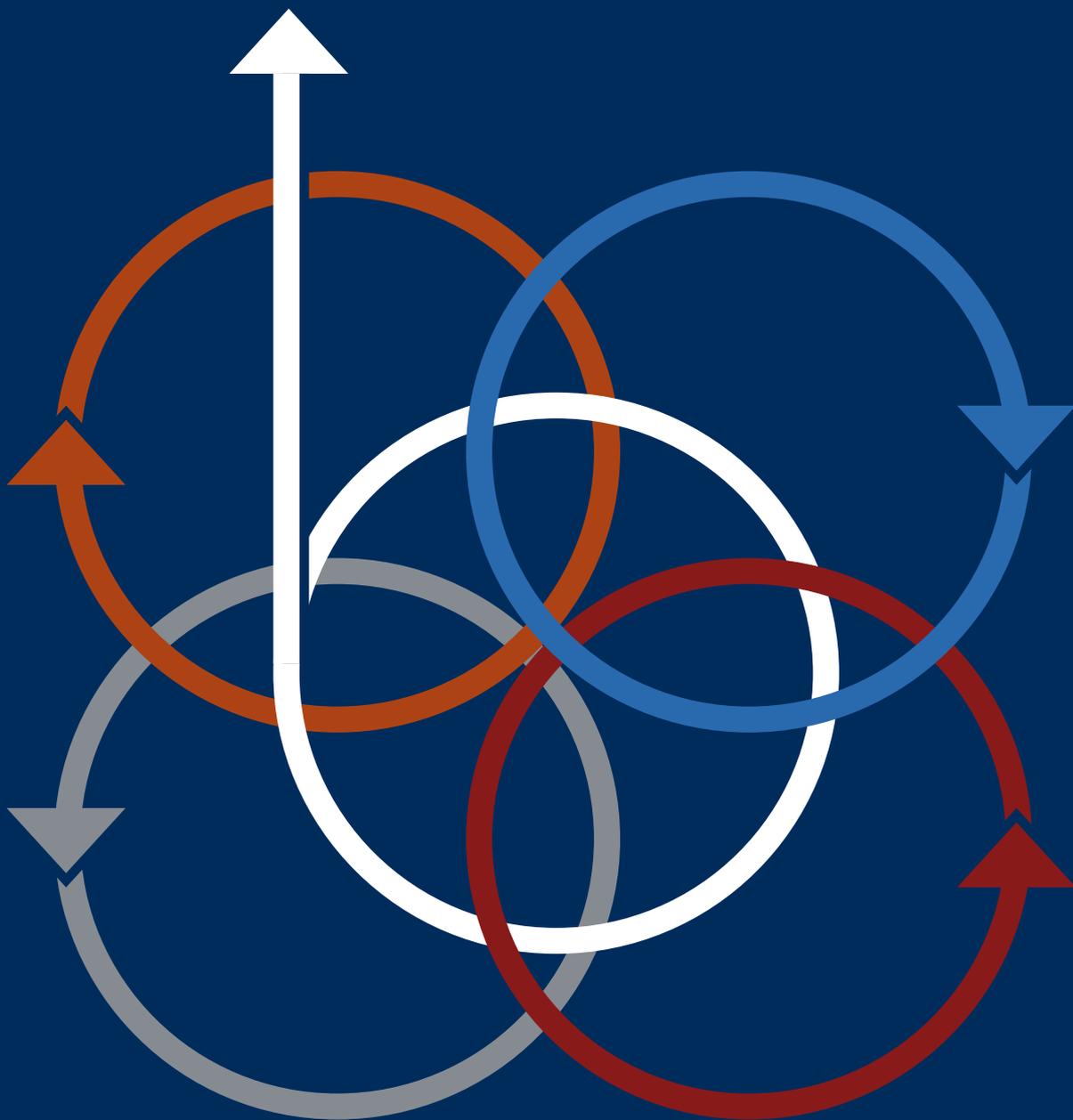


# Significant Event Analysis GP Guide Early Diagnosis of Cancer



The Royal College of General Practitioners was founded in 1952 with this object:

‘To encourage, foster and maintain the highest possible standards in general practice and for that purpose to take or join with others in taking steps consistent with the charitable nature of that object which may assist towards the same.’

Among its responsibilities under its Royal Charter the College is entitled to:

‘Diffuse information on all matters affecting general practice and issue such publications as may assist the object of the College.’

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Published by the Royal College of General Practitioners 2015  
30 Euston Square, London NW1 2FB

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# INTRODUCTION

## WHAT IS A CANCER SEA?

The Significant Event Analysis (SEA) is an approach to quality improvement that has become well-established in general practice and was first promoted 30 years ago. It involves a structured review of all that happened in relation to the event of interest, which may be adverse, exemplary or simply important. The requirements of the care quality commission, annual appraisal and revalidation for GPs are placing increasing emphasis on the quality of continuing professional development and evidencing reflective practice.

## WHY DO A CANCER SEA?

A Cancer SEA done well is worth the effort for the benefits it can bring for clinicians, patients, the practice as a whole and the primary-secondary care interface. Describing and analysing a significant event is an important skill that may be scrutinised at CQC inspections, appraisal and revalidation. Whilst Cancer SEAs are **not** a measure of performance management, the challenge for quality improvement work is to involve the practices that need it most. A CCG-wide Cancer SEA project may generate the 'nudge' across the board towards reflective thinking and quality improvement.

The Cancer SEA enhances the reflective process by prompting the clinician to deconstruct the journey to diagnosis and unpick themes that can lead to a range of improvements, such as modifying practice systems, improving documentation or proactive safety netting.

Whether clinical, administrative or organisational, the SEA process enables the following questions to be answered:

- What happened and why?
- What was the impact on those involved (patient, carer, family, GP, practice)?
- How could things have been different?
- What can we learn from what happened?
- What needs to change?

An account within a Cancer SEA should not allow patients to be identified and should also include:

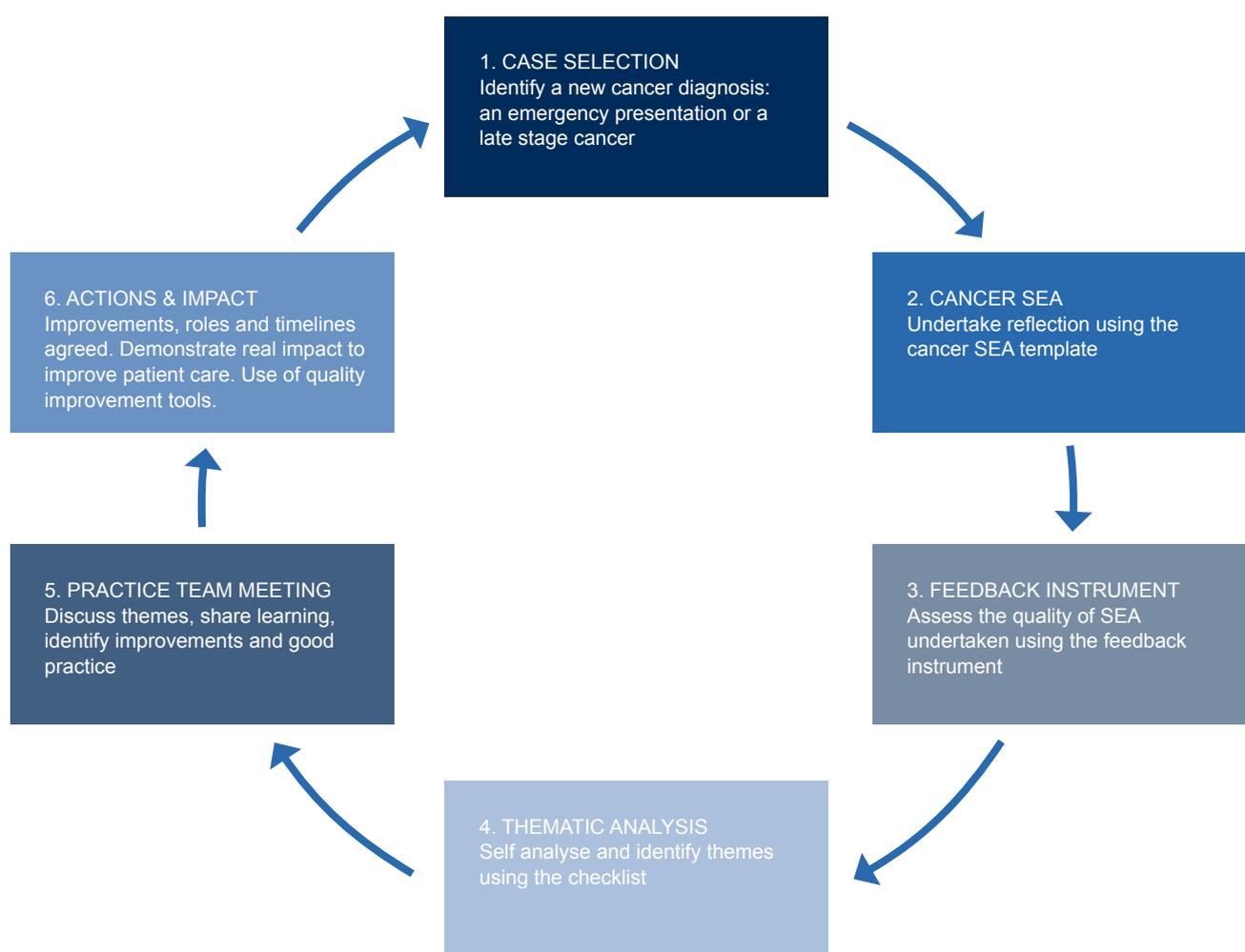
- Title and date of the SEA discussion and subsequent events
- Date the event was discussed and the roles of those present
- A description of the event involving the GP(s) and other colleagues
- Reflections on the event in terms of knowledge, skills and performance
- Consideration of safety and quality
- Thought to communication, partnership and teamwork
- Measures for maintaining trust
- Changes agreed for individuals and the practice team; roles; and agreed timelines for action(s)
- Record of changes carried out and their impact.

# PRACTICE APPROACH TO SEAS

A Cancer SEA is best done as a practice activity to be discussed and shared at a practice team meeting. It should specify who participated and who was responsible for implementing any changes. All practising GPs (including those working in single-handed surgeries, out-of-hours services, urgent care centres and GP locums), can discuss SEAs in service improvement meetings or other forums such as peer learning events or self-directed learning groups. Programme directors of vocational training schemes and GP trainers can arrange small group discussions at the half-day release. The Cancer SEA should document whether all relevant individuals

attended and whether the conclusions should be discussed with any other staff inside or outside the practice. An effective SEA not only identifies the learning points and actions to be taken, but also puts changes into effect and monitors their impact. A high quality Cancer SEA will specify the practice staff member or groups who will be responsible for the agreed action points, and it will decide how their impact will be monitored.

The flow chart below is a suggested process you may wish to set up in your practice.



## 1. CASE SELECTION

Case selection is important – it is recommended that the case requires significant reflection and is likely to generate learning or change to practice. Avoid cases that are unlikely to provoke new learning, such as a patient with a breast lump appropriately referred on first presentation. Cases involving external problems (e.g. secondary care delays) should be discussed with the CCG cancer lead and/or hospitalists involved for escalation, where appropriate, to remedy the external problem. The following are suitable for Cancer SEAs.

- Emergency presentation of cancer
- Delayed diagnosis
- Cancers diagnosed at a late stage (Stage 3 or 4).

In order to track a practice's cancer activity, the Cancer Diagnosis Audit Tool (developed by Durham University and RCGP), allows each new cancer diagnosis to be logged. Using this template, practice teams can identify potential cases for SEA as a continuum rather than waiting for the opportunistic case. Colorectal, lung, ovarian, pancreatic and neurological cancers among others are known to present at a late stage, or as an emergency, and therefore present opportunities for learning.

## 2. HOW TO DO A HIGH QUALITY SEA

The Cancer SEA template prompts clinicians to consider a number of factors that can contribute to a delayed diagnosis. It is divided into six sections:

### 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 outside primary care).
- Note the key consultation at which the diagnosis was made.

- List consultations in the year prior to diagnosis and referral. Say how often the patient had been seen by the practice and give the reasons. Also be clear on who the patient saw, even though the consultation may not relate to the eventual cancer diagnosis.
- Record the type of consultation held: telephone, face-to-face, home visit; and who consulted with the patient (GP1, GP2, Nurse 1).
- Say 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, note what the impact or potential impact of this was.

### Why did it happen?

Reflect on the process of diagnosis for the patient and consider:

- Whether 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 and over what time period the patient was seen before a referral was made; and consider the urgency of referral.
- Whether proactive or electronic 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 with adequate access or availability, and whether the reason for any delay was acceptable or appropriate.

### 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:

- 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 NICE guidelines, NG12 Suspected cancer: recognition and referral (2015) and their usefulness to primary care teams.

Reference the literature, guidance, local pathways and protocols that support the learning points.

### What has been changed?

- Outline here the action(s) agreed and/or implemented and who will/has undertaken them.
- If a protocol is to be introduced, updated or amended, show how it will be implemented.
- Note which staff members or groups will be/were responsible (GPs, Nurses, Receptionist) and how the related changes will be monitored.
- If there are 'actions' that individuals or the practice as a whole will do differently, detail the level at which changes are being made, and how are they being monitored.
- Indicate what improvements will result from the changes; will the improvements benefit diagnosis of a specific cancer group, or will their impact be broader?
- Consider clinical, administrative and cross-team working issues.

### WHAT has been the impact as a result of the cancer SEA?

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

- How did the pathway to diagnosis impact the patient and their family/carer(s)?
- 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?
- Has the practice maximised patient awareness and education measures and worked with the patient participation group? Have the practice website and waiting room posters and leaflets informed patients of 'be clear on cancer' campaigns, screening and 'when to worry' symptoms?

### What has been effective about this SEA?

- Consider how carrying out this SEA has been valuable to individuals, to the practice team and/or to patients.
- Note who attended and whether the relevant people were involved.
- Record the duration of practice team meeting.
- Say what was effective about the SEA discussion and process.
- Consider what could have made the SEA more effective in terms of encouraging reflection, learning and action.

### 3. THE FEEDBACK INSTRUMENT

A peer feedback instrument was developed as part of the Macmillan RCGP pilot in 2012-13 and has been modified for clinicians to self-appraise their own Cancer SEAs. This can be used by individual GPs or practice teams to self-appraise the quality of reflection as well as to review and rate each of the six sections. Feedback on how to improve the event analysis should be constructive and given in the comments section at the end of each relevant area. Similarly, where an area of the analysis has been undertaken well, please comment on this so it too

can be given as positive feedback to the submitting practice. Please remember that all educational feedback should be specific, informative, sensitive and directed towards improving the event analysis.

#### 4. ANALYSE THEMES

In efforts to maximise reflection and to identify the areas for development and improvement generated from a Cancer SEA, we suggest you use the [thematic analysis checklist](#). It may help to explore whether reflection has been extensive enough and also to probe themes that could have been discussed or actioned more proactively. The list of themes includes:

- Avoidable or unavoidable delays
- Clinical presentation
- Case complexity
- Continuity
- Consultation activity
- Communication
- Co-morbid long term conditions
- Documentation quality
- Education and guidelines
- History of a previous cancer
- In-practice systems
- Investigations and access to diagnostics
- Practice staff issues
- Practitioner issues
- Primary-secondary care interface
- Read coding
- Referrals management
- Routes to diagnosis
- Teamwork
- Training
- Patient safety
- Patient education and awareness
- Safety netting
- Screening.

#### 5. PRACTICE TEAM MEETING

A team meeting is essential in the SEA process. Discussions conducted in a protected and non-judgemental environment can stimulate deeper reflection and identify an individual clinician(s) role.

It is also an appropriate forum to address practice systems for quality improvement and involve the entire practice team. The Cancer SEA should document whether all relevant individuals attended and whether the conclusions should be discussed with any other staff inside or outside the practice. Locum GPs should be as involved as practice staff where relevant. A high quality SEA should specify concrete learning points and directed actions that put those changes into effect and monitor their impact. A high quality Cancer SEA will specify practice staff member or groups who will be responsible for the agreed action points and will decide how their impact will be monitored. Informing the patient, family or carer(s) that a Cancer SEA has been conducted may improve the doctor-patient relationship, where appropriate.

#### 6. ACTIONS & IMPACT

The sixth and final section of a Cancer SEA should specify the key roles and responsibilities in the practice team for implementing improvements and changes. It is considered good practice to share the outcomes of a Cancer SEA with the patient where appropriate. A range of actions to impact early diagnosis can be generated from a Cancer SEA, and may include the following:

- Communication protocols
- Continuity approach
- Documentation improved
- Identify learning needs within the team
- In-practice systems modified
- Investigations protocols
- Guidelines refresh and team education
- Patient education and awareness
- Primary care team involvement
- Quality improvement tools
- Read coding
- Referrals read coding and tracking
- Risk assessment tools or clinical decision support tools
- Safety netting
- Screening protocols
- Training.

# EXAMPLES OF SEAs and THEMATIC ANALYSIS

In order to understand the range of quality of Cancer SEAs, subsequent actions and potential impact for change, you may wish to look at the three fictional examples below centred around colorectal and ovarian carcinoma, two cancers known to present as an emergency.

## SEA PATIENT A

This SEA is an example where reflection could have been deeper.

You will notice that potential themes include:

- Avoidable or unavoidable delays
- Communication with colleagues
- Documentation quality
- Emergency presentations
- Patient education and awareness
- Practitioner issues
- Primary-secondary care interface
- Safety netting.

And opportunities for subsequent actions:

- Communication protocols
- Continuity approach
- Documentation improved
- Identify learning needs within the team
- In-practice systems modified
- Guidelines refresh and team education
- Patient education and awareness
- Primary care team involvement
- Referrals read coding and tracking
- Safety netting.

## SEA PATIENT B

This SEA describes a clear timeline description of events, but could have demonstrated deeper reflection including specific learning, action points and impact on practice and the wider profession.

You will notice that potential themes include:

- Co-morbid long-term conditions
- Education and guidelines
- In-practice systems
- Patient education and awareness
- Primary-secondary care interface
- Safety netting.

And opportunities for subsequent actions:

- Communication protocols
- Continuity approach
- Identify learning needs within the team
- In-practice systems modified
- Investigations protocols
- Guidelines refresh and team education
- Patient education and awareness
- Primary care team involvement
- Referrals read coding and tracking
- Risk assessment tools or clinical decision support tools
- Safety netting
- Training.

## SEA PATIENT C

This SEA is thorough in its discussions and demonstrates insightful reflections, specific learning and action points.

You will notice that potential themes include:

- Communication with colleagues
- Education & guidelines
- In-practice systems
- Patient education and awareness
- Risk assessment tools
- Safety netting
- Screening.

And opportunities for actions/impact:

- Communication protocols
- Continuity approach
- Identify learning needs within the team
- In-practice systems modified
- Guidelines refresh and team education
- Patient education and awareness
- Primary care team involvement
- Risk assessment tools or clinical decision support tools
- Safety netting
- Training.

## TESTIMONIALS

Event evaluation comments returned by participants at GP Learning events held in Gloucestershire and Birmingham as part of the Quality Improvement in the Early Diagnosis of Cancer pilot programme run by the RCGP in partnership with NHS England and Macmillan Cancer Support.

*“Interesting to see the various tools and how to implement in practice.”*

*“Good and thought provoking afternoon.”*

*“Enjoyed session and informative.”*

# QUALITY IMPROVEMENT TOOLS

**Quality Improvement** is a commitment to continuously improving the quality of healthcare, focusing on the preferences and needs of the people who use services. It encompasses a set of values (which include a commitment to self-reflection, shared learning, the use of theory, partnership working, leadership and an understanding of context); and a set of methods (which include measurement, understanding variation, cyclical change, benchmarking and a set of tools and techniques).

The Cancer SEA can serve as a quality improvement and **diagnostic** tool to identify problems in the diagnostic pathway. Potential solutions to problems or themes generated from a Cancer SEA, such as **continuity** or **read coding**, can lead to planned changes; and the use of Quality Improvement tools can test the validity of these changes.

Further Quality Improvement information is available from the [Quality Improvement \(QI\) at the RCGP](#) section of the College website. This includes the recently published [RCGP Guide Quality Improvement for General Practice](#).

## SAFETY NETTING

A missed or delayed cancer diagnosis is certainly a fear among the public and the medical profession. As no diagnostic test or clinical decision is ever 100% sensitive, a missed diagnosis is a high probability in primary care. In the cancer realm, individuals present at different stages in the evolution of their illness and the 'red flag' signs and symptoms may be absent or not present at all until the disease has progressed to a late stage. Safety netting can be viewed as a 'diagnostic strategy' or 'consultation technique' to ensure timely re-appraisal of a patient's condition. Safety netting is particularly important for conditions such as suspected cancer where patients present

infrequently and symptoms can be common and non-specific. Safety netting may support healthcare professionals to detect cancers earlier and minimise delayed diagnoses. There are many opportunities to safety-net and these include:

- The first consultation
- Subsequent consultations for the same symptoms or medical problem
- Diagnostics
- Communications with hospitals
- Suspected cancer referrals
- Tracking and follow-up
- Locum arrangements and robust follow up processes.

Examples of safety netting include the following:

1. Offer a timely review and action after investigations have been requested.
2. Actively monitor symptoms in people at low risk (but not no risk) to see if a patient's risk of cancer changes; this may include the use of Cancer Decision Support Tools such as QCancer and the Risk Assessment Tools (RAT).
3. Where appropriate, reassure people who are concerned that they may have cancer that with their current symptoms, their risk of having cancer is low. But don't offer false reassurance – communicate uncertainty too if necessary.
4. Explain to people who are being offered safety netting which symptoms to look out for and when they should return for re-evaluation. It may be appropriate to provide written information.
5. Ensure that results are reviewed and acted upon promptly and appropriately; the healthcare professional who ordered the investigation should either take or explicitly delegate responsibility for this.

6. Consider a review for people with any symptom that is associated with an increased risk of cancer, but who do not meet the criteria for referral or other investigative action.
7. The review may be planned within a time frame agreed with the person or it may be patient-initiated if new symptoms develop, if the person continues to be concerned, or if their symptoms recur, persist or worsen.
8. Read code suspected cancer referrals and direct access diagnostics e.g. fast-track suspected (breast) cancer referral and referral for ultrasound investigation.
9. Track patient attendance and outcomes for blood tests/ imaging/ endoscopy/ suspected cancer outpatient appointments using the relevant software, e.g. ICE software, Tquest list management or other robust electronic safety netting system(s).
10. Pro-actively recall to review patients who do not attend their appointment for diagnostics or suspected cancer clinic appointment within the time frame agreed.

Many GPs are aware of the definition of verbal safety netting; however, proactive **electronic** safety netting refers to maximising IT systems, processes and practice systems to organise patient follow-up. Examples of this include:

- Fixing follow-up appointments before patients leave the consultation.
- Advising patients ‘when to worry’ or to come back for a review of symptoms and signs
- Asking for confirmation of ‘suspected cancer or two-week wait’ appointment receipt and attendance.
- Providing a dedicated telephone hotline for elderly or vulnerable patients.
- Read code referrals and diagnostics requests.
- Following up codes or diary reminders that are searchable on a weekly or fortnightly basis to track and following up patient activity and non-attendance.

- Monitoring quality of documentation in notes, including read coding effectively.
- Communicating with colleagues.
- Following ‘Usual doctor’ systems for continuity
- Sharing patient information leaflets to inform patients when to return to their GP for a clinical review.

SEA – Patient C is an example of a cancer sea with a safety netting theme.

A slide set on safety netting is available.

### RISK ASSESSMENT TOOLS

There are two clinical decision support tools or risk assessment tools that are in operation across the UK in the early detection of cancer. These are based on retrospective UK **primary care data**.

QCancer calculates the risk of a patient having a current but as yet undiagnosed cancer, taking account of their risk factors and current symptoms. This tool is designed to support clinical decision making and does not replace clinical judgement. It is important to note that this is an aid to support clinical decision-making and does not replace clinical judgement.

The Risk Assessment Tool is based on research by Professor Willie Hamilton which identified symptoms of common cancers that presented to primary care, and quantified the risk of cancer associated with them using positive predictive values. The cancer risk assessment tool (RAT) is designed to help GPs decide which patients may benefit from urgent investigation or referral. RATs are available for a number of cancers including bladder, kidney, oesophago-gastric, pancreatic, uterus, colorectal, lung, ovarian and prostate.

# BACKGROUND AND RATIONALE

## SIGNIFICANT EVENT ANALYSIS

Between 2009 and 2012, the RCGP collaborated with NCAT and the Department of Health to develop a cancer-specific SEA template as a quality improvement tool with accompanying advice on its use. This proved to be a popular tool with practices and cancer networks. The template was designed to support GPs to complete a quality Cancer SEA to a high standard, and to be a real vehicle for change with an emphasis on reflection with a non-judgmental approach.

The RCGP produced the [Quality Improvement Guide for General Practice](#) to support the whole primary care team on their quality improvement journey. The significant event analysis is explicitly identified as one of the tools that should be used.

The RCGP and Macmillan Cancer Support have continued to champion the use of cancer-specific Significant Event Analysis with respect to early diagnosis. In 2014 the RCGP partnered with Macmillan Cancer Support to train appraisers to effectively appraise Cancer Significant Event Analysis in a way that supports quality improvement in patient care. In this initiative, systematic peer review was incorporated with RCGP approval in a pilot that was promoted through cancer networks.

## PROJECT BACKGROUND

In 2015 the RCGP launched the next phase supported by NHS England and Macmillan Cancer Support, a project complementary to previous activity and built on the aforementioned successes to support early diagnosis of cancer. [The cancer-specific SEA template](#) was updated to include the impact, or potential impact, on the patient, practice team and wider profession. A [thematic analysis checklist](#) was also created to support GPs to self-appraise their SEAs.

The project delivered peer-learning events, facilitated to create a non-threatening, non-judgemental environment where GPs felt comfortable to reflect openly and share their experiences, but able also to encourage debate and challenge colleagues in a professional manner when improvement(s) from a SEA were identified. The ethos of the project was to share good practice in efforts to drive improvements at practice and CCG level.

The following items were included in the learning events:

- Themes identified by cancer SEAs within a CCG
- Sharing of innovative and good practice
- Sharing barriers and enablers to improving early diagnosis
- Capture and share learnings
- Active reflection and peer discussion
- Quality improvement tools.

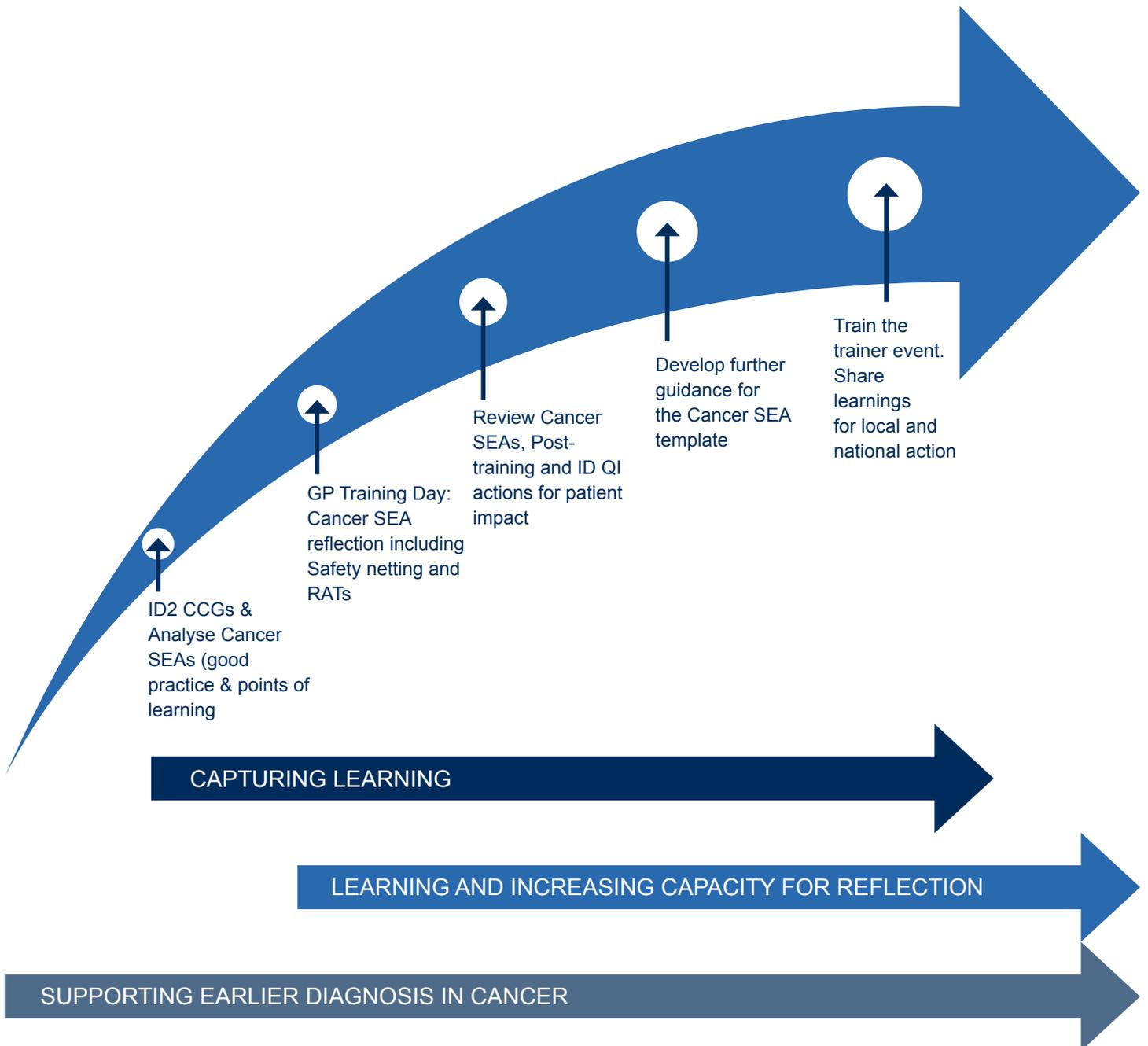
The project also delivered learning events to CCG cancer leads, programme directors, trainers, appraisers and practice cancer leads to maximise engagement and participation. Local CCG leadership was essential to sustain the continuum of using cancer-specific SEAs to improve early diagnosis. Delivery of education on other quality improvement tools, clinical decision support tools and safety netting were additional strands to the project.

This project was valued, by the practices and individuals who participated because of its contribution to their professional development and to the quality of their clinical care. For some participants it set standards that were a surprise, and in some cases that surprise was unwelcome. Overall there was a sense of professional satisfaction from those who had completed a high quality SEA and from those whose SEA resulted in demonstrable change, thereby leading to improvements in patient care.

## THE NATIONAL CANCER STRATEGY

The National Cancer Strategy was published in 2015 containing 96 recommendations to be implemented by 2020. A key part of the strategy includes reducing emergency presentations of a new diagnosis and deciphering whether there are specific avoidable contributors; currently just over 20% per cent of all cancers in England present via this route. Such diagnoses represent a learning opportunity for all concerned. The strategy has made a specific recommendation that GPs should be required to

undertake a Significant Event Analysis for any patient diagnosed with cancer as a result of an emergency presentation. This Cancer SEA Quality Improvement toolkit for the Early Diagnosis of Cancer can be used to support CCG cancer leads and Macmillan GPs to deliver localised schemes aligned with the cancer strategy and embed their use alongside safety netting and risk assessment tools to improve early diagnosis. The SEA template used for this project is an ideal quality improvement tool to implement this recommendation.



# RESOURCES

1. [RCGP Quality Improvement Guide for General Practice](#)
2. [Cancer SEA template \(2016\)](#)
3. [Thematic Analysis Checklist](#)
4. [National Cancer Strategy, 2015](#)
5. [RCGP SEA Feedback instrument](#)
6. [SEA - patient A](#)
7. [SEA - patient B](#)
8. [SEA - patient C](#)
9. [Quality Improvement \(QI\) at the RCGP](#)
10. [Safety netting slide set](#)
11. [Video demonstrating the Cancer SEA template](#)
12. [RCGP Cancer Audit Tool](#).

# ACKNOWLEDGEMENTS

- Royal College of General Practitioner’s (RCGP)
- Clinical Innovation and Research Centre (CIRC)
- Macmillan Cancer Support
- NHS England
- Steering committee members
  - Sally Edwards, National Programme Director Quality Surveillance Team, NHS England
  - Julia Hill, Deputy National Programme Director Quality Surveillance Team, NHS England
  - Dr Ishani Patel, RCGP Clinical Lead for Pilot Project, Quality Improvement in Early Diagnosis of Cancer (author)
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  - Harvey Ward, RCGP patient representative
  - Chris Gush, Assistant Director of CIRC, RCGP
  - Ruth Bridgeman, Strategic Partnership Consultant, CRUK
  - Dr Rajib Pal, Macmillan GP
- Dr. Pawan Randev, GP clinical lead Transforming Cancer Services Team, Healthy London Partnership
- Dr. Afsana Bhuiya, London Cancer
- NHS Gloucestershire CCG
- RCGP Midlands Faculty
- NHS Birmingham Cross City CCG
- Dr. Sarah Luty, NHS Education Scotland
- Dr. John McKay, NHS Education Scotland
- Dr. Liz Mitchell, Senior Research Fellow (Applied Health), University of Leeds
- Prof. Una Macleod, The Hull York Medical School.

# ADDITIONAL RESOURCES

1. [RCGP SEA pilot, 2014: RCGP Macmillan SEA Pilot](#)
2. [Oxford University research on safety netting with introduction](#)
3. [London Cancer & Macmillan Safety Netting Guide](#)
4. [QCancer](#)
5. [Cancer Risk Assessment tool \(RAT\)](#).