Forty nine patients attended their appointments, meaning 78% of the time allocated was used; 
- Fourteen appointments were cancelled. Of the 22% of unused time, 21% of cancellations (three patients) were due to heavy snow during the data collection period; 
- Fifty seven per cent (eight patients) of cancellations were due to the patient’s condition deteriorating, meaning they required a home visit or admission to hospital. Most were new patients who deteriorated before being seen and not those needing review; 
- Twenty one per cent of unused time was due to the patient being well enough not to need a clinic visit (two patients) or transport problems (one patient).

**CNS referral rates**

As the main referrers to the clinic, the CNS team completed a 10 point questionnaire. This covered referral rates, how the clinic affected personal work flow, and the impact of the clinic on patients and the service.

Responses to the questionnaire revealed significant variation in the referral rates for individual CNSs during the audit period (Fig 1). While six CNSs carried out at least two referrals – one referring 11 patients – two had not referred any to the service. This signified the CNSs were not promoting the service by asking patients if they wanted to access the outpatient clinic. Only three CNSs consistently mentioned the clinic at triage.

Of the 63 referrals audited, only three were direct review referrals. The CNS role has traditionally been patient centred and close relationships are often formed between nurse and patient (Skilbeck and Payne, 2003). When asked about the value of another CNS seeing the patient, one of the team said it may be difficult for the patient to reconnect emotionally to a new CNS. However, since the profile of the clinic has been raised, CNSs have said that this is something they will consider in the future.

**Patient feedback**

The National Institute for Health and Clinical Excellence (2004) recommended that patients with cancer be given a choice of services offering support and be consulted about the development of these services. Twenty patients were asked to complete a satisfaction questionnaire:
- Fifteen responded, all of whom felt their expectations had been fulfilled and were happy to continue being seen in the clinic; 
- Forty seven per cent were happy to be seen either in the clinic or at home; 
- Thirty three per cent preferred to be seen at home; 
- Twenty per cent opted to be seen in clinic.

**Accessing other services**

Of the 15 patients who responded to the questionnaire, 12 said they wanted access to more than one service. Only two of the CNS team had tried to access more than one service when referring. Eight referrals had been done by the CNS running the clinic. She found it difficult to coordinate with other members of the MDT as many had full diaries or were off duty when the outpatient review was arranged. Some 16% of the total referrals made had been for two or more concurrent appointments, usually with the complementary therapy team or the patient and family welfare department.

**BACKGROUND**

- The end of life care strategy (Department of Health, 2008) recommends that all patients with palliative care needs should have access to rapid, specialist advice and clinical assessment.
- A hospice based nurse led outpatient clinic was set up in May 2008 to improve services for patients with cancer and palliative care needs.

The clinic is managed by a palliative care clinical nurse specialist who carries out clinical assessments, receives new patient referrals and reviews existing patients as part of a multidisciplinary team.

**DISCUSSION**

NICE (2004) suggested that many aspects of palliative care are applicable earlier in the disease trajectory and that many patients could benefit from referral at the point of diagnosis, not just towards the end of life. The Gold Standard Framework (www.goldstandardsframework.nhs.uk) says the preplanning of future care should be proactive in all care settings.

Seeing patients with low level needs in the clinic proved to be an ideal time to approach advanced care planning, enhancing coping strategies for both patient and carer. Husband (2008) cited Clark, who suggested seeing patients earlier in their cancer journey also allows for more emotional openness. Trust deepens, increasing the therapeutic value by touching on many aspects of the patient experience.

Bennett et al (2009), in discussing care of patients with motor neuron disease, said one of the reasons for setting up a hospice based, nurse led clinic for them was to encourage them to acknowledge palliative care as part of ongoing support, not just for the end of life. The National End of Life Care programme (www.endoflifecareforadults.nhs.uk) describes a community based nurse led palliative care clinic set up in Luton in 2006.

District nurses were initially concerned that a palliative care CNS seeing a patient earlier in the diagnosis would affect their own relationship with the patient. Inviting colleagues to sit in on the clinic assuaged these fears and the service saw a 30% increase in referrals. Patients said it gave them more choice over where they are seen.

Mack (2010) described a community palliative care nurse led clinic in Norfolk. Patients who attended the clinic described it as valuable, enabling them to be seen on their own with the CNS and by more than one member of the MDT. However, only 12% of the 79 patients suitable accepted the offer to visit the clinic – fragility, fatigue or transport problems being cited as reasons for refusing. The study also found patient expectation was a possible reason for low acceptance. Education for the nurse who is