**HOW TO DO A HIGH QUALITY SEA**

The ***Cancer SEA template*** (included in the ***Early Diagnosis of Cancer Significant Event Analysis Toolkit***) prompts clinicians to consider a number of factors that can contribute to a delayed diagnosis. It is divided into six sections:

**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 outside 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 and the reasons
- The type of consultation held: telephone, face-to-face, home visit and who consulted with the patient (GP1, GP2, Nurse 1)
- 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 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.

## 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 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.

## 4. 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, how it will be implemented
- 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
- What improvements will result from the changes; will the improvements benefit diagnosis of a specific cancer group, or will their impact be broader
- Consider both clinical, administrative and cross-team working issues.

## 5. 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?

## 6. WHAT HAS BEEN EFFECTIVE ABOUT THIS CANCER SEA

- Consider how carrying out this SEA has been valuable to individuals, to the practice team and/or to patients.
- Who attended and whether the relevant people were involved
- Duration of practice team meeting
- 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.