

Significant Event Audit (SEA) of Cancer Diagnosis

Cancer SEA Template (2016)

CCG/Health Body name

How did you hear about
this project?

Cancer SEA library

We would like to retain your anonymised SEA in order to build a cancer SEA resource library. This will form a learning aid for other practices and be a resource for bona fide academic researchers. As your report will be anonymised at patient and practice level, would you be happy for your SEA to be included in this library?

Delete as appropriate: Yes/No

SIGNIFICANT EVENT AUDIT OF CANCER DIAGNOSIS

Advice on completing the template

The peer reviewers will be assessing your SEA for points of learning and on the depth of reflection and learning it demonstrates. They will consider your SEA technique and will provide constructive comment, if appropriate, on how it might be improved for future SEAs. Any shared information will be anonymised. The analysis will inform the basis of a learning event for GPs in your CCG/Health Body and will provide generic learning points to support early diagnosis of cancer.

An SEA done well is worth the effort for the benefits it can bring for you, your patients, and the practice as a whole. Describing and analysing a significant event is an important skill that will be scrutinised in your appraisal and revalidation. This pilot gives you and your practice colleagues an opportunity to develop this skill. Here are some tips based on the submissions we have received so far:

1. Choice of case is important:

Choose a case that requires significant reflection, and is likely to generate learning and change to practice. Good examples are a delayed diagnosis or a patient diagnosed after an emergency admission. Avoid cases that are unlikely to provoke new learning, such as a patient with a breast lump appropriately referred on first presentation. Only consider cases involving external problems (e.g. hospital delays) if the practice can demonstrate that, as a consequence of that case, it has been instrumental in attempts to remedy the external problem.

2. An effective SEA is a practice activity:

SEA is best done as a practice activity, perhaps in the course of a practice team meeting. It should specify who participated and who was responsible for actioning any changes. The SEA report should say whether all relevant individuals attended and whether the conclusions should be discussed with any other staff inside or outside the practice.

3. Action the actions:

An effective SEA not only identifies the learning points and actions to be taken but puts those changes into effect and monitors their impact. Specify who in the practice (staff member or groups) will be responsible for your action points and decide how their impact will be monitored.

4. An external reviewer can only assess what is written:

Try to address all the points suggested under each question, and any others you consider relevant. If you don't write key information down, the reviewer will assume that it was not considered or done.

Provide sufficient background to enable the external reviewer to understand what happened. It is best to provide details of all potentially relevant interactions with the patient for the year prior to diagnosis.

Please type your responses in this SEA template; read them through to check that the report reads as you would wish.

SIGNIFICANT EVENT AUDIT OF CANCER DIAGNOSIS

Cancer SEA Report Template

Diagnosis:	
Date of diagnosis:	
Age of patient at diagnosis:	
Sex of patient:	
Is the patient currently alive (Y/N):	
If deceased, please give date of death:	
Date of meeting when SEA discussed:	

N.B.: Please DO NOT include the patient's name in any narrative. Please anonymise the individual involved at each stage by referring to them as GP1, GP2, Nurse1, Nurse2, GP Reg1 etc.

1. WHAT HAPPENED?

Describe the process to diagnosis for this patient in detail, including dates of consultations, referral and diagnosis and the clinicians involved in that process. Consider for instance:

- The initial presentation and presenting symptoms (including where if outwith primary care).
- The key consultation at which the diagnosis was made.
- Consultations in the year prior to diagnosis and referral (how often the patient had been seen by the practice; for what reasons; the type of consultation held: telephone, in clinic etc; and who - GP1, GP2, Nurse 1 - saw them).
- Whether s/he had been seen by the Out of Hours service, at A&E, or in secondary care clinics.
- If there appears to be delay on the part of the patient in presenting with their symptoms.
- What the impact or potential impact of the event was.

2. WHY DID IT HAPPEN?

Reflect on the process of diagnosis for the patient. Consider for instance:

- If this was as good as it could have been (and if so, the factors that contributed to speedy and/or appropriate diagnosis in primary care).
- How often / over what time period the patient was seen before a referral was made (and the urgency of referral).
- Whether safety-netting / follow-up was used (and if so, whether this was appropriate).
- Whether there was any delay in diagnosis (and if so, the underlying factors that contributed to this).
- Whether appropriate diagnostic services were used (and whether there was adequate access to or availability of these, and whether the reason for any delay was acceptable or appropriate).

3. WHAT HAS BEEN LEARNED?

Demonstrate that reflection and learning have taken place, and that team members have been involved in considering the process of cancer diagnosis. Consider, for instance:

- Education and training needs around cancer diagnosis and/or referral.
- The need for protocols and/or specified procedures within the practice for cancer diagnosis and/or referral.
- The robustness of follow-up systems within in the practice.
- The importance and effectiveness of team working and communication (internally and with secondary care).
- The role of the NICE referral guidelines for suspected cancer, and their usefulness to primary care teams.
- Reference the literature, guidance and protocols that support your learning points
- Is the learning the same for all staff members or who does it apply to

Learning point 1:

Learning point 2:

Learning point 3:

Learning point 4:

4. WHAT HAS BEEN CHANGED?

Outline here the action(s) agreed and/or implemented and who will/has undertaken them.

Detail, for instance:

■ If a protocol is to be/has been introduced, updated or amended: how this will be/was done; which staff members or groups will be/were responsible (GPs, Nurses; GP Reg 1, GP2 etc); and how the related changes will be/have been monitored. ■ If there are things that individuals or the practice as a whole will do differently (detail the level at which changes are being/have been made and how are they being monitored). ■ What improvements will result/have resulted from the changes: will/have the improvements benefit(ed) diagnosis of a specific cancer group, or will/has their impact been broader. ■ Consider both clinical, administrative and cross-team working issues.

5. WHAT WAS THE IMPACT/POTENTIAL IMPACT ON THOSE INVOLVED?

Outline here the impact or potential impact on the patient, carer / family, GP and practice.

Consider, for instance:

■ How did the pathway to diagnosis impact on the patient and/or their family. Has the pathway to diagnosis affected the patient–GP (or practice) relationship, and in what way (positive or negative). ■ Has the pathway to diagnosis for this patient impacted on how individual GPs or the practice as a whole deal with other patients ■ What is the potential impact of any changes on the systems within the practice.

6. WHAT WAS EFFECTIVE ABOUT THIS SEA?

Consider how carrying out this SEA has been valuable to individuals, to the practice team and/or to patients. Detail for instance:

- Who attended and whether the relevant people were involved
- What format the meeting followed
- How long the meeting lasted
- What was effective about the SEA discussion and process
- What could have made the SEA more effective in terms of encouraging reflection, learning and action.

SOME INFORMATION ABOUT YOUR PRACTICE *

How many registered patients are there?							
How many F.T.E. GPs are there (inc. principals, salaried GPs, trainees etc.)?							
Is your practice a training practice?					Yes		No
Does your practice teach medical students					Yes		No
What were your QOF points last year?		Clinical		Quality and productivity		Total	
OUT OF:			610		100		900

* This information is useful when collating results across practices and/or localities