (Monday to Friday work day hours).

The patient is assessed by an oncology clinical nurse specialist, and reviewed by a consultant oncologist at the first appointment. The aim is to provide access to most investigations within three to five days (Monday to Friday) and work towards a preliminary diagnosis within one week. The patient attends diagnostic services, wherever possible, as an outpatient.

When cancer is confirmed, patients are referred directly to the appropriate multidisciplinary team (MDT) and entered onto the established tumour site specific clinical pathway.

When cancer is excluded, the patient is referred back to the GP with detailed information on tests and results, and where appropriate, suggestion for onward referral to other specialties. In some cases the ADOC team arranges onward urgent referrals.

4.1 Setting targets

In order to challenge current cancer waiting times and to understand what additional resource, if any, it takes to bring about earlier diagnosis and treatment, the project team agreed the following time targets (Monday to Friday work day hours counted) to:

- review patients within 24 hours of GP referral
- provide GP with a summary within 24 hours of their patient’s first appointment
- carry out investigations within 3 – 5 days of initial appointment
- provide a preliminary diagnosis within 7 days of initial appointment
- answer ADOC calls and messages within two hours
- return emails within four hours.
To meet these targets and reduce the time from GP referral to diagnosis, the ADOC team conducted the following activities for each patient who attended ADOC:

- Pre-appointment planning to enable provisional booking of investigations and tests
- Scheduling tests with minimal elapsed time – so most results are returned within a shorter time frame enabling earlier follow-ups to give patients their results
- Proactively seeking patient results and chasing results where necessary
- Using phone follow-ups, where appropriate, so patients are provided with results promptly
- Providing flexibility with appointment times (possible due to the reactive nature of the AOS service).

### 4.2 Referral criteria for GPs

ADOC focused on accepting GP referrals primarily from the four Clinical Commissioning Groups. Referral criteria were developed by the Project Team in consultation with colleagues, the Cancer Board, and the Outpatient development board.

Patients must meet the criteria:

1. Clinical or radiological evidence to suspect new cancer
2. Too ill to wait for the two week referral clinic
3. Well enough to attend an outpatient clinic
4. Are 18 years or over
5. Aware that they may have cancer.

Exclusion criteria:

1. Medical emergencies must be sent to the ED.
2. Cancers not treated within Chelsea & Westminster were directed to the nearest appropriate provision.

### 4.3 Triage of referrals

In contrast to written referral forms used for the two week wait clinics, the GP is requested to call to discuss the patient direct with the Clinical Nurse Specialist. To provide more GP flexibility we also established a dedicated ADOC email where GPs can establish initial contact with the CNS.
5. The Clinic

5.1 Pre-appointment planning

Planning the initial patient assessment, investigations and care requirements commences at first contact between ADOC and the GP. Direct contact with the GP provides the opportunity for:

- More targeted information about the patient’s symptoms, history, performance status, and comorbidities compared to a standard GP referral letter or two week wait referral form
- Anticipating care needs based on any psychological and social aspects reported by the GP
- Access to recent test results, helping to avoid needless replication of tests, and enabling advance booking of additional tests required
- Ensuring that the patient is aware of suspected cancer diagnosis
- Building better relationships with local GPs to provide support and guidance, and encouraging future liaison when they are uncertain of the most appropriate pathway
- Advising most appropriate pathway if not accepted by ADOC using local knowledge of other services within the Trust and neighbouring organisations.

5.2 ADOC out-patient appointment

At the first appointment the patient is met and assessed by the ADOC CNS. The clinical assessment typically takes one hour. (See Appendix A for clinic assessment form). The CNS then reviews the findings with the consultant oncologist, who also sees the patient. Investigations are conducted on this first day if possible, with subsequent follow-up (either telephone consultations or clinic appointments) scheduled to provide test results. The CNS is established as the patient’s key worker and the first point of contact.

5.3 Communicating with GPs

We aim to contact the patient’s GPs within 24 hours of their patient’s first ADOC appointment. This early GP contact is to reassure them that their patient has been seen, to ensure that they remain abreast of developments, to facilitate continuity of care and to prevent admission. (See Appendix B for GP summary).

Clinic summaries provided to the GP include:

- the outcome of the first visit
- investigations conducted and any results
- plan of action
- information given to the patient.

A formal clinic letter is sent once a formal diagnosis is made. Where needed the CNS contacts the GP with updates on their patient.

Where cancer is excluded, the patient is referred back to the GP with detailed information on tests and results, and where appropriate, suggestion for onward referral to other specialties. Where patients need more urgent referral for non-cancer conditions, this can be organised by the ADOC.
5.4 Communicating with patients

Patients are encouraged to bring family or a friend with them to their ADOC appointment. Information given to the patient is recorded and the patient is provided with instructions of what to do if they become unwell at home. ADOC contact numbers are provided in a patient information card. (See Appendix C).

5.5 Same day investigations for ADOC patients

The target is to book and conduct investigations, if appropriate for the patient, on their first attendance at ADOC or at least ensure that the patient leaves this appointment with a schedule of investigations. This minimises the number of hospital attendances. Investigations are carried out as an out-patient where possible.

Prior agreement was secured with the Radiology Department to allow fast-track bookings for ADOC patients. This is facilitated by the ADOC CNS’s clinical assessment skills and authorisation to request investigations. Tests and investigations requested via ADOC include:

- Computed tomography (CT)
- Endoscopy
- Chest/abdominal/pelvis ultrasound scans
- Bone scan
- Chest X-ray
- Positron emission tomography (PET) scans (done at external organisations)
- Magnetic resonance imaging (MRI) whole spine
- MRI brain
- Radiology guided biopsies
- Other biopsies
- Blood tests, including tumour markers.

5.6 Results, diagnosis and start of treatment

Electronic patient records are monitored closely for patient’s results, and are proactively chased where necessary, ensuring that these are collated efficiently and quickly.

The flexibility in the appointment system enables follow-ups to be scheduled as soon as results are available. Telephone follow-ups are used where appropriate, in agreement with the patient, to reduce delays and patient hospital visits.

Where investigations confirm the likely diagnosis of cancer, patients are discussed at the next available relevant multidisciplinary team (MDT) meeting. This is either a site-specific MDT (e.g. gastrointestinal, lung, breast) if a primary is evident, or the malignancy of unknown origin (MUO) / carcinoma of unknown primary (CUP) MDT if the primary tumour site is not evident.

The scheduling of weekly MDTs was not permitted to delay decisions to start treatment and, where necessary, discussion with relevant core MDTs members outside of the MDT was undertaken to expedite treatment. All patients discussed in MDTs were logged on the Trust’s cancer waiting times pathways to ensure compliance with national standards, auditing of treatment times, and to prevent patients being omitted in error.
6. Implementation of the pathway

There was a three month period of project planning, development, consultation and implementation conducted by the core team members – Project Manager, Consultant Oncologist and Acute Oncology CNS in conjunction with the project steering group (GP liaison manager; Service design; Service Manager, and the project sponsor – the Medical Director).

6.1 Engaging the Trust

Agreeing and documenting the scope of the clinic was important to identify and agree resources and focus efforts on the deliverables of the project. This included discussions with the oncology team to:

- Identify excluded cancers – i.e. those not treated at Chelsea and Westminster or that have well-established fast-track pathways, for example, breast cancers and haematological cancers
- Agree maximum number of patients that can be seen per day, and procedures if exceeded. The predicted numbers were based on the number of emergency admissions from the previous CADIAS study
- Identify and forecast types and number of investigations per day based on the typical diagnostic pathway for patients presenting with suspected cancer

A project charter was produced to document and communicate to the Trust via the key stakeholders, Cancer Board and Outpatient Development Board (comprising local commissioners, GPs, Trust department managers). The charter included:

- reasons for undertaking the project
- objectives and constraints of the project
- identities of the main stakeholders
- in-scope and out-of-scope items
- critical success factors
- deliverables and project benefits.

See Appendix D for project charter.

6.2 Securing resources

The ADOC was based within the well-established Acute Oncology Service (AOS) which already offers a consultant-led, rapid access advice and review service for patients with:

- an emergency new diagnosis of cancer
- complications related to cancer treatments (for example, chemotherapy or radiotherapy)
- complications related to the cancer itself.
**ADOC Staff**

ACE project funding was provided for:

- The Project Manager 0.5 Whole Time Equivalent (WTE) for one year
- Band 6 0.5 WTE to provide cover for the CNS in her existing AOS role for one year.

ADOC clinical staff were already in post as part of the established AOS. Core team members of ADOC:

- Dr. Thomas Newsom-Davis, Consultant Medical Oncologist.
- Rachel Sharkey, Band 8 Macmillan Clinical Nurse Specialist, with advanced clinical assessment skills and authorisation to request radiology investigations
- Jo Simmons, Band 7 Project Manager & Nurse Researcher, with project management and research background
- Minhaz Uddin, Band 3 Administrative Services, working in the Ambulatory Emergency Care (AEC) service.

The service used resources, as required, from:

- Administrative services - one hour (estimate) per ADOC patient seen
- Medical Day Unit
- Medical Oncology Specialist Registrars (providing back-up to cover for the Oncology Consultant on an adhoc basis within their AOS remit)
- Annual leave cover for the CNS and Consultant from the Acute Oncology Service.

**Clinic rooms and services**

The Trust agreed to provide clinic space to see ADOC patients within the exiting Ambulatory Emergency Care (AEC) service. The AEC service was set up to provide a same day service to prevent hospital admission. Locating ADOC within this context provided access to the medical day unit services for:

- new hospital records and registering patients (as needed)
- clinic rooms and waiting areas
- day-case hospital beds for interventional procedures such as biopsies, phlebotomy and blood transfusion
- food and drink for patients.

**Administrative services**

Using the existing ambulatory care department services ensured access to administrative services which were accustomed to GP phone referrals, familiar with same or next-day appointments and were able to provide rapid preparation of patient notes.

**6.3 Engaging GPs**

We engaged with GP Leads from the four Clinical Commissioning Groups (CCGs) at the Outpatient Development Board to provide them with the opportunity to consult on the proposed service, GP referral criteria and clinic procedures.
Communication with GP practices

In order to test the rate of referrals we adopted a phased roll-out to two of the four CCGs, increasing over a two month period to all four CCGs.

Once referral criteria and clinic booking procedures had been agreed, these were communicated to GP Practices across the four CCGs using a managed communication programme using:

- Existing Trust channels of communication, such as the Trust GP liaison department, presenting articles and performance data in the Trust GP newsletter, establishing an ADOC option on the existing GP advice line
- Existing CCG channels of communication, such as contacting cancer leads, attending locality meetings attended by multiple GPs
- Liaison with regional Macmillan Cancer Leads
- Direct emails to GP practices. Five email campaigns were undertaken, mailing directly to 95 practices with some CCGs arranging additional dissemination of information
- Contact with GP trainees working within our oncology department, who subsequently work in the community.

Communications with GPs needed to be sustained and at regular intervals in order to keep abreast of practice personnel changes, and in recognition that an ‘ADOC patient’ may only be encountered by the average GP once or twice per year.

Visits to GP practices

In all communications we offered visits to individual Practices to introduce ADOC, answer questions and provide progress updates. A GP ADOC information leaflet was sent to GPs with all oncology clinic letters, distributed at GP practice visits, and emailed to all practice managers. (See Appendix E for GP leaflet)

GP Practice visits were one of the most successful activities. To date, we have engaged directly with about 30 GP Practices and this has yielded many of the clinic referrals. (See Appendix F for communication plan).

6.4 Establishing new referral and clinic booking procedures

To enable patients to be seen within 24 hours, ADOC-specific booking procedures were required. Two ways to contact the service were established:

- selecting the ADOC option on the existing GP telephone advice line – phone carried by on-duty CNS
- emailing the secure NHS.net email monitored every four hours (within office hours, Monday-Friday).

If a patient referral was accepted, the following procedure was followed:

1. CNS records GP direct phone number and NHS.net email address
2. CNS records patient information
3. Administrator books clinic times via electronic patient records
4. GP is emailed a confirmation of the clinic booking, with patient information letter attached. GP to contact the patient.
7. Data collection

We collected the following data:

7.1 Clinic performance and outcomes

- number of patient referrals made to clinic and number accepted
- mean time from GP referral to appointment
- mean time from GP referral to diagnosis
- mean time from GP referral to start of treatment
- number of patients with diagnosis of cancer
- number of patients where cancer is excluded
- number of admissions and length of in-patient stay
- number of investigations per patient
- number of patients refused appointment at ADOC and alternative pathway /advice given to GP
- number of patients referred back to GP.

7.2 Patient information:

- patient demographics
- presenting symptoms
- Eastern Cooperative Oncology Group (ECOG) performance status.

7.3 Patient experience questionnaire

A paper based questionnaire posted to patients attending ADOC. A selection of questions, relevant to ADOC, was taken from the National Cancer Patient Experience Survey and the NHS Outpatients question bank. (See Appendix G for patient questionnaire).

7.4 GP experience questionnaire

An internet based questionnaire was sent to all referring GPs, irrespective of whether their referral was accepted. Feedback was sought about the referral process and support for the GP from the ADOC team. (See Appendix H for GP experience questionnaire).
8. Results

The results are based on data collected between 13\textsuperscript{th} May 2015 and 10\textsuperscript{th} June and arranged into:

- Clinic performance and outcomes
- Patient demographics
- Patient experience
- GP experience.

8.1 Clinic performance and outcomes

Table 1: Summary of results

<table>
<thead>
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<th>Dataset Description</th>
<th>Value(s)</th>
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<tr>
<td>Estimated eligible population size</td>
<td>500,000</td>
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<tr>
<td>Referrals made to clinic</td>
<td>92 patients</td>
</tr>
<tr>
<td>Referrals accepted to clinic</td>
<td>55%</td>
</tr>
<tr>
<td>Outpatient appointments for patients accepted in clinic</td>
<td>86 appointments</td>
</tr>
<tr>
<td>Conversion rate - percentage of patients referred who are subsequently diagnosed with cancer</td>
<td>47%</td>
</tr>
<tr>
<td>Patients reviewed within 24 hours of GP referral</td>
<td>98%</td>
</tr>
<tr>
<td>GP referral to first appointment with consultant</td>
<td>7.1 hours (mean) 6 days (SD)</td>
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<tr>
<td>GP referral to cancer diagnosis</td>
<td>7 days (mean) 6.1 days (SD)</td>
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<tr>
<td>GP referral to treatment</td>
<td>16.4 days (mean) 11.1 days (SD)</td>
</tr>
<tr>
<td>Cancer diagnosis to treatment</td>
<td>8.9 days (mean) 11.8 days (SD)</td>
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<tr>
<td>Patients admitted as an inpatient from 1\textsuperscript{st} clinic appointment</td>
<td>29%</td>
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<tr>
<td>Length of in-patient stay (patients admitted at 1\textsuperscript{st} appointment)</td>
<td>11.8 days 13.7 days (SD)</td>
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Table 2: Types of cancers diagnosed

<table>
<thead>
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<th>Cancers diagnosed</th>
<th>No. patients</th>
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<tr>
<td>Lower gastrointestinal</td>
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<tr>
<td>Upper gastrointestinal</td>
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<tr>
<td>Lung</td>
<td>3</td>
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<tr>
<td>Hepatocellular carcinoma</td>
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<td>Haematological</td>
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<td>Gynaecological</td>
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<td>Lymphoma</td>
<td>3</td>
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<td>Breast</td>
<td>1</td>
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<td>Prostate</td>
<td>2</td>
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<tr>
<td>CUP - 1</td>
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<tr>
<td>Neurofibroma</td>
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Table 3: Stage of cancer at diagnosis

<table>
<thead>
<tr>
<th>Stage at diagnosis</th>
<th>No. patients</th>
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<tr>
<td>I</td>
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<tr>
<td>II</td>
<td>0</td>
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<td>III</td>
<td>4</td>
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<td>IV</td>
<td>16</td>
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<td>Unknown</td>
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Investigations and results

73% of imaging investigations were conducted on the day of the patient’s first ADOC visit. The mean number of imaging investigations per patient:

- diagnosed with cancer: 3 investigations (SD 1)
- cancer was excluded: 1 investigation (SD 1).

67% of all results were available the same day. The mean number of days for the return of results for all investigations was <3 days (measured from the time the investigation was conducted). Results for biopsies took the longest:

- mean time to results of ultrasound biopsies – 6.1 days
- mean time to results of CT guided biopsies – 12 days.
Figure 3: ADOC patients - number and types of investigations

Patients where cancer was excluded:

- 18 patients were discharged to their GP
- 2 referred for more investigations
- 7 referred to secondary care (including older adult services, gynaecology, neurology, dermatology, and lung).

In-patient admissions and length of stay

29% of patients were admitted as an in-patient from clinic at the first appointment.
The mean length of stay was 11.9 days (13.7 days SD).

8.2 About the patients

Presenting symptoms

The presenting and secondary symptoms were diverse and similar for both patients that had cancer and where cancer was excluded.

- Most common symptoms in patients with a cancer diagnosis:
  - weight loss
  - back pain
  - hip or other bone pain
  - abdominal pain
  - hypercalcaemia.
- Most common symptoms in patients where cancer was excluded:
  - weight loss
  - abdominal pain
  - hip or other bone pain.

**Age and gender**

- Patients referred to ADOC were 54% female and 46% male.
- There was a marked increase of females in the 50 – 79 age group - 74% females to 26% males.

**Figure 4: Age of patients referred to ADOC**

**Ethnicity**

Ethnicity was collected for patients seen from Trust data:

- 22 white British
- 3 white Irish
- 14 any other white background
- 5 not collected
- 5 Caribbean
- 2 any other ethnic group
8.3 Patient satisfaction

37 patients seen in ADOC were sent the patient satisfaction questionnaire (excluding patients who were too unwell). The CNS determined when it was appropriate to send on a patient by patient basis. Nine patients responded and returned the questionnaires (24% response rate).

Figure 5: Patient responses

1. Before your appointment, did you know the reason for the appointment?
   - Yes, definitely
   - Yes, to some extent
   - No
   - Don’t know / can’t remember

2. Before your appointment, did you know who to contact if your symptoms or condition got worse?
   - Yes
   - No

3. How was the length of waiting time up until your appointment date?
   - Too short
   - About right
   - Too long

4. At your appointment did a member of staff explain why you needed tests in a way you could understand?
   - Yes, completely
   - Yes, to some extent
   - No
   - I didn’t need an explanation

5. Did a member of staff explain what would happen during these tests in a way you could understand?
   - Yes, completely
   - Yes, to some extent
   - No
   - Don’t know / can’t remember

6. How was the length of waiting time up until your tests were carried out?
   - Too short
   - About right
   - Too long

7. Did a member of staff tell you when you would find out the results of your tests?
   - Yes
   - No
   - Not sure / can’t remember

8. Did a member of staff explain the results of the tests in a way you could understand?
   - Yes, completely
   - Yes, to some extent
   - No
   - Not sure / can’t remember
   - I was never told the results

9. If you had questions to ask about the test results, did you get answers that you could understand?
   - Yes, completely
   - Yes, to some extent
   - No
   - I did not need to ask
   - I did not have an opportunity

10. At the end of your appointment did clinic staff tell you who to contact if you were concerned?
    - Yes
    - No
    - Don’t know / can’t remember

11. Overall, did you feel you were treated with respect and dignity while you were at the ADOC clinic?
    - Yes, all of the time
    - Yes, some of the time
    - No

12. Overall, how would you rate the care you received at the ADOC clinic?
    - Excellent
    - Very good
    - Good
    - Fair
    - Poor, very poor

13. Overall, were you treated with kindness and respect?
    - Yes, all of the time
    - Yes, some of the time
    - No

Comments from patients taken from questionnaire responses:

“The oncology nurse I had from the beginning was very professional and caring towards myself”.
78 year old female patient.

“The service was superb from the beginning, to the end. The consultants, doctors, and nurses were brilliant. The NHS was fantastic”.
76 year old male.

Excerpts from more detailed patient interview:

“Rachel took me into a room with my family...she was very calming. I wasn’t frightened, I should have been as I’ve not been in hospital all of my life....I was in a bit of a state...I was in a daze...but I must say everyone looked after me exceptionally well”.

Patient: Mr. Angus Bain
8.4 GP satisfaction

Seventy five different GPs from forty three GP practices referred to ADOC. All referring GPs were sent the online questionnaire to complete following the attendance of their patient at ADOC. Seventeen GPs responded (18.5% response rate).

Figure 6: GP responses

Did we answer your call within 2 hours or return your email within 4 hours?

Did we provide sufficient information, within 24 hours, about your patient’s first visit?

Did we provide sufficient information about your patient’s diagnosis or the exclusion of cancer?

Did we provide sufficient information about the plan of action?

Would you use the clinic again?

Comments from GPs taken from questionnaire responses:

“…an absolutely excellent service. The only other alternative would have been A&E ... not ideal for this potential diagnosis.”

Wandsworth GP

“Speedy response, very helpful and removed need for an admission. Great communication with patient and their family.”

West London GP

“Brilliant service, very reassuring for the patient and clinicians. Very good communication with the GPs and holistic care for the patient.”

Hammersmith & Fulham GP
9. Impact and benefits of the new pathway or service

The intended consequences of the new service were:

- better patient experience
- faster access to the service
- faster diagnosis and treatment
- fewer patient admissions.

9.1 Benefits to patients

Better patient experience

Questionnaire data shows high levels of patient satisfaction with waiting times and the quality of care provided for them and their family within ADOC.

Other factors that are likely to contribute to high levels of patient experience include:

- Immediate assessment by oncology staff increasing the likelihood of appropriate tests and investigations.
- Less likely to be admitted as an in-patient
- Communication with the GP within 24 hours ensures that the GP can provide relevant and appropriate support for their patient in the community
- Fewer hospital attendances
- An out-patients cancer setting where patients are cared for by staff who are trained in communicating with patients and their families dealing with cancer
- Personalised and holistic approach assisted by the opportunity to glean more information from the GP before the appointment
- The allocation of a key worker at the first meeting and the provision of contact details
- Access to a Macmillan Centre providing advice, information and counselling.

Faster access to the service

98% of the referrals were seen within 24 hours (Monday – Friday work day hours). Benefits associated with faster access may include:

- Reducing patient anxiety and stress associated with longer waiting times
- Patients are less likely to attend the ED
- Confidence in the ADOC team and hospital.
**Faster diagnosis and treatment**

There are clear national targets for time from GP referral to review in a specialist clinic (14 days), decision to treat (31 days), and initiation of treatment (62 days). Figure 7 illustrates the pathway of an ADOC patient (using mean times) and a typical two week wait colorectal pathway that meets the national cancer waiting time.

A faster time from GP referral to cancer diagnosis (mean - 7 days) was achieved by minimising the wait to see a consultant, same day tests and results, proactive chasing of results and flexible follow-up appointments or phone calls. ADOC achieved a mean of 16.4 days from referral to treatment.

Figure 7: Illustration of an ADOC patient pathway versus a typical two week wait pathway

**Fewer patient admissions**

Previous work has found that 60% of patients with a new cancer diagnosed following an emergency presentation will be admitted to hospital. In contrast 29% of patients seen in ADOC were admitted as an in-patient at their first appointment. This in part reflects that specialist oncology teams have the skills and confidence to manage these patients as an outpatient, but may also be that ADOC patients are less acutely unwell than those who attend ED. The mean length of stay was 11.9 days (13.7 days SD).

---

Even for patients who did not go onto receive treatment, there is growing evidence that good supportive care provided early to patients with advanced cancer can improve quality of life, possibly lengthen survival and reduce the need for aggressive treatment near the end of life. This helps avoid or reduce the length of in-patient stays, and is known to reduce the costs of care⁴.

**Unintended benefits: patients with co-morbidities**

ADOC saw two patients with formal mental health diagnoses and one patient with a learning disability. Support from a key worker, a coordinated plan of action, and fewer hospital visits enabled these patients, whom had a history of failing to attend appointments, to complete their investigations.

Elderly ill patients that did not meet the ADOC criteria, but who had medical problems which required investigation, were discussed with the Older Adult Services Team (OAST). Joint consultations were sometimes organised so that the all the patient’s needs could be addressed.

### 10. Resources

The following resources were produced to support implementation:

- Business case
- Operational policy for the investigation and diagnosis of MUO and CUP patients
- GP ADOC information leaflet
- GP communication plan
- Patient ADOC information sheet
- ADOC clinic assessment form used during triage and first physical patient assessment
- Job descriptions

See Appendix A-H for selected documents.

We used the London Cancer Alliance (LCA) MUO / CUP guidelines, and followed NICE guidance on the diagnosis and treatment of cancer.

---


11. Barriers and enablers to the progression of the project

11.1 Barriers

There were a number of issues arising during the setting up and running of the clinic:

Recruitment

There was insufficient time to recruit a member of staff to cover the AOS CNS for her acute oncology duties, whilst she was in ADOC. Instead, this cover was fulfilled, with an internal agreement, for a limited period of 8 weeks by a Research Nurse already within the Oncology department at 0.18 WTE, a degree of cover which was much less than wanted or anticipated. This arrangement was in place during the early weeks of ADOC to mitigate the risk of fluctuations in referral rates, but was discontinued due to internal staffing pressures.

Cover for annual leave and sickness absence

The absence of formal CNS cover arrangement (above) meant that cover for study, sickness, and annual leave instead relied on the goodwill of team members. However this is not sustainable in the longer term.

Pre-project consultation with GPs and CCGs

There was initial resistance from some members of the local CCGs and some GPs regarding the need for this project to test the feasibility of earlier diagnosis. Amongst the opinions voiced:

- The two week wait is an established route that fits the needs of most patients
- The two week wait does not require any triaging or GP effort beyond completing a referral form
- GP perception that there is nothing wrong with referring patients to ED (as safe and fast route to secondary care)
- There is already too much complexity in the system.

We worked with stakeholders to address their concerns from the outset. Once the project gathered momentum and we were able to provide interim performance data, GPs and CCGs engaged with the concept and, to our great pleasure, the most resistant GPs became some of our most common referrers.

Sustaining communication with GPs

The budget available to us limited the scope of communication materials that we were able to produce and circulate.

Communicating with 120 practices, operating as ‘individual businesses’, across a large geographical area in London, is very time consuming. Furthermore, it is challenging to find personnel with the appropriate combination of nursing background and communication skills to undertake this work. Over the year some GP practices ceased to operate, new practices emerged or changed names and GPs themselves move between practices. The high density of other secondary healthcare trusts and services meant GPs were inundated with other communication drives from healthcare providers.
11.2 Enablers to the project

Factors supporting implementation:

- Financial support from the ACE programme
- Team briefed and prepared about roles and responsibilities
- Strong team working and staff prepared to contribute to the project
- Good relationship and support from Medical Day Unit, Radiology and other departments
- Procedures and clinical pathways agreed and in place before starting the clinic
- Support from the Trust at departmental, divisional and executive level
- Planned and sustained promotion of ADOC to primary care.

Factors supporting sustainability:

- An alternative expedited pathway for patients that would otherwise attend ED, with no additional material resource
- Exists within established Acute Oncology Service
- Alignment with other ambulatory services, with sharing of facilities and resource
- Trust support
- Colleague and staff satisfaction, assisting with attracting high caliber staff, staff development and staff retention.

Factors supporting Expansion:

- Strong business case See Appendix D
- Prospective data collection all showing demonstration of performance, costs, benefits and risks
- Regional and national interest: other NHS Trusts, Cancer Vanguards and Macmillan Cancer Support UK (including shortlist for a National Excellence Award)
- International interest: presentation at European Society of Medical Oncology 2016, with inclusion in conference press releases and other media interest
- An opportunity to educate and develop primary and secondary care colleagues
- Trust support, based on the factors listed
- High rates of patient satisfaction
- High rates of GP satisfaction.
12. Outcome

Following the one year pilot, ADOC continues to run at Chelsea and Westminster as part of routine clinical services, receiving referrals from primary care. This is beyond the current job plans and timetables of those involved, and so a more sustainable future is being sought.

The plan is to arrange sufficient CNS input and cover so that the clinic can run five days per week, with cross cover, and not at the detriment of other AOS duties. This, combined with improved consultant cover, will allow an expansion of the service to also accept direct referrals from the emergency and radiology departments. Furthermore, it is planned to extend ADOC to the other site within our Trust, West Middlesex University Hospital.

All the above is contingent on obtaining additional CNS and consultant cover.

**A strong business case shows that the clinic:**

- Generates funds for the Trust via increased outpatient volumes, investigations, outpatient appointments (using the multi-disciplinary team tariff)
- Reduces costs and pressures of ED attendance
- Reduces admissions and length of stay
- Increases primary care oncology referrals, reflecting the reputation of ADOC clinic
- Attracts additional downstream tariff income (e.g. surgery, chemotherapy) for patients via ADOC.

The cost of comparative pathways has not been forthcoming or easy to estimate, the complexity and individualised care of each patient makes cost estimate difficult. Work is ongoing, but beyond the scope of this project, to provide meaningful baselines for comparison of costs.

**ADOC improves the cancer pathway by ensuring:**

- Fewer presentations via ED
- Patients seen within a cancer setting
- Reduced inpatient admission and length of stay
- Earlier treatment and support and increases the likelihood of a better quality of life for patients with advanced and progressing cancer
- Improved patient experience.
13. Conclusion

ADOC has shown that the cancer pathway can be improved for patients by identifying a specific population, working innovatively, with similar resources but to tighter timeframes.

ADOC is neither designed nor appropriate for the very large number of patients that receive ‘two week wait’ referrals, and as such is not aimed at competing with this. However there are aspects of the way that ADOC works, which may improve the two week wait pathway, for example:

- Additional acute pathway based on prioritisation by the GP, triaged by a CNS or doctor. In our experience, GP’s judgement of a high suspicion of cancer was reliable (47% of patients seen were diagnosed with cancer) compared to the 5.9% conversion rate for two week wait clinics
- Reduced time from investigations to follow-up appointments, with CNS as point of contact for urgent results
- Flexible follow-up, including use of telephone follow up when results are unremarkable, to minimise number of clinic appointments
- Improved communication between GP and hospital, including email.
14. Acknowledgements

We would like to thank all our colleagues and the following departments and individuals who made this project possible:

Medical Day Unit

Radiology Department

Minhaz Uddin (Administration)

Oncology and Palliative Care Department

Professor Mark Bower

Chelsea & Westminster Cancer Board

Older Adult Services Team

15. Appendices
Appendix A: Clinic assessment form
## Patient Details

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB:</th>
<th>Referral Date:</th>
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<tbody>
<tr>
<td>NHS No.</td>
<td>Hospital No.</td>
<td></td>
</tr>
<tr>
<td>Contact</td>
<td></td>
<td>Clinic Date:</td>
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## GP Information

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<tr>
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<th>Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact</td>
<td>Email</td>
</tr>
<tr>
<td>Fax</td>
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## Assessment

**Reason for Referral**

**Pre-Clinic Plan**
### Past Medical History

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<thead>
<tr>
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<th>Recurrent chest infections</th>
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<tr>
<td></td>
<td>TB</td>
</tr>
<tr>
<td></td>
<td>Skin moles/marks</td>
</tr>
<tr>
<td></td>
<td>Night sweats</td>
</tr>
<tr>
<td></td>
<td>Foreign travel</td>
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</table>

### History of presenting complaint (reported by patient)

### Social Background

#### Family History

#### Occupation:

#### Smoking:

<table>
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<tr>
<th>Y</th>
<th>N</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Amount/frequency:</th>
<th>Advice given:</th>
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</table>

#### Alcohol:

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<th>N</th>
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</table>

<table>
<thead>
<tr>
<th>Units/wk.:</th>
<th>Advice given:</th>
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</thead>
</table>

#### Accommodation (and other persons at home):

#### Baseline (prior to admission):

#### Dependants / Carers:

#### Services on admission:

### ECOG Performance Status Scale

<p>| | |</p>
<table>
<thead>
<tr>
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<th></th>
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<tbody>
<tr>
<td>0</td>
<td>Asymptomatic</td>
</tr>
<tr>
<td>1</td>
<td>Symptomatic, fully ambulatory</td>
</tr>
<tr>
<td>2</td>
<td>Symptomatic, in bed &lt;50% of the day</td>
</tr>
<tr>
<td>3</td>
<td>Symptomatic, in bed &gt;50% of the day but not bedridden</td>
</tr>
<tr>
<td>4</td>
<td>Bedridden</td>
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Medications (Route / Dose / Frequency)

Allergies / Adverse Reactions

Review of Systems

<table>
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<tr>
<th>CVS</th>
<th>RS</th>
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<tr>
<td>Chest pain</td>
<td>Cough</td>
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<td>Breathlessness</td>
<td>Sputum</td>
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<td>Orthopnoea / PND</td>
<td>Haemoptysis</td>
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<tr>
<td>Claudication</td>
<td>Wheeze</td>
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<td>Ankle oedema</td>
<td>Calf swelling</td>
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<table>
<thead>
<tr>
<th>GI</th>
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<tr>
<td>Appetite change</td>
<td>Haematuria</td>
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<td>Vomiting</td>
<td>Dysuria</td>
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<td>Weight loss</td>
<td>Voiding difficulty</td>
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<td>Hematemesis / Melaena</td>
<td>Frequency</td>
</tr>
<tr>
<td>Change in bowel habit</td>
<td>D</td>
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<td>Abdominal pain</td>
<td>LMP</td>
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<td>Rectal bleeding</td>
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<td>Headaches</td>
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<td>Visual disturbances</td>
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<td>Syncope</td>
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<td>Weakness</td>
<td>BP</td>
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<td>Sats</td>
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<td>FiO2</td>
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Physical Examinations

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<tr>
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<td>Lymphadenopathy:</td>
<td>Skin:</td>
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CVS

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<tr>
<th>JVP</th>
<th>Heart sounds</th>
<th>Apex beat</th>
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<tr>
<td>Oedema</td>
<td></td>
<td>Bruits</td>
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</table>

RS

- Trachea
- Expansion
- Percussion note
- Breath sounds

Breast

Abdomen

Per rectum / Prostate
### CNS

<table>
<thead>
<tr>
<th>Glasgow coma scale</th>
<th>............ / 15</th>
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<tbody>
<tr>
<td>Gait</td>
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<tr>
<td>Speech</td>
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<tr>
<td>Swallowing</td>
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### Arms

<table>
<thead>
<tr>
<th>R</th>
<th>L</th>
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- Tone
- Power
- Coordination
- Sensation

### Legs

<table>
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<tr>
<th>R</th>
<th>L</th>
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- Reflexes
  - B
  - Tr
  - S
  - K
  - A
  - PI

- Right
- Left

### AMTS

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<th>Age:</th>
<th>DOB:</th>
<th>Year:</th>
<th>Time of day:</th>
<th>Place:</th>
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</tr>
<tr>
<td>Monarch:</td>
<td>WW1:</td>
<td>20 to 1:</td>
<td>2 people recognition:</td>
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<td></td>
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**Total Score: ** ___ / 10

### Investigations

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<tr>
<th>Type</th>
<th>Date</th>
<th>Done by GP</th>
<th>Done by ADOC</th>
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CHELSEA & WESTMINSTER NHS HOSPITAL
## Impression and Summary

### Management

<table>
<thead>
<tr>
<th>Admission date:</th>
<th>Discharge date:</th>
<th>Review date:</th>
</tr>
</thead>
</table>

### Suspected primary cancer site

- [ ] Breast
- [ ] Brain/CNS
- [ ] CUP
- [ ] Gynaecology
- [ ] GI (lower)
- [ ] GI (upper)
- [ ] Haematology
- [ ] Head & Neck
- [ ] Lung
- [ ] Sarcoma
- [ ] Skin
- [ ] Prostate
- [ ] Urology

[ ] Referred to MDT meeting

### Information given to Patient / relative:  

### Information given to GP:

Case discussed with Consultant / Registrar (*Name & Grade*):

---

### Form completed by:

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Date:</th>
<th>Grade/ Bleep:</th>
</tr>
</thead>
</table>
Dear Doctor,

Your patient was seen in the Acute Diagnostic Oncology Clinic. To provide you with the outcome of their visit without delay, please find a brief summary below. A formal letter will follow.

**Primary symptoms and findings:**

**Secondary symptoms and findings**

---

**The following investigations have been arranged:**

<table>
<thead>
<tr>
<th>Investigations:</th>
<th>Date</th>
<th>Result</th>
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</thead>
<tbody>
<tr>
<td>PET scan</td>
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<tr>
<td>Abdominal US</td>
<td></td>
<td></td>
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<tr>
<td>Blood tests</td>
<td></td>
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<tr>
<td>Bone scan</td>
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<tr>
<td>Chest US</td>
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<td>Chest X-ray</td>
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<td>CT</td>
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<td>CT/US guided biopsies</td>
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<td>Endoscopy</td>
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<td>MRI brain</td>
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<td>MRI whole spine</td>
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</tr>
<tr>
<td>Pelvic US</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any other investigation:</td>
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**Diagnosis:**

The patient was informed of:

The patient was given the following written information:

**Next steps**

<table>
<thead>
<tr>
<th>Action</th>
<th>Date for each</th>
<th>Details</th>
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<tbody>
<tr>
<td>Patient referred back to GP</td>
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<td></td>
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<tr>
<td>Patient admitted to Chelsea &amp; Westminster as an inpatient</td>
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<td></td>
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<tr>
<td>Further investigations on-going</td>
<td></td>
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<tr>
<td>Patient referred to oncology multi-disciplinary team</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Yours sincerely,

Tom Newsom-Davis (Consultant Medical Oncologist)  
Rachel Sharkey (Clinical Nurse Specialist)

Acute Oncology Service  
Mobile: 07791472630  
Bleep: 020 3315 8000 X 8908
Appendix C: Patient information card
Patient Information Sheet

You have been referred by your GP to the Acute Diagnostic Oncology Clinic. This is run by Dr Thomas Newsom-Davis (consultant oncologist) and Rachel Sharkey (acute oncology specialist nurse).

Your doctor has asked you to see us so we can look into your symptoms. This specialist clinic allows us to do this quickly and usually we are able to arrange the necessary tests within 1 or 2 days of your first visit. This does not mean that you definitely have cancer, but further tests are needed to exclude the possibility.

Our team will contact you by telephone to arrange your appointment within 24 hours of receiving the referral from your GP (Mon-Fri). If you have not heard from us within 2 working days of receiving this letter please contact us using the contact details below. It is important that you provide your GP with your current telephone numbers.

When you come for your appointment, please report to the Medical Day Unit reception on the Ground Floor, lift bank D, of Chelsea & Westminster Hospital, 369 Fulham Road.

What happens at the clinic?

You will be seen by our specialist nurses, who will ask you some questions and examine you, and then by a consultant oncologist. You may spend up to 4 hours at the clinic depending on which tests are needed, but this means you will have had a complete medical assessment in one visit. The team might decide you need further tests to be carried out. These will be booked for you before you leave the clinic.

What happens next?

We will arrange a follow-up visit to the clinic after your tests have been done. We will discuss the results of these, what they mean, and what needs to be done next. If no further tests or treatment are needed we will refer you back to your GP.

A letter containing all the information will be emailed to your GP after your first clinic visit to let them know what we are doing.

If your symptoms get worse before your clinic appointment, please contact your GP for advice.

Contact us

If you are unable to attend, please let us know by calling the Medical Day Unit reception on 020 3315 8000 extension: 53265.

If you have any questions about the clinic please contact Rachel Sharkey, (acute oncology specialist nurse), Mobile: 07791 472630 Monday to Friday 0830 to 1630
ADOC clinic – Acute Diagnostic Oncology Clinic

You have been seen at the Acute Diagnostic Oncology Clinic. This is run by:

Dr. Thomas Newsom-Davis (Consultant Oncologist) and Rachel Sharkey (Acute Oncology Specialist Nurse).

Your GP referred you to this specialist clinic to allow us to look into your symptoms quickly. This does not mean that you definitely have cancer, but further tests are needed to exclude the possibility.

If your symptoms get worse before your next appointment, please call the clinic staff or your GP for advice. If you become very unwell, please go to your nearest Accident & Emergency Department.

See over the page for the tests that have been booked for you.

You can call to speak to us:
Telephone: 020 3315 8000
Ask for Bleep Number: 8908

Out of office hours:
Telephone: 020 8746 8000
Ask for the Acute On-Call Oncology Special Registrar

ADOC clinic – Acute Diagnostic Oncology Clinic

You have been seen at the Acute Diagnostic Oncology Clinic. This is run by:

Dr. Thomas Newsom-Davis (Consultant Oncologist) and Rachel Sharkey (Acute Oncology Specialist Nurse).

Your GP referred you to this specialist clinic to allow us to look into your symptoms quickly. This does not mean that you definitely have cancer, but further tests are needed to exclude the possibility.

If your symptoms get worse before your next appointment, please call the clinic staff or your GP for advice. If you become very unwell, please go to your nearest Accident & Emergency Department.

See over the page for the tests that have been booked for you.
The following tests have been booked for you. If you can’t make your appointment please call the clinic staff on 0203 3315 8000 and ask for Bleep Number 8908. You will be asked to stay on the line and a member of clinic staff will answer your call.
Appendix D: Project charter
## Project Charter:

### Establishing and measuring the impact of the Acute Diagnostic Oncology Clinic

**DRAFT FOR DISCUSSION version 0-3** A project funded by NHS England for the ACE (Accelerate, Coordinate and Evaluate) Programme on the Early Diagnosis of Cancer

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Benefits:</th>
<th>Scope:</th>
<th>Deliverables:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Identify the procedures and resources to set up a rapid access clinic for the diagnosis of cancer, for patients who are too ill to wait for a two week referral or when the GP is unsure of the cancer site, and referral path.</td>
<td>• Reduce new cancer presentations via acute medical services. • Reduce time to diagnosis • Improve the patient experience • Reduce the number of investigations per patient • Provide more support for GPs • Produce financial savings • Provide high quality rapid access clinic and support for primary care</td>
<td>In scope: • Design of clinic procedures • Service provided to a defined group of GPs • Providing a clinic service for up to three patients per day for one year • Fulfillment of CNS and consultant roles • Data to support analysis of the benefits listed here.</td>
<td>1. Documentation of clinic scope, procedures, and clinical protocols</td>
</tr>
<tr>
<td>2. Run the Acute Diagnostic Oncology Clinic for a one year period where patients can be seen within 24 hours of GP referral.</td>
<td>•</td>
<td>Not in scope: • Administrative support for the clinic • Infrastructure facilities of the clinic (booking process, reception service, investigations etc.) • Patients who should be referred via the 2 week wait referral.</td>
<td>2. Criteria for patient referral</td>
</tr>
<tr>
<td>3. Clinic utilisation and collecting data of clinic performance to assess benefits and clinic feasibility.</td>
<td>•</td>
<td>•</td>
<td>3. Patient communication material</td>
</tr>
</tbody>
</table>

### Critical Success Factors:

- Commitment within C&W to host clinic
- Clear criteria for GPs to ensure appropriate referral
- Resources to ensure that the Clinic runs daily with appropriately qualified clinical and administrative resource
- Rapid clinical investigations
- Rapid investigation results returned to clinic within 24 hours.

### Team & Sponsors

**Lead & Consultant Acute Oncology**: Tom Newsom Davies, 1 day pw

**Project Manager**: Jo Simmons 2.5 days pw

**Clinical Nurse Specialist CNS**: Rachel Sharkey 2.5 days pw

**Steering Group**: Mark Bower Head of Department; Justine Currie (GP liaison); Barry Quinn (Service design); Laura Bewick (Service Manager); Anna Letchworth (Emergency Nurse Practitioner); and Ellie <surname>

### Key Activities

1. Define scope of clinic
2. Set ‘faster diagnosis’ targets
3. Specify clinic resources, booking procedures, referral pathways and protocols
4. Communicate with GPs
5. Communicate with patients
6. Design data collection materials
7. Run clinic and collect data for a one year period
8. Analyse data and report

### Timing

<table>
<thead>
<tr>
<th>Feb 2015</th>
<th>March 2015</th>
<th>April 2015</th>
<th>April 2016</th>
</tr>
</thead>
</table>

2-Feb-15

Establishing and measuring the impact of the Acute Diagnostic Oncology Clinic · Version 0-2
Appendix E: GP Leaflet
The acute diagnostic oncology clinic (ADOC) is an outpatient clinic for patients with urgent suspected cancer who are too unwell to wait for a two-week referral.

Please contact us to discuss referrals with our team before an appointment can be agreed.

Contact information
Dr Thomas Newsom-Davis
Medical Day Unit
Chelsea and Westminster Hospital
369 Fulham Road
London
SW10 9NH

Booking
Please check that your patient meets referral criteria shown inside this leaflet.

Mon–Fri, 9am–5pm
T: 020 3315 5000 (GP advice line—select option 6 for ADOC)
E: chelwest.acuteoncology@nhs.net

Chelsea and Westminster Hospital
369 Fulham Road
London
SW10 9NH
T: 020 3315 8000
W: www.chelwest.nhs.uk
May 2015
Acute diagnostic oncology clinic

An oncology-led clinic

This clinic is for patients with urgent suspected new cancer who are too unwell to wait for a 'two week referral'. It is aimed at providing an alternative to referring your patient to A&E.

The clinic is not designed to compete with or replace the established two week wait pathways.

The purpose is to provide a better patient and GP experience with faster access to relevant diagnostic tests to diagnose or exclude cancer in a cost effective manner.

We aim to see patients, at an appointed time, within 24 hours of referral, Monday to Friday.

Criteria

Patients must meet the criteria:

1. Clinical or radiological evidence of new cancer diagnosis
2. Too ill to wait for the two week referral clinic
3. Well enough to attend an outpatient clinic
4. Are 18 years or over
5. Aware that they may have cancer

It is essential that you have discussed with your patient that they may have cancer before you refer them to the clinic.

Medical emergencies should not be referred to the clinic and instead should be sent to A&E.

If you are unsure that your patient meets these criteria, please contact the clinic for advice.

Booking an appointment

All referrals need to be discussed with our team before an appointment can be agreed.

Contacting the clinic by telephone

Call the GP advice line on 020 3315 5000 and select option 6 for ADOC.

If your call cannot be answered, please leave a message and our team will get back to you within two hours during working hours.

Contact the clinic by email

Email a referral letter including your direct telephone number to chelwest.acuteoncology@nhs.net.

A member of our clinic team will get back to you to discuss the case within four hours during working hours.

Once the referral has been accepted

We will confirm the appointment by telephone, and email. If possible, please print the patient information and give this to the patient.

We will contact the patient directly to let them know the details of the appointment.

The clinic

Your patient

Your patient will be met and assessed by an oncology nurse specialist, and will then be reviewed by a consultant oncologist. We aim to provide access to most investigations within 3–5 days (Mon–Fri) and work towards a preliminary diagnosis within one week. Your patient will attend diagnostic services, wherever possible, as an outpatient. We will inform you if your patient is admitted.

Next steps

We will notify you by email of our initial assessment and plans on the day of your patient’s first appointment. A formal consultant letter will follow.

If cancer is diagnosed, patients will be referred directly to the appropriate multidisciplinary team (MDT). If cancer is excluded, your patient will be referred back to you with detailed information on tests and results, and where appropriate, suggestion for onward referral to other specialities.

The clinic team

The clinic is led by Dr Tom Newsom-Davis (Consultant Medical Oncologist) and Rachel Sharkey (Clinical Nurse Specialist in Acute Oncology). We value your opinion and invite you to provide us with feedback.

Jo Simmons (ADOC Project Manager)
E: chelwest.acuteoncology@nhs.net
Appendix F: Communications plan
Managed communications - Acute Diagnostic Oncology Clinic

*Project to Establish and measure the impact of the Acute Diagnostic Oncology Clinic*

Version 1.0

25<sup>th</sup> March 2015
Project overview

Cancer research UK has funded a feasibility project to set up and run a new Acute Oncology Diagnostic Clinic at Chelsea & Westminster, to provide a five day direct access service for GPs to refer patients (who will be seen within 24 hours) who may have cancer and are too unwell to wait for the two week referral pathway.

The Clinic benefits are expected to:

- Reduce new cancer presentations via acute medical services and the emergency department
- Reduce time to diagnosis by reducing the time to referral, and expediting access to diagnostics
- Improve the patient experience by providing more specialist care within the cancer setting
- Reduce the number of investigations per patient
- Provide more support for GPs
- Produce financial savings
- Provide high quality rapid access clinic and support for primary care

The Acute Diagnostic Oncology Clinic Project is part of the ACE Programme, an NHS England led national programme, funded by Cancer Research UK and Macmillan Cancer Support. The Programme aims to build a national body of evidence and evaluation that documents the impact of innovative approaches to earlier diagnosis of cancer being taken across the country. It will also support the development of commissioning tools where they are absent and facilitate the removal of barriers to implementation where possible.

The ACE program was set up following a summit held in June 2014 that debated how the NHS could achieve earlier diagnosis of cancer. It was agreed that a national approach that would Accelerate, Co-ordinate and Evaluate best practice and innovative projects either under consideration or already underway in the NHS would be of value to commissioners and providers.

Clinic opening

The clinic is scheduled to open in May 2015, will run Monday to Friday with scheduled appointment slots and be made available to GP practices in our local Clinical Commissioning Groups (West London, Central London, Wandsworth, Hammersmith and Fulham).
Patients eligible for referral:

- Clinical or radiological evidence to suspect cancer
- Are too ill to wait for the two week referral clinic
- Are well enough to attend an out-patient clinic
- Are 18 or over
- Are aware that they may have cancer

Background to the project

The Acute Diagnostic Oncology Clinic is being set up in response to the findings of the project, Cancer Diagnosis in the Acute Setting (CADIAS). CADIAS findings suggested that up to 50% of GPs instruct/refer patients to attend A&E and conversations with GP stakeholders confirm that some GPs use A&E as a rapid means of assessment for patients who need to be seen, or have diagnostic tests, sooner than the two week wait referral allows and ensures a ‘safe’ pathway into secondary care. There are also a number of patients who are referred under the two week wait pathway but who present at A&E while they are waiting for the appointment of for tests.

CADIAS sought to understand the whole diagnostic pathway and events that lead to lung or colorectal cancer patients receiving a diagnosis as a result of an emergency admission and to identify the patient, clinical and organisational factors that contribute to an emergency cancer diagnosis. CADIAS was funded by the Department of Health, NHS England and run on behalf of the London Cancer Alliance (LCA). Seven hospital sites participated across London. A further 16 sites across East of England Strategic Clinical Network continued to recruit until the end of 2015 bringing the total to more than 400 patients in the study.

Project team

The project is led by Tom Newsom-Davis (Consultant in Acute Oncology).

Project Manager: Jo Simmons
Clinical Nurse Specialist CNS: Rachel Sharkey
Steering Group: Mark Bower (Head of Department); Justine Currie (GP liaison); Barry Quinn (Asst Chief Nurse); Laura Bewick (Service Manager); Anna Letchworth (Emergency Nurse Practitioner); and Ellie Shepheard (Sister MDU).
C&W Sponsor: Zoe Penn (Medical Director)
# Acute Diagnostic Oncology clinic – Managed communications

<table>
<thead>
<tr>
<th>Timing</th>
<th>Objective</th>
<th>Message</th>
<th>Audience</th>
<th>Channel</th>
<th>Measure</th>
<th>Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>W/c 9&lt;sup&gt;th&lt;/sup&gt; March 2015</td>
<td>Identify key stakeholders in each CCG – cancer lead.</td>
<td>Seek support and request assistance to promote clinic to local GPs through existing channels</td>
<td>Central London CCG&lt;br&gt;West London CCG&lt;br&gt;Hammersmith &amp; Fulham CCG&lt;br&gt;Wandsworth CCG</td>
<td>Existing communication channels</td>
<td>One contact per CCG.</td>
<td>Direct contact with project team</td>
</tr>
<tr>
<td></td>
<td>Identify existing communication channels.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>W/c 13th April 2015</td>
<td>Advance notice that clinic is due to open May 2015.</td>
<td>Purpose and background to clinic, who GPs can refer. How Clinic seeks to provide more support for GPs</td>
<td>Central London CCG 37 GP practices; West London CCG 53 GP practices; Hammersmith &amp; Fulham CCG 33 GP practices; Wandsworth CCG 52 Practices</td>
<td>Monthly GP bulletin&lt;br&gt;CCG bulletin&lt;br&gt;C&amp;W</td>
<td>No. of GP responses and nature of GP feedback</td>
<td>Tracking of emails opened</td>
</tr>
<tr>
<td></td>
<td>Opportunity for GPs to tell us what will be useful to them, comments re. concept, referral guidelines, booking procedure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>W/c 14th April 2015</td>
<td>Personal introduction to clinic</td>
<td>Purpose and background to clinic, who GPs can refer. How Clinic seeks to provide more support for GPs</td>
<td>Focussing on the GPs that currently have high referral rates to C&amp;W ED</td>
<td>Practice visits</td>
<td>No. of GP</td>
<td>Direct GP feedback</td>
</tr>
<tr>
<td>May 2015</td>
<td>Announce clinic is open to accept patients</td>
<td>Clinic open. How to book. Who to refer.</td>
<td>Phased roll-out across CCGs to assess patient throughput. West London CCG 53 GP practices. Followed by other CCGs</td>
<td>Direct email</td>
<td>No. of GP enquiries&lt;br&gt;No. of patients referred</td>
<td>Tracking of emails opened</td>
</tr>
<tr>
<td>Oct 2015</td>
<td>6 monthly clinic update</td>
<td>Progress so far. Any changes. Requests for feedback</td>
<td>Central London CCG 37 GP practices; West London CCG 53 GP practices; Hammersmith &amp; Fulham CCG; 33 GP practices Wandsworth CCG 52 Practices</td>
<td>Monthly GP bulletin&lt;br&gt;CCG bulletin&lt;br&gt;C&amp;W</td>
<td>Data collection tool to collect GP satisfaction</td>
<td>Tracking of emails opened</td>
</tr>
<tr>
<td></td>
<td>Opportunity for GPs to feedback re their experience if they have referred into the clinic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>May/June 2016</td>
<td>Project end</td>
<td>Project outcomes</td>
<td>All referring GPs</td>
<td>Direct email</td>
<td>As above</td>
<td></td>
</tr>
</tbody>
</table>

**Contact details**

Project Manager - Jo Simmons - Joanne.simmons@chelwest.nhs.uk

Project Lead - Dr Tom Newsom-Davis (Consultant Medical Oncologist) - Tom.Newsom-Davis@chelwest.nhs.uk

25 March 2015
Appendix G: Patient questionnaire
Dear

Your feedback on the Acute Diagnostic Oncology Clinic (ADOC)

This questionnaire is about your visit to the ADOC clinic at Chelsea & Westminster Hospital run by Rachel Sharkey (Clinical nurse specialist). You were referred to this clinic by your GP so that we could arrange fast access to tests.

Your feedback is very important to us, it is your opportunity to let us know if there are things that we could improve as well as anything that we are doing well.

Who should complete the questionnaire?

The questions should be answered by the person named on the front of the envelope. If that person needs help to complete the questionnaire, the answers should be given from his or her point of view - not the point of view of the person who is helping.

Completing the questionnaire

Taking part in this survey is voluntary. Your answers will be treated in confidence. Please do not write your name or address anywhere on the questionnaire.

Questions or help with this questionnaire?

If you need help with any of the questions please can you contact Joanne.Simmons@chelwest.nhs.uk

Yours sincerely

Joanne Simmons (Project manager ADOC clinic)
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
</table>
| 1. Before your appointment, did you know the reason for the appointment? | □ Yes, definitely  
□ Yes, to some extent  
□ No |
| 2. Before your appointment, did you know who to contact if your symptoms or condition got worse? | □ Yes  
□ No |
| 3. How was the length of waiting time up until your appointment date?   | □ Too short  
□ About right  
□ Too long |
| 4. At your appointment did a member of staff explain why you needed tests in a way you could understand? | □ Yes, completely  
□ Yes, to some extent  
□ No  
□ I did not need an explanation |
| 5. Did a member of staff explain what would happen during these tests in a way you could understand? | □ Yes, completely  
□ Yes, to some extent  
□ No |
| 6. How was the length of waiting time up until your tests were carried out? | □ Too short  
□ About right  
□ Too long |
| 7. Did a member of staff tell you when you would find out the results of your tests? | □ Yes  
□ No  
□ Not sure / Can't remember |
| 8. Did a member of staff explain the results of the tests in a way you could understand? | □ Yes, completely  
□ Yes, to some extent  
□ No  
□ Not sure / Can't remember  
□ I was never told the results of the tests |
| 9. If you had questions to ask about the test results, did you get answers that you could understand? | □ Yes, completely  
□ Yes, to some extent  
□ No  
□ I did not need to ask  
□ I did not have an opportunity to ask |
| 10. At the end of your appointment did clinic staff tell you who to contact if you were concerned? | □ Yes  
□ No  
□ Don't know / Can't remember |
| 11. Overall, did you feel you were treated with respect and dignity while you were at the ADOC clinic? | □ Yes, all of the time  
□ Yes, some of the time  
□ No |
12. Overall, how would you rate the care you received at the ADOC clinic?

   □ Excellent
   □ Very good
   □ Good
   □ Fair
   □ Poor
   □ Very poor

13. Overall, were you treated with kindness and understanding while you were the ADOC clinic?

   □ Yes, all of the time
   □ Yes, some of the time
   □ No

14. What was your year of birth? (Please write in) e.g. 1934

15. Are you male or female?

   □ Male
   □ Female

16. Please comment if there was anything that did well during your clinic visit?

17. Was there anything that could have been improved?

Thank you very much for your time to complete the questionnaire.
Please post this questionnaire back in the FREEPOST envelope provided. No stamp is needed.
Appendix H: GP Questionnaire
Acute Diagnostic Oncology Clinic (ADOC)

Dear Colleague, You referred a patient to the ADOC clinic at Chelsea & Westminster recently. We would be grateful if you could tell us about your experience so that we can better meet GP and patients’ needs.

Your name: 

In which Clinical Commissioning Group is your Practice?
- Central London
- West London
- Hammersmith & Fulham
- Wandsworth

How did you hear about the clinic?
- Newsletter
- Email from Clinic
- Visit from Clinic team member
- Via your Clinical Commissioning Group
- Other: 

How did you FIRST contact the clinic?
- Email
- GP Advice Line
- Other: 

Did we answer your call within 2 hours or return your email within 4 hours? (during office hours excluding weekends)
- Yes
- No
- Not applicable

Was your patient given an appointment?
- Yes
- No

Continue »

33% completed
Are you satisfied with the appointment you had?

Were we able to confirm your appointment? 

☐ Yes
☐ No

Did we provide sufficient information, within 24 hours, about your patient’s first visit? 

0 1 2 3 4
Not at all ☐ ☐ ☐ ☐ Completely

Did we provide sufficient information about your patient’s diagnosis or the exclusion of cancer?

0 1 2 3 4
Not at all ☐ ☐ ☐ ☐ Completely

Did we provide sufficient information about the plan of action?

0 1 2 3 4
Not at all ☐ ☐ ☐ ☐ Completely

Would you use the clinic again?

☐ Yes
☐ No

What did we do well?


What could we improve?


Acute Diagnostic Oncology Clinic (ADOC)

For patients not seen in ADOC but discussed

Was the information given by the clinic team sufficient to assist you to decide a plan of action for your patient?
- Yes
- No
- Other: [ ]

Where did you refer your patient to?

[ ]

What was the outcome of this episode of care?

[ ]

Any other comments:

[ ]

Never submit passwords through Google Forms.