Rapid Diagnostic Neck Lump Service
March 2016
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1 Introduction

The 2010 Model of Care recommended that “Rapid access diagnostic one-stop clinics should be established locally for patients with neck lumps and these should be integrated with equivalent services for haematological cancers”.

The aim of this initiative is to improve the pathway from referral to diagnosis for patients presenting with a neck lump and suspected of having cancer. This will include the development of rapid access diagnostic services with specialist expertise and clarity regarding inward and onward referral routes and criteria. This will ensure patients have timely access to the correct pathway, reducing inappropriate activity at the front end of the pathway and improving efficiency in services.

The LCA Haematology Oncology Pathway Group and the LCA Head and Neck Pathway Group have collaborated on a project aimed at developing a joint neck lump service. Clinicians from either discipline have taken part in the development of a number of documents and guidelines aimed at assisting Trusts across the LCA to implement the neck lump service.

1.1 Document purpose

This document has been developed to assist membership organisations in implementing a neck lump service. The document provides guidance on the optimal approach and minimum expectations of the service. The recommendations included within this document pertain to non-thyroid neck lump services. Local practice may dictate whether thyroid lumps are part of this service or a separate thyroid lump service runs parallel.

The aim of this document is to set standards and an outline of service provision to help reduce the waiting times for patients with neck lumps.

The benefit of the neck lump service is that it will enable those patients whose neck lump is benign to be reassured early whilst also allowing for patients with a malignant neck lump to be swiftly diagnosed and transferred to the relevant specialist to commence appropriate treatment rapidly.

The expected outcomes of implementation of the rapid access neck lump diagnostic service are:

- Reduction in variation for 62 day wait from referral to first treatment for patients with head and neck cancer
- Reduction in variation for 62 day wait from referral to first treatment for patients with haematological malignancies
- Reduction in time taken from referral to diagnosis
- Reduction in number of appointments for diagnostic tests
- Reduction in number of attendances (between specialties) prior to diagnosis
- Improved efficiency of test result turnaround time
1.2 Document contents

- Standard Operating Policy (section 2)
- Service Standards for Rapid Access Neck Lump Diagnostic Service (section 3)
- Service Quality Metrics (section 4)
- Exemplar timed pathway (Appendix 4)

1.3 Document development

The document was developed following a standardised process of information gathering, base lining current provision, understanding the gap, using a best practice model and collaboration on pathway development to meet the identified need. Both the LCA Head and Neck and the Haematology Oncology Pathway Group members were pivotal in the development of the pathway and associated documents. From April 2015 to March 2016 the following activities were undertaken and completed as part of the development of the service model;

- Process mapping of existing pathways of care for patients presenting with neck lumps
- Audit of current referrals to existing neck lump services
- Mapping of existing neck lump service hosted by King’s College Hospital NHS Foundation Trust haematology service
- Development of best practice model for rapid diagnostics service
- Workshop with representation from LCA head and neck and haematology pathway groups including all necessary disciplines and geographies
- Agreement and sign off of best practice model, service standards and quality metrics
- Final sign off of Standard Operating Policy
- Identification and agreement of pathway of care for patients presenting with neck lumps including onward referral to relevant specialties beyond cancer
- Supporting Standard Operating Policy, quality metrics and service standards published
- Agreed mode of implementation of pathway of care across all member organisations of the LCA.

The following stakeholders were involved either directly or in-directly in the development of these documents as detailed below:

- Mr Peter Clarke (LCA Head and Neck Pathway Group chair) and Dr Piers Patten (LCA Haematology Pathway Group member) co-chaired the workshop and were instrumental in reviewing repeated drafts of the documents published here.
- The LCA would like to extend specific and heartfelt thanks to King’s Health Partners haematology service for sharing their experience, audit data and their patient model with the project.
- Both the LCA Head and Neck and Haematology Oncology Pathway Groups were consulted on the document as it was developed and signed off the final draft.
- Mr Nick Hyde, LCA Clinical Director and maxillofacial surgeon was involved throughout the entire process of developing the rapid access service and has signed off the document on behalf of the LCA Clinical Board.
1.4  Next steps

The roll out of these rapid access services will be led and driven at a Trust level. The tumour specific pathway groups will support on-going implementation through clinical collaboration, common problem resolution and escalating issues to individual Trust boards.

The pathway groups will support the base lining of current provision against the service standards to help plan for implementation including resources required based on the gap analysis of the current provision.

There will be support from informatics, in line with the service quality metrics, to extract readily available data to baseline the current service, minimising where possible the burden of data collection on individual Trusts.
2 Standard Operating Policy

2.1 Referral to the service

2.1.1 General considerations
- Patients considered for referral to this service will present with a lump above the clavicle.
- Patients referred to a Trust with a rapid diagnostic neck lump service where a neck lump is indicated on the referral should be filtered into the neck lump diagnostic service.
- Patients referred to hospitals with no rapid diagnostic neck lump service and where a neck lump is confirmed on examination (through a clinic appointment or as an inpatient) should be referred directly to a neck lump diagnostic service for rapid investigations. All investigations will be undertaken within the diagnostic service, to avoid unnecessary delays and duplications; it is advised that no further investigations are scheduled prior to referral.
- The neck lump diagnostic service should be accessible by referral from a secondary care clinic/service. These will include:
  - Two week wait clinics (both head and neck and haemato-oncology)
  - ENT and maxillofacial clinics
  - Haemato-oncology clinics
  - Other referrals will come direct from MDTs – head and neck, haemato-oncology particularly but also breast, lung, upper GI and melanoma
  - One of the most common routes of referral is likely to be from direct access ultrasound clinics. There are a large number of direct access ultrasound clinics in the region and suspicious masses should be fast tracked from these to the service rather than patients being directed back to their GP for onward referral.
  - Consultant referral whether from a specialist, general or joint clinic or direct access ultrasound clinic referral should all follow the same route into the service
- All referrals to the neck lump service either through 2 week wait, routine or consultant referral or from direct access ultrasound should be triaged against the same inclusion criteria.
- The patient should be given information regarding what to expect when they attend for the neck lump service. The information should include anticipated time of appointment(s) as a whole, what tests to expect, any pre-biopsy considerations, number of clinicians present. See Appendix 5 for an example of a patient information leaflet.
- The patient should be made aware of how they will be contacted with their results and when to expect this contact. If a further appointment is needed after the neck lump service visit the patient should be given the date and time of this before leaving the service whenever possible.

2.1.2 GP referral

At Trusts with the rapid diagnostic neck lump service:
- Haematology and head and neck 2 week wait (2ww) referrals should be reviewed and triaged daily. The clinician reviewing the referrals should direct patients to the neck lump service if the following criteria are satisfied:
A patient is indicated as having a palpable mass on their neck via a haematology 2ww wait form (Appendix 1)

A patient has a neck lump indicated on the head and neck 2ww form (Appendix 2)

It should be noted that most GPs will not have access to a specific neck lump form and that a neck lump will be indicated on either the head and neck 2ww form or the haematology 2ww form. Triage of the referral forms should be undertaken daily to filter the most appropriate patients into the service.

- Patients referred using the above criteria should be booked into the neck lump service within 7 days of GP referral

At Trusts with no rapid diagnostic neck lump service:

- Haematology and head and neck 2 week wait (2ww) referral forms should be reviewed and triaged daily for the patients to be booked in to the appropriate clinic.
- Patients referred under 2ww should be booked into the appropriate 2ww clinic within 7 days of GP referral.
- If there is the confirmed presence of a palpable lump the patient should be referred directly to the neck lump diagnostic service for an appointment within 7 days.

2.1.3 Consultant referral including MDT

All consultants will be able to refer into the neck lump diagnostic service either directly from their clinic or via MDT discussion and non-2ww referrals.

- Consultant referrals should be directed to the neck lump service via a dedicated email address.
- Consultant referrals should be directly booked into the rapid diagnostic neck lump service via the service navigator.
- Consultant referrals must indicate the reason for referral to the neck lump service and include:
  - Confirmed presence of a palpable lump and location
  - Any relevant imaging, biopsy, blood results undertaken in the last 4 weeks contemporaneous to the imaging or physical findings
  - Any relevant risk factors
  - Any relevant reported symptoms
- Patients referred using the above criteria should be offered an appointment within 7 days into the neck lump service on receipt of referral.
- Patients should be booked directly into the diagnostic service for an initial appointment and follow-up appointment for the results on the same day with a named consultant.

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1 If patients have been inappropriately referred under the Two Week Rule, the official Cancer Waiting Times Guidance (http://systems.hscic.gov.uk/ssd/cancerwaiting/cwtguide9.pdf) should be followed and a consultant should discuss downgrading the referral with the GP. In cases of persistent misuse of 2ww forms by GP practices, the Trust should consider formal contact to communicate appropriate referrals.
2.1.4 Referral from direct access ultrasound clinics

This may be a common route of referral and GPs will have to inform patients that they may be referred directly from these clinics into a central service which will have all the appropriate investigations and clinicians available to provide a diagnosis. The TCST Pan London Early Detection and Awareness Group\(^2\) has agreed that onward referral from a local ultrasound service for results suspicious of cancer should be treated as an onward 2ww type referral and should be sent straight to a neck lump rapid diagnostic service. The GP should be informed within 24 hours of this onward referral by the direct access clinic.

- Referrals from direct access ultrasound clinics should be directed to the neck lump service via a dedicated email address.
- Referrals from direct access ultrasound clinics should be directly booked into the rapid diagnostic neck lump service via the service navigator.
- Referrals from direct access ultrasound clinics must indicate the reason for referral to the neck lump service and include:
  - confirmed presence of a palpable lump and location
  - copy of the ultrasound (ideal)
  - copy of the sonographer/radiologist report (essential)
  - any relevant risk factors
  - any relevant reported symptoms
- Patients referred using the above criteria should be offered an appointment within 7 days into the neck lump service on receipt of referral.
- The direct access ultrasound clinic should have a copy of the patient information leaflet to offer the patients once an onward referral has been confirmed.
- Patients should be booked directly into the diagnostic service for an initial appointment and follow-up appointment for the results on the same day with a named consultant.

2.1.5 Inpatient referral

All inpatients presenting with a neck lump or developing a palpable mass in the neck while in hospital should be referred into the neck lump service.

Inpatient referrals should follow the same route as the consultant referral (see section 2.1.3).

2.1.6 Unit to Trust with a neck lump diagnostic service referral

All consultants will be able to refer into a neck lump diagnostic service either directly from their clinic or via MDT discussion and non-2ww referrals.

On confirmation of the presence of a palpable lump the patient should be referred directly to a neck lump diagnostic service to be seen within 7 days for rapid investigations.

- Consultant referrals should be directed to the neck lump service via a dedicated email address.
- Consultant referrals must indicate the reason for referral to the neck lump service and include:

\(^2\) This was agreed at the TCST Pan London Early Detection and Awareness Group meeting on 28 January 2016.
– confirmed presence of a palpable lump and location
– any relevant imaging, biopsy, blood results undertaken as part of the investigation of the neck lump (within last 4 weeks)
– any relevant risk factors
– any relevant reported symptoms

• Patients referred using the above criteria should be offered an appointment within 7 days into the neck lump service on receipt of referral.
• Patients should be booked directly into the diagnostic service for an initial appointment and follow-up appointment for the results on the same day with a named consultant.

2.2 Operation of the neck lump diagnostic service

2.2.1 General considerations

• The service should be jointly operated between haematology and head and neck. It is at the discretion of the Trust as to which service has overall responsibility.
• The service should have, at a minimum, physical presence of a:
  – haematologist
  – head and neck surgeon (either ENT or maxillofacial surgeon)
  – consultant radiologist
  – consultant cytopathologist
  – clinical nurse specialist (CNS)
  – biomedical scientist (cytology)
  – administrative support

• Local demand and capacity analysis should determine the number of slots designated for the service. This analysis should also determine the new to follow-up ratio of slots.
• The service should be held weekly, or more frequently, to accommodate patients within a timely manner and to reduce the overall pathway from initiation of referral to diagnosis in line with the demand and capacity analysis allocating provision for growth over time.
• There should be cross cover arrangements in place to ensure that the service is able to run each week for an entire calendar year.
• Local practice will dictate whether thyroid lumps are part of this service or a separate thyroid lump service runs parallel based on current practice at each individual institution.

2.2.2 Available specialists and roles

• All of the following specialists should be available and cover should be sought in the event of a known absence. The initial triaging of patients could be undertaken by any of the consultant specialists below and this will depend on local set up.
  – Haematology consultant to:
    • establish the history and undertake appropriate examination as well as plan appropriate further investigations should the neck lump diagnostic service investigations suggest a haemato-lymphoid diagnosis.
Head and neck consultant to:

- establish the history and undertake appropriate upper airway examination as well as plan appropriate further investigations should the neck lump diagnostic service investigations suggest a head and neck malignancy.
- carry out upper airway examination

Radiologist to carry out:

- ultrasound
- FNA
- ultrasound guided biopsy
- core biopsy
- same session reporting
- navigation of patients onto correct pathway for next investigation within the service (agreement must be reached who will be responsible within each service either the radiologist or the cytologist, not both, to prevent patients falling through the gaps)
- planning of appropriate next radiological investigation and have a number of CT slots available during the session
- referral of patient to appropriate MDT

Cytopathologist to undertake:

- FNA
- flow cytometry, immunohistochemical analysis and P16 determination as appropriate
- same session reporting
- organisation of appropriate further pathology testing as indicated by on site assessment
- Navigation of patients onto correct pathway for next investigation within the service (agreement must be reached who will be responsible with each service either the radiologist or the cytologist, not both, to prevent patients falling through the gaps)
- referral of patient to appropriate MDT

CNS – head and neck CNS (with access to haematology CNS when appropriate) to:

- support breaking bad news conversations
- act as point of contact for patient
- review results prior to clinic to expedite appointments/further investigations

Administrative support to:

- be responsible for booking further appointments for the patient
- be responsible for written communication to be sent to the patient regarding future appointments
- support navigation of patients onto correct pathway (with appropriate clinical oversight)

### 2.2.3 Service set-up

This will be a virtual ‘joint service,’ run either from the ultrasound department with direct access to the haematology and head and neck clinic running in parallel or directly as part of an outpatient clinic. The expectation is that this will be a ‘one stop’ minimally invasive diagnostic service. There must be close
geographic availability of the cytology lab/room. The exact set up will vary depending on local factors however the following should be considered in the development of this service.

- The cytologist and radiologist should be co-located, with the patient, to maximise diagnostic yield and accuracy.
- There should be one clinical examination room large enough to host all the relevant professionals with the patient, their carer, interpreter, family member etc.
- There should be one room to undertake invasive procedures in an aseptic environment (following local infection control policy).
- There should be one room for palpable FNA/microscopy/staining of the FNA material.

Considering experience from large centres, it is preferable that there is co-location of the radiologist and the cytopathologist as this generates the lowest non-diagnostic rate/repeat procedure rate, facilitates communication, significantly reduces error and promotes best patient experience.

### 2.2.4 Initial assessment

All patients will require an initial examination to confirm the presence of a palpable lump. All patients will then go on to have a history taken and an upper airway examination. It is expected that the minimum intervention for each patient will be:

- history taking
- clinical examination/presence of a palpable lump confirmed

This may have already taken place locally prior to referral into the Trust with the neck lump diagnostic service by the unit hospital and should form the basis of the referral and will therefore not need to be repeated.

### 2.2.5 Diagnostic tests on same day

Once the presence of a palpable lump has been confirmed and the need for an ultrasound/FNA has been confirmed the patient should then progress directly to an ultrasound/FNA of the lump. The neck lump service team should then ensure that the patient undertakes any combination of the investigations below within the same visit (excluding contraindications for any test combinations) to establish a tissue diagnosis.

- The following diagnostic tests should all be available on the day of the clinic:
  - examination of upper airway tract (UAT)
  - FNA and cytology (see cytopathology / histopathology considerations Appendix 3)
  - ultrasound
  - core biopsy (see cytopathology/histopathology considerations Appendix 3)
  - facilities for ancillary testing including microbiologic tests, flow cytometry, cell block preparation for immunohistochemistry, fluorescence in situ hybridisation (FISH) and molecular studies (see cytopathology/histopathology considerations Appendix 3)

### 2.2.6 Follow-up diagnostic tests

On examination of the original findings the patient should be booked in for the necessary follow-up investigations as directed by the neck lump service team. Ideally these tests should be available on the
same day where practicable or within a maximum of 7 days of the neck lump service visit. As a minimum the team will need to have access to/be able to book patients for:

- Excision biopsy. An identified purpose of this service is to explicitly speed up the pathway to excision biopsy, including listing the patient for excision biopsy directly from the diagnostic appointment, where appropriate.
- Examination under anaesthetic (EUA) – panendoscopy and biopsies
- Cross sectional imaging (CT/PET/MRI scan)

These investigations should be booked prior to the patient leaving the diagnostic service.

2.2.7 Discharge

As is consistent with the rest of the service, the patient should be managed by a single named clinician (usually the haematology or head and neck consultant) who is also responsible for discharging the patient, and informing the GP or original referring clinician of this decision.

If the patient is referred between specialties for further investigations prior to decision to discharge the consultant who orders the extra investigations will be responsible for discharging the patient on receipt of the results, i.e. if a patient is seen originally under head and neck and is then referred to haematology for further investigations the haematology consultant would be responsible for discharging the patient on receipt of results.

In the event that the referral has originated from a direct access ultrasound clinic the named clinician should inform the GP of the outcome of the investigations and notify them of discharge from the service.

The patient should receive a copy of the correspondence relating to their discharge.

For those patients who require onward referral see section 2.3.

2.2.8 Disclosure of results for high likelihood of cancer

- At the earliest possible opportunity, without causing unnecessary alarm, it should be communicated to the patient if the results show there is a high probability of cancer.
- Any patient who requires follow-up should follow the procedure outline in section 2.3.
- The patients should be booked for all further tumour specific investigations prior to follow-up attendance with results (see sections 2.3.3-2.3.5).

2.3 Onward referral from the service

2.3.1 General considerations

The responsibility for the patient should ideally be taken by a single named clinician. If the responsibility is shared between the consultants running the neck lump service, the service navigator should monitor the patient’s results and be responsible for managing onward referrals. Most onward cancer referrals will be to head and neck or haematology-oncology who are present in the clinic although haematology-oncology

3 Please note it is advised for lymphoma diagnosis, excision biopsy of a superficial lymph node (cervical, axillary or inguinal) is preferable to a needle core biopsy. Local agreement and reflected in the latest NICE guidance (NG47) Haematological cancers: improving outcomes May 2016
patients may be referred back to their local provider for treatment depending on local agreements and patient choice.

2.3.2 Review of test results and next steps

If the patient requires further tests to confirm or rule-out a cancer diagnosis, the tests should be booked immediately by the neck lump service administrator and communicated to the patient as soon as possible, ideally before leaving their initial assessment appointment. In the event that a test is booked after the patient has left they should be telephoned to inform them of the time and date.

If a patient has a confirmed cancer diagnosis, sections 2.3.3-2.3.5 should be followed.

- If the patient does not have a cancer diagnosis but requires referral to another specialty, a referral letter from the neck lump service consultant responsible for the patient should be sent to the original referrer to manage the patient further or, where appropriate, directly to the relevant speciality. Local agreement will dictate the flow of these referrals.

If the patient does not require further follow-up section 2.2.7 should be followed.

2.3.3 Patient diagnosed with head and neck malignancy

It is expected that the head and neck consultant, from within the Neck Lump Service Team will inform the patient of their diagnosis and is responsible for booking onward diagnostic investigations. The following diagnostic tests need to be available to the consultant as a minimum:

- CT of head and chest
- PET
- Panendoscopy

2.3.4 Patient diagnosed with haematology malignancy

It is expected that the consultant haematologist, from within the Neck Lump Service Team, will inform the patient of their diagnosis and is responsible for booking onward diagnostic investigations. The following diagnostic tests need to be available to the consultant as a minimum:

- CT
- PET
- Blood count
- Excision biopsy/core biopsy

All relevant tests should be completed within 2 weeks of diagnosis/lump service appointment at which point the patient should be given an opportunity to discuss treatment options with their specialist.

2.3.5 Patient has a confirmed other cancer diagnosis or cancer of unknown primary

The patient should be referred to the relevant specialist MDT and will follow either the tumour specific pathway indicated for that tumour type or the cancer of unknown primary pathway under local policy (http://www.londoncanceralliance.nhs.uk/media/116285/lca_cup_group_oppolicy_nov2015final.pdf). It is recommended that discussion should take place with the relevant specialty to arrange booking of patients for any specific investigations prior to MDT to avoid any delay in treatment.
The team in the neck lump service will take on the responsibility for referring the patient to the most appropriate specialty and will inform the patient of the next steps and who they are being referred to. Patients will then follow local policy and standard pathway as per the particular specialty.

The patient receives a confirmed diagnosis in an appropriate setting with the appropriate specialist team. This should follow all breaking bad news guidance and there should be the presence of a CNS (tumour specific cancer nurse) or the patient should be able to see the relevant tumour specific CNS on the same day.

### 2.3.6 Confirmed other diagnosis, i.e. TB

The team in the neck lump service will take on the responsibility for referring the patient to the most appropriate specialty and will inform the patient of the next steps and who they are being referred to.

The team in the neck lump service will inform the patient’s GP of the next steps for the patient.

Patients will then follow local policy and standard pathway as per the particular specialty.

### 2.3.7 Inconclusive result

In the event that the results are inconclusive the patient will be followed up by the head and neck team for further investigation.

### 2.3.8 No presence of cancer or disease

In the event that the results show no presence of a confirmed cancer or further disease the patient should be discharged as per section 2.2.7.
3 Service Standards

All Rapid Diagnostic Neck Lump Services across the LCA must meet the following minimum criteria:

1. The neck lump service must be accessible to internal and external referrals for patients with a palpable neck lump where there is a suspicion of cancer.
2. The following specialists must be available on the day of the neck lump service:
   - haematologist
   - head and neck surgeon
   - consultant radiologist
   - CNS
   - consultant cytopathologist
   - biomedical scientist
   - administrative support
3. The following diagnostic tests must be available on the day of the service:
   - examination of UAT
   - FNA and cytology
   - ultrasound
   - core biopsy
   - flow cytometry
   - CT (optimal standard to be available on the day but at the very least the patients should be booked into a slot before leaving clinic)
   - blood test
4. Results of the following tests should be available on the same day and disclosed to the patient if a diagnosis is confirmed or there is a high suspicion of a diagnosis:
   - examination of UAT
   - FNA and cytology
   - ultrasound
   - CT (if available on the same day)
   - blood test
5. In the event that a core biopsy is inconclusive, the patient must be brought back to the clinic to see a consultant to confirm and list the patient for an excision biopsy if required. An excision biopsy should be performed within 7 days from decision to undertake excision biopsy.
6. Patients who have a confirmed cancer diagnosis made post clinic must be referred to the specialist MDT responsible and the patient informed of the onward referral.
7. The service must have an admin/navigator position responsible for coordinating and being the focal point of contact for incoming and onward referrals, and patient queries.

Prior to their attendance, patients should be given adequate information regarding expectations of the clinic through either verbal or written communication.

4 See quality metrics below for aspirational targets (section 4)
### Quality Metrics (in development)

<table>
<thead>
<tr>
<th>Metric</th>
<th>Why</th>
<th>Target</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>62 day performance for haematology patients referred under a head and neck 2ww</td>
<td>To understand the overall effectiveness and timeliness of the new neck lump pathway as a representation of all patients regardless of referral route.</td>
<td>85%</td>
<td>Cancer Waiting Times</td>
</tr>
<tr>
<td>62 day performance for head and neck patients referred under a haematology 2ww</td>
<td>To understand the overall effectiveness and timeliness of the new neck lump pathway as a representation of all patients regardless of referral route.</td>
<td>85%</td>
<td>Cancer Waiting Times</td>
</tr>
<tr>
<td>Length of time from initial 2ww referral to first MDT discussion should be within 3 weeks</td>
<td>Will provide an indication of the timeliness of the pathway as it is expected that the patient will have a diagnosis and treatment options discussed within 3 weeks</td>
<td>tbc</td>
<td>Cancer Outcomes Services Dataset/Cancer Waiting Times</td>
</tr>
<tr>
<td>Dates of investigations for:</td>
<td>Will provide an indication that a one stop clinic contains access to all diagnostics and they are being performed on the same day.</td>
<td>tbc</td>
<td>Cancer Outcomes Services Dataset</td>
</tr>
<tr>
<td>- Ultrasound</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- FNA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Other investigations Whether being performed on same day.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral to the neck lump service and time patient is seen is no more than 7 days</td>
<td>Will provide an indication that these patients are being prioritised and have immediate access to the service.</td>
<td>tbc</td>
<td>Local audit/outpatient activity data</td>
</tr>
<tr>
<td>Time between first patient appointment at neck lump service and second should be no more than 7 days</td>
<td>Will provide an indication of the timeliness of the reporting for diagnostics and the efficiency of the pathway</td>
<td>tbc</td>
<td>Local audit/outpatient activity data</td>
</tr>
<tr>
<td>Time between decision to excision biopsy and actual procedure should be no more than 7 days</td>
<td>Will provide an indication of the timeliness of the booking of excision biopsy directly from the clinic and to prevent delays in hand off between the two specialties</td>
<td>tbc</td>
<td>Local audit/outpatient activity data</td>
</tr>
<tr>
<td>Turnaround for reporting of FNA, cytometry, immunochemistry, flow cytometry and biopsy samples to be:</td>
<td>Will provide an indication of how quickly results can be reported to be able to give patients a confirmed diagnosis within a week of investigation</td>
<td>tbc</td>
<td>Cancer Outcomes Services Dataset/Local audit</td>
</tr>
<tr>
<td>- % available same day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- % available within 48 hours</td>
<td></td>
<td></td>
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<tr>
<td>- 100% within 96 hours</td>
<td></td>
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</tr>
<tr>
<td>Audit against the 8 Service Standards</td>
<td>This metric is to allow trusts to self assess their progress in implementing the neck lump service using the 8 key Service Standards.</td>
<td>tbc</td>
<td>Local audit</td>
</tr>
</tbody>
</table>
Appendix 1: Pan-London Suspected Haematological Cancer 2 Week Wait Referral Form EXAMPLE

This is an example of the new 2016 pan-London suspected haematological cancer referral form, which can be found at: https://www.myhealth.london.nhs.uk/healthy-london/cancer/pan-london-suspected-cancer-referrals.

<table>
<thead>
<tr>
<th>DOB:</th>
<th>NHS no:</th>
</tr>
</thead>
</table>

**PAN-LONDON SUSPECTED HAEMATOLOGICAL CANCER REFERRAL FORM**

Press the <Ctrl> key while you click here to view Pan London Suspected Cancer Referral Guide

| REFERRAL DATE: |

Please email or send e-referral within 24 hours.

Fax is no longer supported due to patient safety and confidentiality risks.

Press the <Ctrl> key while you click here to view the list of hospitals you can refer to.

Copy the hospital details from the webpage and paste them onto the line below.

<table>
<thead>
<tr>
<th>PATIENT DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surname:</td>
</tr>
<tr>
<td>Gender:</td>
</tr>
<tr>
<td>Ethnicity:</td>
</tr>
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</table>

☐ Interpreter required
☐ Transport required

<table>
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**DAYTIME CONTACT:**

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<th>Work?:</th>
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**CARER/KEY WORKER DETAILS**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Contact?:</th>
<th>Relationship to patient:</th>
</tr>
</thead>
</table>

**COGNITIVE, SENSORY OR MOBILITY IMPAIRMENT**

☐ Cognitive
☐ Sensory
☐ Mobility
☐ Disabled access required

Please include relevant details:

**SAFEGUARDING**

☐ Safeguarding concerns

Please include relevant details:

<table>
<thead>
<tr>
<th>GP DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Usual GP name:</td>
</tr>
<tr>
<td>Practice name:</td>
</tr>
<tr>
<td>Practice address:</td>
</tr>
<tr>
<td>Bypass?:</td>
</tr>
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</table>

<table>
<thead>
<tr>
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<th>Fax:</th>
<th>Email:</th>
</tr>
</thead>
</table>

Referring clinician:

Pan London Suspected Haematological Cancer Referral Form

(Version: Pan London changes MSW v1.0; 12/04/2016)
The following should be referred IMMEDIATELY as an emergency
- Children and young people with unexplained hepatosplenomegaly, lymphadenopathy or petechiae.
- Blood count/film suggesting acute leukaemia
- Spinal cord compression from a possible malignancy
- Renal failure suspicious of myeloma

**REASON FOR SUSPECTED CANCER REFERRAL**
Press the <Ctrl> key while you click here to view Pan London Suspected Haematological Cancer Referral Guide

### LEUKAEMIA
- Abnormal FULL BLOOD COUNT / BLOOD FILM suggestive of leukaemia
- Unexplained persistent or recurrent infections
- Unexplained bruising, bleeding or petechiae

### MYELOMA
- Protein electrophoresis suggestive of myeloma (reports attached)
- Urine Bence-Jones proteins suggestive of myeloma
- Unexplained fracture
- ≥ 6 weeks of bone pain
- Back pain with ‘red flag’ symptoms

### LYMPHOMA
- Unexplained lymphadenopathy
- Persistent lymphadenopathy ≥ 6 weeks; lymph nodes ≥ 2cm or increasing in size
  - Location of enlarged lymph nodes: Neck, Groin, Axilla
- Unexplained splenomegaly
- Associated symptoms (fever, night sweats, shortness of breath, pruritus or weight loss)

Referral is due to CLINICAL CONCERNS that do not meet NICE/pan-London referral criteria (the GP MUST give full clinical details in the ‘additional clinical information’ box at time of referral)

**Additional clinical information:**

**Personal/relevant patient information:**

**Past history of cancer:**

**Relevant family history of cancer:**
DOB: NHS no:

- I have discussed the possible diagnosis of cancer with the patient
- The patient has been advised and confirmed they will be available for an appointment within the next two weeks
- I have counselled the patient regarding the referral process and offered the pan-London information leaflet. Offering written patient information increases patient experience and reduces non-attendance. These are available in 11 different languages.
- Press the <Ctrl> key while you click here to view the leaflet
- This patient has been added to the practice suspected cancer safety-netting system
  - Press the <Ctrl> key while you click here to view Pan London Practice-based Suspected Cancer Safety Netting System

INVESTIGATIONS
Please ensure this referral includes ALL the relevant investigations including blood tests and imaging. If there are any pending test results that you have organised at the time of this referral please provide information including TYPE OF INVESTIGATION requested (bloods, imaging) and TRUST performing the tests in the box below.

CLINICALLY-SPECIFIC AUTOMATIC TABULATED DATA
Please state hospital laboratory where blood tests below were performed:

<table>
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<tr>
<th>IMAGING STUDIES (in past 3 months)</th>
<th>Please include date: ___ and location: ___</th>
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<tr>
<td>FBC (most recent recorded in past 3 months)</td>
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<td>CRP (most recent recorded in past 3 months)</td>
<td></td>
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<tr>
<td>RENAL FUNCTION (most recent recorded in past 3 months)</td>
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<tr>
<td>LFT (most recent recorded in past 3 months)</td>
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<tr>
<td>BONE PROFILE (most recent recorded in past 3 months)</td>
<td></td>
</tr>
<tr>
<td>SERUM PROTEIN ELECTROPHORESIS (most recent recorded in past 3 months)</td>
<td></td>
</tr>
<tr>
<td><strong>DOB:</strong></td>
<td><strong>NHS no:</strong></td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
</tr>
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</table>

**URINARY BENCE JONES PROTEIN (most recent recorded in past 3 months)**

---

**ROUTINE AUTOMATIC TABULATED DATA**

**MEDICAL HISTORY**

**ALLERGIES**

**MEDICATION**

**OFFICE USE ONLY**
Appendix 2: Pan-London Suspected Head and Neck Cancer 2 Week Wait Referral Form EXAMPLE

This is an example of the new 2016 pan-London suspected head and neck cancer referral form, which can be found at: https://www.myhealth.london.nhs.uk/healthy-london/cancer/pan-london-suspected-cancer-referrals

<table>
<thead>
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</table>

<table>
<thead>
<tr>
<th>CARER/KEY WORKER DETAILS</th>
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</thead>
<tbody>
<tr>
<td>NAME:</td>
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<td>CONTACT ®:</td>
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<td>RELATIONSHIP TO PATIENT:</td>
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<table>
<thead>
<tr>
<th>COGNITIVE, SENSORY OR MOBILITY IMPAIRMENT</th>
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<td>MOBILITY:</td>
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<td>PLEASE INCLUDE RELEVANT DETAILS:</td>
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<table>
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<td>SAFEGUARDING CONCERNS:</td>
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<tr>
<td>PLEASE INCLUDE RELEVANT DETAILS:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GP DETAILS</th>
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</thead>
<tbody>
<tr>
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<td>PRACTICE NAME:</td>
</tr>
<tr>
<td>PRACTICE CODE:</td>
</tr>
<tr>
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<tr>
<td>FAX:</td>
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<tr>
<td>EMAIL:</td>
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<tr>
<td>REFERRING CLINICIAN:</td>
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</table>

Pan London Suspected HEAD AND NECK Cancer Referral Form
(Version: Pan London changes MSW v1.0; 12/04/2016)
### CANCER TYPE SUSPECTED

<table>
<thead>
<tr>
<th></th>
<th>LARYNGEAL/PHARYNGEAL</th>
<th>EAR/NOSE/SINUS</th>
<th>THYROID</th>
<th>ORAL/LIP</th>
<th>SALIVARY</th>
</tr>
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<tbody>
<tr>
<td>Current smoker</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ex-smoker</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral tobacco use</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol history</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>HPV</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous irradiation to head and neck</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family history of thyroid cancer</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### CLINICAL RISK FACTORS

- Current smoker  Pack year [insert number [ ]]
- Ex-smoker
- Oral tobacco use
- Alcohol history
- HPV
- HIV
- Previous irradiation to head and neck
- Family history of thyroid cancer

### REASON FOR SUSPECTED CANCER REFERRAL

Press the <Ctrl> key while you click here to view Pan London Suspected Head and Neck Cancer Referral Guide

#### LARYNGEAL/PHARYNGEAL CANCER

Concurrent chest X-ray at time of referral for symptoms including hoarseness and unexplained neck lump to exclude lung/haematological cancer/infectious diseases

- ≥ 40 years old with persistent unexplained hoarseness (≥ 3 weeks)
- Lump/mass in the neck with suspicious clinical features
- ≥ 4 weeks of persistent, particularly unilateral, discomfort in the throat or throat pain
- ≥ 40 years old with ≥ 3 weeks of dysphagia
- ≥ 40 years old with ≥ 3 weeks of odynophagia
- ≥ 40 years old with ≥ 3 weeks of otalgia

#### EAR/NOSE/SINUS CANCER

- Persistent unilateral otalgia
- Unilateral tinnitus
- Serosanguinous nasal discharge which persists for more than three weeks
- Unilateral nasal obstruction associated with a purulent discharge
- Facial palsy/cranial neuropathies
- Orbital masses
- Severe facial pain

#### THYROID CANCER

- Unexplained solitary thyroid lump
- Ultrasound suggestive of a thyroid cancer
<table>
<thead>
<tr>
<th>ORAL/LIP</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>✗ ≥ 3 weeks unexplained ulceration in the oral cavity</td>
<td>✗ Suspicious lump/mass on the lip or in the oral cavity</td>
</tr>
<tr>
<td>✗ A red or red and white patch in the oral cavity suggestive of leukoplakia or erythroplakia</td>
<td>✗ Tooth mobility not associated with periodontal disease</td>
</tr>
<tr>
<td>✗ Poor healing ≥ 3 weeks post tooth extraction</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SALIVARY CANCER</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>✗ ≥ 40 years old with unexplained or persistent parotid or submandibular swelling</td>
<td>✗ Firm sub-mucosal swelling in the oral cavity</td>
</tr>
<tr>
<td>✗ Referral is due to CLINICAL CONCERNS that do not meet NICE/pan-London referral criteria (the GP/GDP MUST give full clinical details in the ‘additional clinical information’ box at time of referral)</td>
<td></td>
</tr>
</tbody>
</table>

**Additional clinical information:**

- **Personal/relevant patient information:**
- **Past history of cancer:**
- **Relevant family history of cancer:**

- **I have discussed the possible diagnosis of cancer with the patient**
- **The patient has been advised and confirmed they will be available for an appointment within the next two weeks**
- **I have counselled the patient regarding the referral process and offered the pan-London information leaflet. Offering written patient information increases patient experience and reduces non-attendance. These are available in 11 different languages.**

  Press the <Ctrl> key while you click here to view the leaflet

- **This patient has been added to the practice suspected cancer safety-netting system**

  Press the <Ctrl> key while you click here to view Pan London Practice-based Suspected Cancer Safety Netting System

<table>
<thead>
<tr>
<th>INVESTIGATIONS</th>
<th></th>
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<tbody>
<tr>
<td>Please ensure this referral includes ALL the relevant investigations including blood tests and imaging. If there are any pending test results that you have organised at the time of this referral please provide information including TYPE OF INVESTIGATION requested (bloods, imaging) and TRUST performing the tests in the box below.</td>
<td></td>
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<th>CLINICALLY-SPECIFIC AUTOMATIC TABULATED DATA</th>
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</tr>
<tr>
<td>THYROID FUNCTION (most recent recorded in past 3 months)</td>
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Pan London Suspected HEAD AND NECK Cancer Referral Form
(Version: Pan London changes MSW v1.0; 12/04/2016)
DOB: NHS no:

FULL BLOOD COUNT (most recent recorded in past 3 months)

ROUTINE AUTOMATIC TABULATED DATA
MEDICAL HISTORY

ALLERGIES

MEDICATION

OFFICE USE ONLY
Appendix 3: Cytopathology/Histopathology Considerations

- Following rapid on-site evaluation (ROSE), a diagnosis will be apparent in the vast majority of patients at the end of the procedure.
- Appropriate additional material should be collected for ancillary testing as dictated by ROSE and those laboratory tests should be ordered during the same visit.
- It is advised for lymphoma diagnosis, excision biopsy of a superficial lymph node (cervical, axillary or inguinal) is preferable to a needle core biopsy.

Where a core biopsy is indicated:

- Consideration should be given to the scheduling of the clinic such that the appropriate clinician (usually the radiologist) has the time to perform a core biopsy during the same clinic visit.
- For suspected lymphoma patients, there should be an established pathway to refer the core biopsy directly to a Haematopathologist. This would ensure time and material is not wasted by the sample going to a non-specialist Histopathologist.
- A local protocol should be in place between the neck lump service team, the Haematopathology team & the Haemato-oncology team regarding the number of core biopsies needed for lymphoma diagnostic purposes, molecular testing and subsequent enrolment in trials. In most centres, three 16 gauge core biopsies would be considered sufficient for all purposes.
- It is expected that there will be local established protocols within the relevant histopathology departments which stipulate that core biopsies for lymphoma diagnostics should each be embedded in a separate block.
Appendix 4: Exemplar Pathway – Flow of Patient Journey with Expected Timelines

Referral Route in to Neck Lump Clinic

**Available human resource:**
- Haematologist
- Head and neck surgeon
- Consultant Radiologist
- CNS
- Consultant Cytopathologist
- Biomedical scientist
- Administrative support

This service can be either a dedicated neck lump clinic* or a one stop service that runs concurrently between the two specialties**

**Same Day access to:**
- UAT examination
- FNA and Cytology
- Ultrasound
- Core biopsy
- Flow cytometry
- CT (gold standard for same day but at least a slot booked)
- Blood tests

*Haematological cancer pathway
**Head and neck cancer pathway
†Other cancer diagnosis (follow local pathways)
‡Non cancer diagnosis (refer to appropriate specialist)
§No diagnosis (D/C back to GP)

Cancer diagnosis <29 days (if on a 2ww pathway)
Appendix 5: Patient Information Leaflet

Where is the Neck Lump Service?
Address
X clinic room
Y wing
Z floor, abc hospital, postcode

When is it open?
Clinic times are every x days between xam – ypm
Indicate if patient will be given a specific time to attend.
Indicate how long the patient should expect to be in the clinic for (i.e. please allow 4 hours for your appointment)

When you arrive, please check in at the clinic reception. The receptionist will welcome you and may ask you to stay in the reception area until you are called. You also book any follow-up appointments here at reception.

We make every effort to keep your appointment time. But sometimes other patients need more time than we planned. We will tell you if there are any delays.

Can I bring a relative or a friend with me?
You are welcome to bring family members, carers and friends with you.

Do I need to prepare for the appointment?
Please eat and drink as normal before coming to the clinic. Bring with you your completed medical history questionnaire, any information about your health needs or allergies, and a list of the medications you are currently taking.

Can I get transport to the hospital?
Please insert local protocol/contact details here

Will I need to go elsewhere for treatment?
Please insert local protocol or referral pathways here

Please consider how the patient will be notified with their results/need for follow-up appointments

Neck Lump Service
A guide for patients and carers

© London Cancer Alliance 2016
LCA Neck Lump Service Patient Information
Review date: June 2017
This leaflet explains what to expect when you visit the neck lump service. You will be seen in a safe and reassuring environment by members of our friendly team who will care for and support you during your time with us.

**Who is in the team?**

Our team is multidisciplinary, which means it is made up of a number of specialist doctors and nurses as well as support staff. It includes:

- Consultant maxillofacial surgeons who diagnose and treat diseases affecting your mouth, jaws, face and neck
- Consultant haematologists who diagnose and treat diseases affecting your blood and blood-forming organs
- Consultant pathologists who examine tissue samples and cells to make diagnosis
- Consultant radiologists who use imaging investigations such as x-rays to diagnose, treat and monitor various diseases
- Clinical nurse specialists (CNSs)
- Administrative staff

Everyone in our team is experienced and caring. You can talk to us about any queries and concerns you may have. We will respect your care choices and support you during your treatment.

Please ask one of our team for more detailed information about your illness or treatment.

---

**Contact details for the service with named person if possible (navigator/CNS/administrator)**

---

**What conditions does the clinic treat?**

We treat many conditions that cause neck lumps. You may be worried that the cause is serious, so we aim to make the diagnosis as quickly as possible and, if you need it, start you on the correct treatment straight away.

Because we have the whole specialist team in the clinic, we are often able to examine you and make a diagnosis in the same morning/afternoon.

**What happens at the clinic?**

You will be examined and have tests and investigations to find the cause of your lump. This enables us to work out the best treatment for your condition.

Tests and investigations include:

- Review and assessments by doctors and nurses
- Biopsy and fine needle aspiration (FNA)
- X-rays
- Ultrasound scan
- CT or MRI scan
- Blood tests

---

**What is a biopsy?**

A biopsy involves having a small sample of tissue taken from the lump on your neck. This tissue can then be examined under a microscope to look for abnormal cells. Sometimes it is tested to look for abnormal chemicals, or for bacteria or other organisms.

**What is a fine needle aspiration (FNA)?**

This involves having a thin, hollow needle put into a lump under your skin to take samples of tissue or fluid. The samples are looked at under a microscope in the clinic and sent to a laboratory for more tests. You usually have an FNA to find out the type of cells inside a lump.

After an FNA or biopsy you may have a small dressing put on your neck lump. We will explain at your appointment how to take care of the dressing at home.

**Will the biopsy or FNA be painful?**

If you have a biopsy we will give you a local anaesthetic injection. This takes only a few minutes to work and numbs the area so you do not feel any pain during the procedure. The anaesthetic we use is the same as you have at your dentist.

During an FNA you may have some discomfort for a few seconds as the needle is put in. If it is painful, we will give you a local anaesthetic injection to numb the area.
Appendix 6: Minutes from Rapid Diagnostic Neck Lump Service Meeting

<table>
<thead>
<tr>
<th>Date</th>
<th>28th January 2016</th>
<th>Time</th>
<th>16:30-18:00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meeting Chair</td>
<td>Peter Clarke and Piers Patten</td>
<td>Location</td>
<td>LCA Boardroom</td>
</tr>
<tr>
<td>Attendees</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peter Clarke</td>
<td>Head and Neck Consultant Surgeon, Imperial and Royal Marsden Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Piers Patten</td>
<td>Consultant Haematologist, Kings College Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Edward Truelove</td>
<td>Consultant Haematologist, Croydon University Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Robert Marcus</td>
<td>Consultant Haematologist, Kings College Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amy Collinson</td>
<td>Max-Faxs CNS, Kings College Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>David Wrench</td>
<td>Consultant Haematologist, Guys and St Thomas’ Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mufaddal T. Moonim</td>
<td>Consultant Histopathologist, Guys and St Thomas’ Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michael Gilhooly</td>
<td>Consultant Oral/Maxillofacial Surgeon, London North West Hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gitta Madani</td>
<td>Consultant Radiologist, Imperial College</td>
<td></td>
<td></td>
</tr>
<tr>
<td>James Pilcher</td>
<td>Consultant Radiologist, St George’s Hospital</td>
<td></td>
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</tr>
<tr>
<td>Elizabeth Pegers</td>
<td>LCA Head and Neck Project Manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tim Bill</td>
<td>LCA Haematology Project Manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apologies</td>
<td>Nicholas Hyde</td>
<td>Consultant Maxillofacial Surgeon, St George’s Hospital</td>
<td></td>
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</tbody>
</table>

Notes and actions

<table>
<thead>
<tr>
<th>Agenda item</th>
<th>Notes and actions</th>
</tr>
</thead>
</table>
| 1 | Welcome and Introductions  
Peter Clarke welcomed everybody to the meeting and the attendees were introduced. It was agreed that there was good representation from all specialities and from across the LCA geography.  
The purpose of the meeting was communicated to the attendees. The group were made aware of the issues surrounding the diagnostic timelines for patients with a query cancer neck lump who present through various referral routes to secondary care. The meetings primary aim was to develop specifications for a rapid diagnostic service which aimed to reduce diagnostic timelines and improve patient experience for this cohort. |
<table>
<thead>
<tr>
<th>2</th>
<th><strong>SOP Review and Discussion</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A draft SOP for the proposed service had been circulated to the group prior to the meeting. The group reviewed the document and the following areas were discussed and agreed:</td>
</tr>
<tr>
<td></td>
<td>• Referral routes into the service. The group agreed that, referrals received at the site hosting a rapid diagnostic service would, where possible, be directed to the rapid access service. The referrals received in hospitals without the service would be seen by a clinician under a routine or urgent appointment before being referred directly to the service. Patients could also be referred from direct access u/s, inpatient beds, consultant to consultant and other MDTs.</td>
</tr>
<tr>
<td></td>
<td>• Where a non-cancer diagnosis was made by the rapid diagnostic service, it was agreed that the clinicians at the site with the service should open dialogue with the referring clinician to discuss the onward referral. This would decide whether the patient is followed up at the hospital with the rapid diagnostic service or whether they are referred back to the hospital who initiated referral. This would prevent patients being consumed by the lump service provider.</td>
</tr>
<tr>
<td></td>
<td>• The requirement for a haematologist was discussed as it may be necessary to operate the service through head and neck consultants only. It was agreed that the gold standard for the service should include a haematologist to ensure continued communication as well as a seamless transfer of pathways.</td>
</tr>
<tr>
<td></td>
<td>• The group agreed that a biomedical scientist should be added to the list of specialities needed on the day of the clinic to support the histopathologist.</td>
</tr>
<tr>
<td></td>
<td>• The group reviewed the tests that should be available on the day of the service and clarified that, whilst samples for flow cytometry can be taken on the day, the results would take longer to be returned and would have to be discussed with the patient at their next visit.</td>
</tr>
<tr>
<td></td>
<td>• A request was made to add in a section with regards to maintaining a database for patient’s appointments and for the purposes of audit.</td>
</tr>
<tr>
<td></td>
<td>• The group agreed that an admin support or dedicated navigator to support the new service would be essential in managing the flow of patients.</td>
</tr>
<tr>
<td></td>
<td>• The patient information element of the pathway was felt to be pivotal and it was essential that patients received adequate information, preparing them for a visit to the service. Kings shared their patient information leaflet given for their patients which can be adapted for other providers.</td>
</tr>
<tr>
<td></td>
<td>• A point was raised regarding likely inappropriate referrals received from direct u/s third party providers due to the quality of imaging/staff. The group agreed to specify that referrals can only be received via direct access u/s from NHS providers. It was also noted that there had been agreement from the Pan London Early Diagnosis group to allow direct access referrals to NHS providers to be forwarded onto the Neck Lump service without the need to refer back to the GP first. As long as the GP was informed, this was felt to be an essential time saving step.</td>
</tr>
</tbody>
</table>
All other sections of the SOP were agreed. Edits will be made based on the above feedback prior to sign off.

### 3 Quality Measures

The group reviewed the quality measures for the service and the following comments and additions were noted:

- The turnaround for flow cytometry results was discussed and it was agreed that test results should be reported in a maximum of 96 hours from sample collection.
- The group agreed to add a further metric regarding the time between the patients initial appointment at the service and their follow-up. It was expected that this should be within 7 days to ensure that the diagnostics were being performed as quickly as possible.

All other quality measures were agreed. Edits will be made to the final document based on the above feedback prior to sign off.

### 4 Implementation and Communication Strategy

The group briefly discussed the likely implementation of these services across the LCA. It was recommended that the services would be best placed at the head and neck centres throughout the LCA due to availability of clinical staff needed to operate the clinic. However, discussions would need to take place between providers to provide sufficient coverage for their network.

### 5 Next Steps and Sum-Up

The group agreed that the meeting had covered all pertinent aspects of the prospective service. Edits to the documentation discussed above will be made prior to circulation to the attendees and both haematology and head and neck pathway groups. Once all comments had been received, these would be signed off and circulated to MDT leads across the LCA.