

Final report

Pilot of a peer review scheme for significant event analysis of cancer diagnosis



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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NCAT closed in March 2013 and NHS Improving Quality has continued to support the work since then.

This report was prepared by:

Professor Greg Rubin and Sarah Pollet, with input from the pilot's steering group (appendix 4). It was peer reviewed by Dr William Taylor, CIRC Quality Improvement Lead, RCGP.

Executive summary

Significant event analysis (SEA) provides an opportunity for clinicians to demonstrate reflection and commitment to quality improvement.

In a pilot of external assessment and feedback for SEAs of cancer diagnoses, practices in 11 cancer networks in England were given the opportunity to submit SEAs to the RCGP.

Over a ten-month period, 96 SEAs were received from 52 practices in ten cancer networks.

The process of submission and the quality and usefulness of feedback received was rated well by most participants.

There was significant variation in the standard to which an SEA was undertaken, with many examples of excellent reflection and learning but some that were unacceptably poor.

SEA is not an examination of clinical competence, but of the capacity to reflect on events and learn from them. This distinction was not appreciated by a significant minority of participants.

GPs should receive formal training in undertaking SEA. Because it forms a part of revalidation, such training should not be limited to their training years, but should be offered to established practitioners as well.

There is a need for GPs to be trained in the assessment of SEA. The priority is that those responsible for GP training or for appraisal and revalidation should be competent in this.

This pilot provides a model for objective assessment of SEA that has the scope to be applied in other clinical areas.

Project development

Background

SEA is an approach to quality improvement that has become well-established in general practice. It involves a structured review of all that happened in relation to the event of interest, which may be adverse, exemplary or simply important. It addresses the questions:

- What happened?
- Why did it happen?
- What can be learned?
- What should be changed?

Between 2009 and 2012, the RCGP in collaboration with NCAT and the Department of Health developed a cancer-specific SEA template with accompanying advice on its use¹. This proved to be a popular quality improvement tool with practices and cancer networks.

The requirements of annual appraisal and revalidation for GPs are placing increasing emphasis on the quality of continuing professional development and performance. SEA is explicitly identified as one of the tools that should be used.

Concept

The aim of this pilot was to assess the feasibility of providing peer review feedback to practitioners who submitted completed SEAs of cancer diagnosis (appendix 1). This would be through a process administered by staff in RCGP (appendix 2 for flowchart).

Process

The format for cancer SEAs was one which had been developed specifically for the purpose (appendix 3.1), and was an adaptation of the generic format published by the National Patient Safety Agency (NPSA) and RCGP¹. This was accompanied by guidance on completion and a link to the NPSA/RCGP joint guidance on SEA. Additional guidance for users was provided on the assessment process.

Assessment of completed SEAs was provided by two GP cancer leads, one of whom was from the cancer network within which the submitting practitioner worked. This peer review task was funded, initially, on the basis of an assessment taking 15 minutes.

The assessment process used predetermined criteria and an assessment template that had previously been developed and published by Dr John McKay, a GP and expert in SEA (appendix 3.2).

1 Bowie P, Pringle M. *Significant event audit: guidance for primary care teams*. London: National Patient Safety Agency, 2008. www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=61501 [accessed 31 Jul 2014].

Funding

The pilot was resourced through a collaboration between NCAT, Macmillan Cancer Support and the RCGP. NCAT provided financial support for the administration of the scheme, Macmillan Cancer Support funded the participation of the reviewers, while RCGP provided administrative and project management support.

Implementation

Following discussion between NCAT and RCGP, two lead cancer networks were identified, with GP leads contributing their expertise to the process. Additionally a further nine cancer networks expressed their interest in participating (appendix 4 for participants).

To introduce the project, a briefing meeting for these GP leads was held at which the processes involved were addressed in detail. The meeting was attended by Dr John McKay, who delivered a training session on the assessment process (appendix 5.1). GP reviewers subsequently completed additional assessments, sharing their results as a means of standardising them.

A webpage on the RCGP site was developed to support the pilot. It described the nature of the pilot, contained all relevant documents and provided hypertext links to relevant sites. During the course of the pilot examples of good and inadequate SEAs were developed to provide additional guidance to practices on what was required (appendix 5.2).

The scheme was promoted through the RCGP's paper and online publications and through its email communication channels. In participating cancer networks, the scheme was promoted through local channels and during face-to-face contact with practices.

Modifications implemented during the course of the pilot

Two further cancer networks joined the pilot once it had commenced, Dorset and Thames Valley.

The SEA template was modified after three months and more detailed guidance on completion was provided (appendix 3.1). An initial screening process was introduced to ensure a minimum standard of submission going forward to peer review. The expected time taken for peer review was increased to 45 minutes.

Promotion of the pilot

The pilot was extensively promoted at a national level through RCGP channels – RCGP news, Chair's blog, CIRC bulletin, RCGP Faculties. It was also promoted through the National Awareness and Early Diagnosis Initiative (NAEDI)/NCAT newsletters and the blog of Kathy Elliott, then NCAT National Lead for Prevention, Early Diagnosis and Inequalities. Articles about the pilot appeared in *GP Online* and Cancer Research UK newsletter. In addition, local promotion was through the GP leads in each participating cancer network.

Management of the project

SEA administration

SEA submissions were accepted for one year, from 1 July 2012 to 30 June 2013. The first SEA was submitted on 3 September 2012 and the last on 30 June 2013.

A CIRC Programme Officer was allocated to the project from March 2012. The post was vacant from June until Sarah Pollet was appointed and commenced work on 4 September 2012. The administrative systems for appointing reviewers for each SEA and processing the SEAs within the 15-working day timeframe were established by October 2012 and henceforth were managed by CIRC Programme Administrator, Samina Ladhani.

Sixteen GP leads were trained as reviewers but one reviewer dropped out from January 2013. Quality assurance for the first four (SEA001-004) feedback reports was provided by CIRC Chair, Dr Imran Rafi, and thereafter by Professor Greg Rubin, RCGP Clinical Lead for Cancer.

By November 2012, the task of processing the SEAs was increasingly onerous. The requirements for any future extension of the project became apparent at this stage: a more sophisticated IT system, online submission of SEAs and reviews, the capacity to automatically generate a feedback report, automated monitoring of task flows and reminders. The processes and systems used for this pilot are documented in 'Cancer SEA Pilot Admin Process v1', some of which is summarised in appendix 6.

In March 2013, RCGP instituted an organisational restructure which restricted CIRC's capacity and impacted on the support provided to the project, particularly its promotion.

Peer reviewer training and calibration

Nominated cancer network GP leads received their initial training in peer review of SEAs at a one-day workshop in London on 23 May 2012. This included reviewing practice SEAs together, to agree a common approach to assessing and marking them. The approach to be taken was to be encouraging to participants, particularly with the scoring, but to use the comments section to highlight opportunities for improvement. Reviewers from the two networks that joined the pilot later were trained by teleconference.

Practice SEAs

To reinforce the learning from the workshop and further assist calibration, the reviewers were asked to each assess another three practice SEAs. These assessments were reviewed by Dr John McKay. Across all reviewers, completion of this task was 96%.

In practice, reviewers started assessing the SEA submissions before they had received feedback on their practice SEAs. This was due to a hiatus in RCGP staff support between July and September 2012. The reviewers asked for it to be noted as a lesson learnt that benchmarking of practice SEAs should be completed before real submissions are accepted.

The reviewers received from Dr John McKay the following feedback:

- A spreadsheet of their global scores for each SEA.
- A written summary of the common themes in their feedback for each SEA.

Based on this, they were able to compare their marks and where their feedback comments differed from those provided by the majority. They were asked to review this and consider if they would adjust their marks and feedback in the light of it. Dr McKay's overarching summary was:

“There are some generic points which we probably need to emphasise to help calibration, but in fact although there is some work to be done on this, much of the written feedback was similar.”

Ongoing calibration

It became quickly apparent that the reviewers would appreciate ongoing feedback on their SEA assessments, to help them to know if they were:

- Marking consistently with the other reviewers.
- Identifying and commenting on the same aspects of the SEAs they reviewed.
- Failing to identify key aspects of a SEA report.

By early October, all the reviewers had agreed to sharing the anonymised feedback reports. Therefore, when the feedback report was sent to the submitter with a covering letter including comments from the Quality Assurer, a copy of the feedback report was also sent to the reviewing pair with a covering comment from the Quality Assurer for them. They found receiving these invaluable, as demonstrated by their quarterly evaluation feedback and the final 'lessons learnt' discussion (appendix 6).

SEA Snapshot

For the November 2012 Steering Group meeting – the first once submissions commenced, an Excel spreadsheet of the content of the first 16 SEAs was produced to provide the members with an insight into the quality of the SEAs received. It contained the content of the SEA reports, their feedback reports, as well as the Quality Assurer's comments to submitters and reviewers. This became known as a 'SEA Snapshot'. It was agreed that it should be shared with the reviewers and the exercise repeated for a batch of SEAs at the pilot's conclusion.

Reviewer meetings

At beginning of November three-monthly webinars, facilitated by the Quality Assurer, were instituted to allow group discussion of the assessment process, promotion of the pilot and any other issues of concern. The webinars were held on 29 November 2012, 19 and 20 February 2013.

A lessons learned workshop was held in London on 20 June 2013, at the end of the pilot. Six peer reviewers were able to attend. Two who could not attend submitted content ahead of the meeting. The content of that meeting is incorporated in the discussion section of this report (appendix 6).

The reviewer webinars and meetings were informed by quarterly evaluations which were discussed in those forums enabling the project to iteratively improve its process. The changes made as a result included:

- Revising the SEA template to make it more explicit and to remove the Satisfactory/Unsatisfactory validation judgement (there was a general disinclination to select 'Unsatisfactory' when a SEA was borderline or worse). Instead, the reviewer would use their comments to express what was not done well and how it could have been done better.
- To revise the anticipated time taken per review per reviewer from 15 to 45 minutes.
- To implement a screening process (all sections sufficiently complete; diagnosis and the SEA meeting date must not be more than 12 months post diagnosis – learning is not useful unless immediate; benign tumours acceptable if the case is sufficiently documented and reflective).
- That the principle of the reviewing pair to include an own-patch reviewer be retained, unless the own-patch reviewer was unavailable, even if this meant the workload was not shared equitably, so that they might retain an overview of their locality.
- The 15-working day turnaround would not be sustainable long-term given the multiplicity of individuals involved in the process.

Results

SEA submissions and process

Distribution of submissions

In total, the pilot received 96 SEAs from 52 practices. One SEA was assessed twice, following resubmission, and thus 97 assessments were completed.

A disproportionate number of SEAs were received from Dorset Cancer Network, which ran a financial incentive scheme until the end of February 2013 to encourage participation.

Practice size ranged from 1960 to 26,000 patients; the number of full-time equivalent GPs per practice ranged from one to 23.

Thirty-eight submissions were from training practices (seven not stated); 48 were from undergraduate teaching practices (eight not stated).

| | Sept 12 | Oct 12 | Nov 12 | Dec 12 | Jan 13 | Feb 13 | Mar 13 | Apr 13 | May 13 | June 13 | Total | |
|--------------|------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|------------|-----------|-----|
| Dorset | 2 | 4 | 3 | 6 | 20 | 11 | 4 | 0 | 0 | 0 | 50 | 52% |
| Other | 3 | 7 | 5 | 1 | 8 | 3 | 2 | 3 | 9 | 5 | 46 | 48% |
| Total | 5 | 9 | 8 | 9 | 28 | 14 | 6 | 3 | 9 | 5 | 96 | |

Networks submitting

- 11 Avon, Somerset & Wiltshire
- 50 Dorset
- 3 Greater Manchester & Cheshire
- 3 Lancashire & South Cumbria
- 12 Merseyside and Cheshire
- 3 Mount Vernon
- 3 North of England
- 1 North West London
- 3 Pan Birmingham
- 2 Sussex
- 2 Thames Valley
- 3 Yorkshire

Networks with no submissions

- North East Yorkshire & Humber Clinical Alliance

Distribution of reviews per reviewer

| Peer reviewer | A1 | B1 | B2 | C1 | D1 | E1 | F1 | G1 | G2 | H1 | I1 | I2 | J1 | K1 | L1 | M1 |
|---------------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| No. reviewed | 18 | 43 | 7 | 8 | 9 | 17 | 10 | 10 | 7 | 8 | 8 | 8 | 11 | 9 | 8 | 11 |

Turnaround times

Of the 97 assessments, the 15-working day deadline from receipt of SEA to return of report was met for 47 (48.5%) and not met for 50 (51.5%):

| No. days | 0 | -1 | -2 | -3 | -4 | |
|---|----|----|----|----|----|------------|
| No. of submissions returned by/ ahead of the deadline | 18 | 12 | 7 | 8 | 2 | Total (47) |

Number of days by which the deadline was missed:

| No. days | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 13 | 14 | 15 | 18 | 19 | |
|---|---|----|---|---|---|---|---|---|---|----|----|----|----|----|------------|
| No. of submissions that missed deadline | 5 | 15 | 3 | 3 | 4 | 4 | 5 | 1 | 5 | 1 | 1 | 1 | 1 | 1 | Total (50) |

The deadline was more frequently met in the pilot's initial months:

| Pre-Jan 2013 (Sept-Dec 2012) | No. SEAs | % |
|------------------------------------|-----------|-----|
| Met | 25 | 81% |
| Missed | 6 | 19% |
| Total submissions in period | 31 | |

| Post-Jan 2013 (Jan-June 2013) | No. SEAs | % |
|------------------------------------|-----------|-----|
| Met | 22 | 33% |
| Missed | 44 | 67% |
| Total submissions in period | 66 | |

SEA content

Patient gender and age range

Of the 96 SEAs, 42 related to male patients. The age range was four months to 90 years.

Distribution of cases

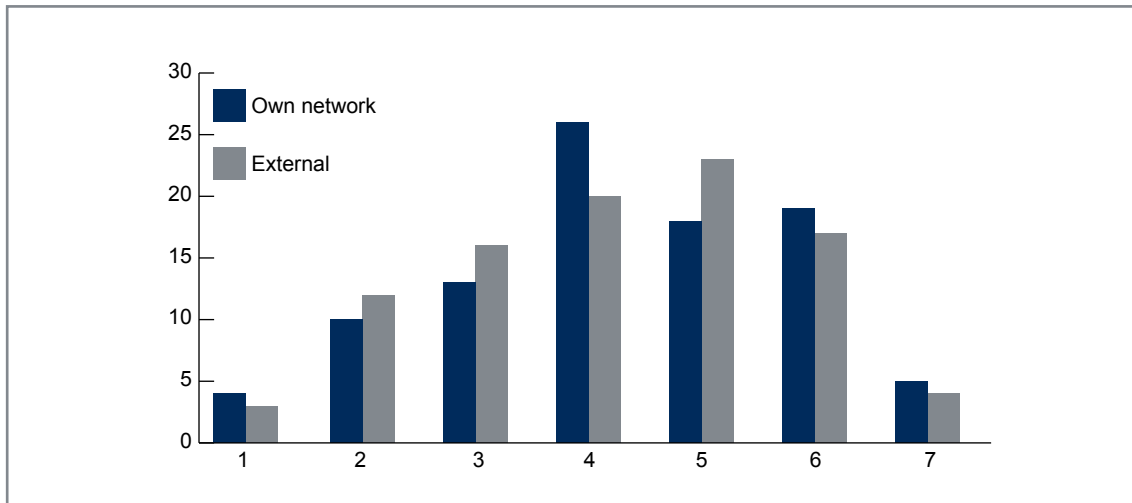
| No. cases | Cancer site |
|------------------|--|
| 8 | Prostate |
| 4 | Melanoma |
| 11 | Lung |
| 8 | Kidney/bladder |
| 15 | Colorectal |
| 6 | Oesophageal |
| 5 | ENT |
| 7 | Pancreas |
| 3 | Carcinoma of unknown primary |
| 4 | Gynaecological |
| 7 | Lymphoma/leukaemia |
| 3 | Myeloma |
| 3 | Brain |
| 3 | Liver/biliary |
| 9 | Other (breast, testis, rare UGI, stomach, sarcoma) |

SEA assessments

Assessments were made independently by a reviewer from the cancer network of the submitting practice and by an assessor from an unrelated cancer network. Scores were not amalgamated.

Distribution of scores

Scores differed by two points in 15/96 assessments, by three points in 2/96 and by four points in 1/96 assessments.



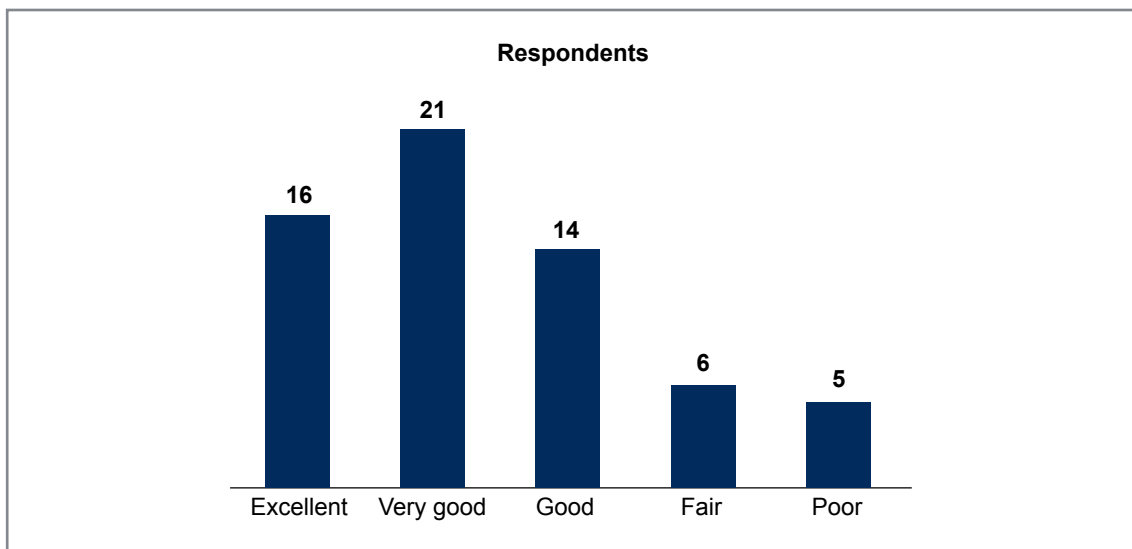
Reviewer scores

- 1 Very poor
- 2 Poor
- 3 Fair
- 4 Good
- 5 Very good
- 6 Excellent
- 7 Outstanding

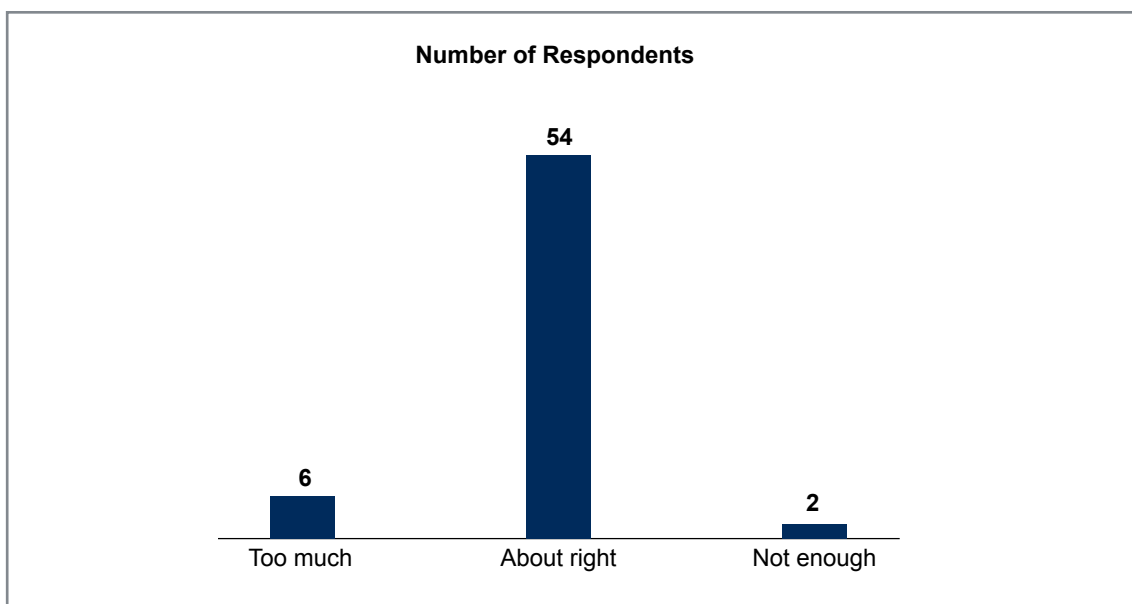
Post-submission evaluation

All submitting practices received an evaluation questionnaire by email. The first was sent soon after the feedback had been provided. It asked about the submission process and the usefulness of the feedback provided. It also asked what action(s) the practice would be addressing as a result of the exercise.

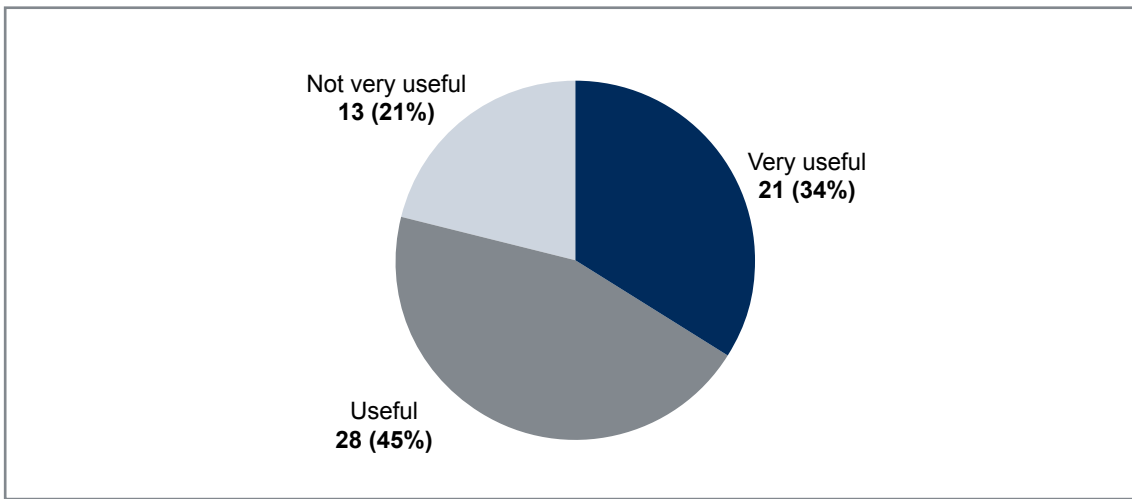
How did you find the submission process?



What was your view on the level of detail provided in the feedback?



How useful was the feedback provided?



Follow-up evaluation

All submitters received a follow-up questionnaire six months after the SEA, in which they were asked about the actions they had taken as a result and their view of the value of the exercise.

Twenty-one responses were received, with 13 stating that they had acted upon the findings of the SEA (eight – no response). Actions related to changes in clinical practice, changes to diagnostic or referral practice, practice system changes and future use of SEA.

Value to the practice team: All 21 responses stated that the SEA experience had been valuable. The main themes emerging from their comments related to the benefit for working practices, and SEA as a supportive and effective process for quality improvement.

Value to patients: all 21 responses stated that the SEA experience had been valuable. The main themes were of increased consistency of clinical care, safer practice and more timely care.

Value to the individual clinician: all 21 responses stated that the SEA experience had been valuable. The benefit for appraisal and revalidation was a strong theme, together with the opportunity for reflection on clinical practice.

Value in improving SEA technique: all 21 responses stated that the SEA experience had been valuable. The principal themes were of being exposed to a more thorough and rigorous approach to SEA, and that this would influence their use of the technique in the future.

All 21 responses wished to see the pilot extended beyond its closing date. Areas for improvement were identified by ten respondents and included a less lengthy process, faster turnaround of reviews and more supportive feedback. All 21 respondents wished to see the approach extended to other clinical areas. Suggestions as to which areas came from 11 and included unexpected death, suicide and emergency admissions.

Peer reviewer feedback

At the end of the pilot, feedback was obtained from 13/16 reviewers. The areas of learning for reviewers included the benefits of SEA and how to do one well, insights into their own clinical practice and that of others, and the problems of cancer diagnosis.

All 13 wished to see the pilot extended and would continue as reviewers if it was. All would encourage others to become a reviewer, with the benefits seen as the learning as a clinician and the insights into the clinical practice of others. There was some disappointment in the low level of participation and the lack of opportunity for local learning but appreciation for the efficiency of the administration of the pilot.

A lessons learned workshop was held at the end of the pilot.

The key conclusions were:

- Two types of submission were apparent – those that were in the right spirit (good case selection and reflection) and those that missed the point (superficial/not reflective).
- The time taken to review submissions was significant (45 not 15 minutes) but the experience was rewarding.
- Change as a result of doing SEA may be difficult to demonstrate in the short term. Prochaska's change model was useful in understanding why this might be.

For the future, the group agreed that:

- The process needed two reviewers.
- Clinical Commission Group (CCG) backing was important to encourage participation.
- Payment by practices for peer review was unlikely to work in the current climate.

Possible developments to the pilot model included:

- The random selection by CCGs of one SEA from each practice for review, on an annual basis.
- A broader remit across multiple clinical areas or domains to widen this approach to reflective thinking and quality improvement.
- A more efficient and online solution to the administration of the peer review model.

Financial report

A financial report for the pilot is appended (appendix 7). Attention is drawn to the note regarding additional in-kind support not appearing in the financial report. This was significant, and the full economic costs of the pilot were estimated at £57,000.

Discussion

This report describes an innovative approach to the use of SEA in general practice. SEA is a well-established approach to quality improvement, first promoted nearly 30 years ago. Its use was included in the Quality and Outcomes Framework (QOF) until recently. In this initiative, we incorporated systematic peer review to the process, under the imprimatur of the RCGP, in a pilot that was promoted through the NHS (cancer networks) and focused on a specific clinical area.

It was an approach that was valued, by those practices and individuals who participated, for its contribution to their professional development and the quality of their clinical care. For some participants it set standards that were a surprise, and in some cases that surprise was unwelcome. Our experience raises questions about the standard of SEAs that were undertaken when they were a QOF requirement. More importantly, it suggests that those responsible for revalidation should be prepared for portfolios that contain SEAs of an unacceptably poor standard. Most participants welcomed the quality and depth of the reviews they received. The peer reviewers also found their involvement a valuable learning experience, both in terms of clinical knowledge and for their understanding of variation in general practice.

Uptake of the initiative was disappointing. The initiative was repeatedly promoted through RCGP media channels, including feature articles in RCGP News. Local promotion within individual networks, and the vehicles available to do this, were very variable however, and awareness levels may have been low in some. Factors that may have contributed to low uptake may also have included the low potential gain from doing SEA in the QOF criteria and competition for promotion of primary care initiatives in cancer networks. One network accounted for half of all submissions and this reflected incentive payments to practices. We were aware of SEA being promoted in some cancer networks outwith this pilot scheme.

Nevertheless, we were surprised that the opportunity to address a requirement of appraisal and revalidation was not more widely recognised. SEA is a desirable component of the former and will be mandatory for the latter. The opportunity to undertake a SEA and have it externally assessed through the RCGP was expected to be a major attraction. It may be that GPs had not grasped the detailed requirements of revalidation at the time of the pilot.

As a result of the lower than expected number of submissions, one of the anticipated benefits to reviewers – to gain insights into issues in their own cancer networks – was not realised. A second anticipated benefit – of developing a library of SEAs that could be accessed for the purpose of greater shared learning – was not pursued. It is notable, however, that most submitting practices gave consent for their SEA to be used in this way.

SEA has been supported by the RCGP for many years as a quality improvement activity that is valuable for GPs and practice teams. It is now an integral part of revalidation. However, the quality of SEAs undertaken by practices is known to be very variable. If peer review of SEA is to be developed further, the key considerations will be the business model and the development of efficient administrative systems. It is possible that the requirements of revalidation may prompt GPs to value its benefits more. Alternatively, means by which practices would be obliged to participate in the process could be explored. Reviewers find it a rewarding experience and their recruitment would be unlikely to be a rate-limiting problem.

Recommendations

1. SEA templates should include supplementary guidance notes for each of the four standard questions.

Approaches to consider: The SEA templates in use in the sector should be designed to provoke a depth of reflection that results in real change for the better. They should provide GPs and practices with a structured framework and guidance to follow when undertaking an SEA. All SEA templates should therefore adopt the four essential reflective questions and supplementary guidance notes of the pilot's templates (appendix 3), i.e.

What happened?; Why did it happen?; What has been learned?; What has been changed?

Asking why an event has taken place is a crucial step to establish the systems and human factors issues that need to be reflected upon. We commend the learning from the NHS Education for Scotland pilot (2014)², funded by the Health Foundation Shine programme. Their enhanced SEA framework should be incorporated as a further step to help individuals and practices explore and answer 'Why did it happen?' in an objective and constructive way.

2. When undertaking an SEA the impact on those involved should be considered.

Approaches to consider: The RCGP and other organisations should consider adding to their template for SEA a fifth question regarding impact on those involved.

What was the impact/potential impact on those involved (patient, carer, family, GP, practice)?

3. SEA in primary care should be of sufficient quality.

Approaches to consider: To improve the quality of SEA and reduce variation in quality in general practice:

- GPs responsible for training, appraisal and revalidation should be trained in the assessment of SEA.
- GPs should receive formal training in undertaking SEA.
- Educational packages relevant to SEA in practice should be developed for this purpose.

Any future programme should consider how to include all primary care staff and patients in the process; and have a system for handling SEA reports that do not meet a predefined standard of acceptable quality.

2 NHS Education for Scotland (NES). *Shine 2012 final report: addressing the psychological and emotional barriers hindering the disclosure and constructive analysis of patient safety incidents in the primary care professions*. Edinburgh: NES, Mar 2014.
www.nes.scot.nhs.uk/media/2580001/shine_2012_final_report.pdf [accessed 11 Aug 2014].

4. The relevant bodies should consider how peer review of SEA could be implemented across the broader range of general practice.

Approaches to consider: The pilot's peer review model should be implemented:

- With the support of the NHS and local health organisations/CCGs.
- Retaining the model's elements of peer review learning and calibration (two reviewers, one of whom is local to the submitter; sharing feedback reports; discussion opportunities; quality assurance).
- Retaining the emphasis on quality improvement – the capacity to reflect on events and learn from them – and not on performance management.
- With the following variations:
 - a broader remit across any clinical area and domain
 - annual random selection of one SEA from each practice or individual GP for peer review.
- Supported by a common automated peer review management system for processing the SEAs which would make the model efficient and affordable at full scale.

5. The potential benefit of peer-reviewed SEA for shared learning should be utilised.

Approaches to consider: Peer review of SEAs provides the reviewers involved with an insight into how other practices operate, transforming such a model into a vehicle for cascading good practice and innovation across the sector. Implementing the recommendation above would harness that potential.

In the event of peer-reviewed SEA being widely implemented, consideration should be given to how a library of suitably anonymised SEA reports could be created and held by a trusted party, to enable shared learning from the events reported. An online, searchable library to house the anonymised SEA reports would make the learning they contain available for individual, local and national benefit.

Further reading

McKay J, Murphy DJ, Bowie P, *et al.* Development and testing of an assessment instrument for the formative peer review of significant event analyses. *Qual Saf Health Care* 2007;16(2):150-153; DOI: 10.1136/qshc.2006.020750.

Pringle M, Bradley CP, Carmichael CM, *et al.* *Significant event auditing: a study in the feasibility and potential of case-based auditing in primary medical care* (Occasional Paper 70). Exeter: Royal College of General Practitioners, 1995. www.ncbi.nlm.nih.gov/pmc/issues/172785/ [accessed 31 Jul 2014].

NHS Education for Scotland (NES). *Shine 2012 final report: addressing the psychological and emotional barriers hindering the disclosure and constructive analysis of patient safety incidents in the primary care professions*. Edinburgh: NES, 2014. www.nes.scot.nhs.uk/media/2580001/shine_2012_final_report.pdf [accessed 11 Aug 2014].

Tools and resources from that pilot, including booklet, deskpad, SEA report format and e-learning module, are available from www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/patient-safety-and-clinical-skills/enhanced-significant-event-analysis.aspx [accessed 11 Aug 2014].

Appendices

Appendix 1: Pilot information sheet

Appendix 2: Submission process for GPs/practice teams

Appendix 3: Pilot templates

3.1 for SEA of cancer diagnosis

3.2 for peer review of SEA

www.rcgp.org.uk/clinical-and-research/clinical-resources/cancer.aspx

Appendix 4: Pilot participants

Appendix 5: Pilot training materials

5.1 Presentation on peer review of SEA, Dr John McKay

**5.2 Examples of poor and better SEAs, with comments on why,
Prof Greg Rubin and Dr John McKay**

Appendix 6: Peer Reviewer lessons learned workshop discussion notes

Appendix 7: Finance Report

Appendix 1: Pilot information sheet



Royal College of
General Practitioners



National Cancer Action Team
Part of the National Cancer Programme

Cancer Significant Event Audit (SEA) Peer Review Pilot

A pilot initiative for general practice supported by
the National Cancer Action Team and Macmillan Cancer Care.

Cancer and the RCGP

The RCGP has made cancer its first enduring clinical priority, recognising the importance of high quality care for patients with cancer and those in whom it is suspected. Although a GP will, on average, see only eight new cases of cancer each year, he or she will consider the possibility during the consultation on a daily basis, sometimes ordering investigations to clarify the situation. It continues to be a diagnosis overlaid with great emotional significance for both patient and doctor, one that greatly exercises the diagnostic and management skills of general practice.

Significant Event Analysis of cancer diagnosis¹

Significant Event Audit (SEA) as a quality improvement technique is already widely used in general practice. It provides a structured narrative analysis of the circumstances surrounding an event of interest and can be applied to any aspect of care. Considering cancer diagnosis as a significant event is a valuable way of learning from the strengths and weaknesses in the processes involved.

The cancer SEA template that accompanies this initiative adapts the generic SEA format developed jointly by the RCGP and the National Patient Safety Agency (NPSA), to facilitate reflection and learning around the key elements that surround the process of cancer diagnosis in primary care. By using this template to collect information and structure discussion, you and your practice team will be able to reflect on the specific factors that are relevant to cancer diagnosis, to identify learning points and learning needs related to this, and to highlight and implement any changes that may be necessary.

What is on offer?

The RCGP is offering anonymised external peer assessment of your significant event analysis of cancer diagnosis. Your SEA will be assessed by two cancer network GP leads trained in peer review and you will receive a report containing the two assessments.

The SEA you complete and the feedback you receive will be a valuable addition to your practice quality improvement and your personal appraisal portfolio, and will contribute to your revalidation when the time comes. It will help you improve your SEA technique as well as preparing you for the discussion with your appraiser.

Participating Cancer Networks

To take advantage of this offer your practice should be in a participating cancer network:

| | | | |
|-------------------------------|-----------------------|----------------|--------------------------|
| Avon, Somerset & Wiltshire | Merseyside & Cheshire | Pan Birmingham | |
| Dorset | Mount Vernon | Sussex | North East Yorkshire |
| Greater Manchester & Cheshire | North of England | Thames Valley | Humber Clinical Alliance |
| Lancashire & South Cumbria | North West London | Yorkshire | |

¹ From: Mitchell et al. Toolkit for improving cancer diagnosis. 2012



Royal College of
General Practitioners

WE ARE
MACMILLAN.
CANCER SUPPORT



National Cancer Action Team
Part of the National Cancer Programme

How to get involved?

To get involved follow the steps below:

- 1) Access the SEA report template and guidelines via this link www.rcgp.org.uk/sea-pilot
- 2) Undertake the SEA discussion and complete the report template with your team
- 3) Submit your SEA report to the RCGP for peer review - audit@rcgp.org.uk
- 4) Receive the peer review feedback and integrate this into any practice-based and/or individual development you may be undertaking
- 5) Complete the two short pilot programme evaluation forms you will receive i) with your feedback report and ii) approximately six months later

What do you need to know?

Support

You can find the resources to enable your participation via the web page above. This includes a cancer SEA template, NPSA guidance on undertaking SEA and a 'Toolkit for improving cancer diagnosis', which can help you plan your practice improvements. Also available on the web page are examples of a 'poor' and a 'better' SEA, annotated with reviewer comments, to compare your SEA technique against.

Free

Conducting an SEA is a quality improvement exercise undertaken by practices. There is no charge for submitting your SEA to us for peer review. If you find the feedback report you receive helpful, you can submit as many cancer SEAs to us for assessment as you wish until the pilot concludes at the end of June 2013.

Confidential and anonymous

Through their NHS contracts, the peer reviewers are bound by the rules of NHS confidentiality. Furthermore, the SEA you submit to us should have been anonymised at patient and practice level by you. The reviewers will receive only the SEA and no identifiable data about you or your practice.

Assessment process

Using a validated assessment tool, the peer reviewers will appraise your report on the clarity with which the event and its impact is described; the depth of reflection and learning demonstrated; whether appropriate action was taken; and their overall impression of the report.² They are looking for a report that evidences that an effective, thought provoking analysis of the event was conducted by the practice, from which useful learning was drawn and implemented.

By assessing the SEA on these criteria they hope to be able to offer, where appropriate, fresh insights and perspectives on the challenges you face, that might assist your practice as well as your SEA technique.

Writing reflectively is a skill, the SEA report template now includes tips on what to include. The UK Faculty of Public Health has also produced useful guidance on how to write effective reflective notes: http://www.fph.org.uk/recording_cpd

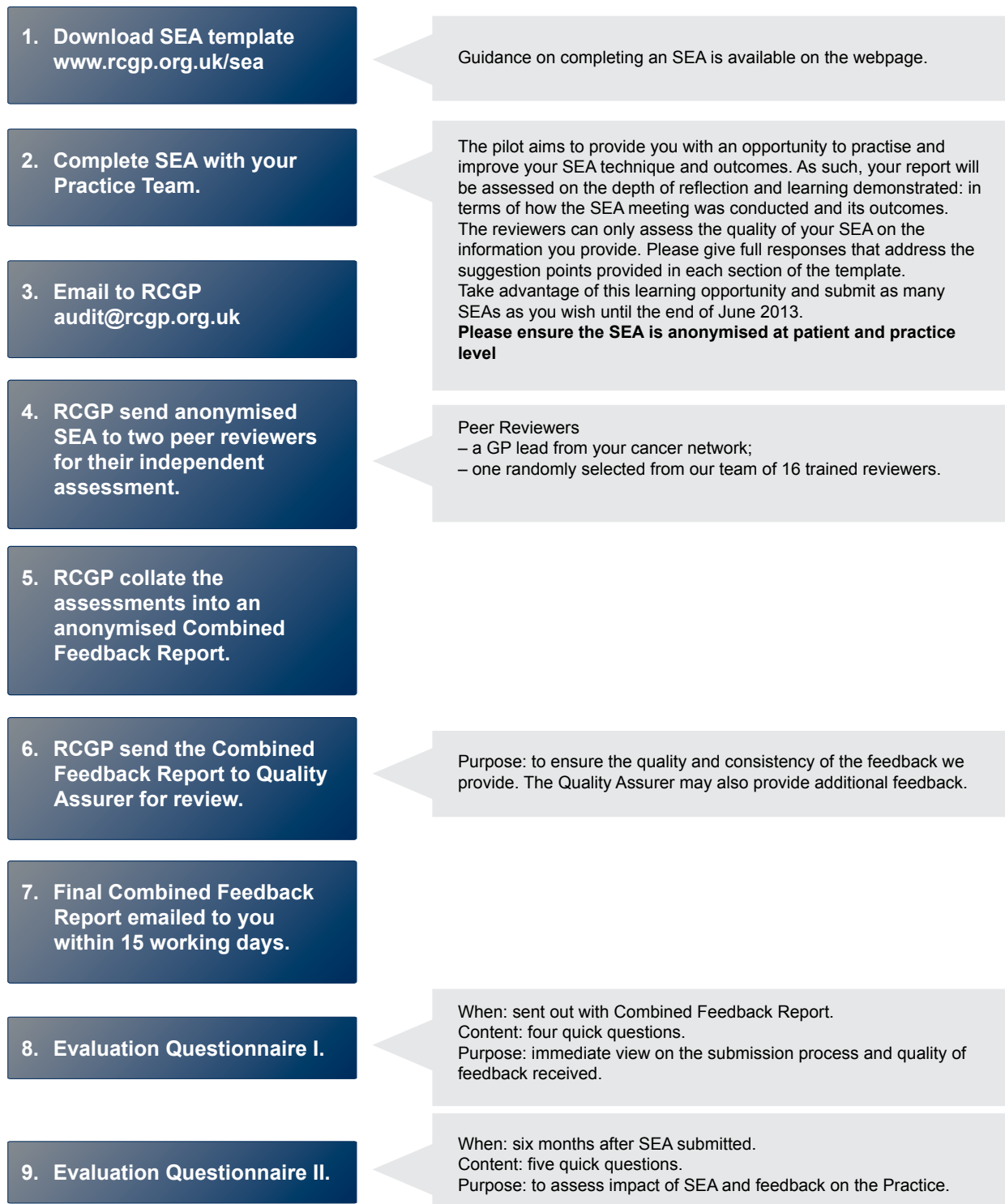
Contributing to knowledge

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.

Through your submissions, your cancer network and the national cancer agencies will obtain an overview of the challenges cancer diagnoses present for practices: an evidence base to influence the wider cancer pathway.

² McKay J et al. Development and testing of an assessment instrument for the formative peer review of significant event analyses. Qual Saf Health Care. 2007 Apr;16(2):150-3.

Appendix 2: Submission process for GPs/practice teams



Appendix 3: Pilot templates

3.1 for SEA of cancer diagnosis

3.2 for peer review of SEA

www.rcgp.org.uk/clinical-and-research/clinical-resources/cancer.aspx

Appendix 3.1: Template for SEA of cancer diagnosis

Significant Event Audit (SEA) of Cancer Diagnosis Cancer SEA Report Template

To help us process your SEA for peer review, please complete the following:

Which cancer network do you belong?

How did you hear about the 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**

~ 2 ~

SIGNIFICANT EVENT AUDIT OF CANCER DIAGNOSIS

Advice on completing the template

The peer reviewers will be assessing your SEA 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.

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 and email to audit@rcgp.org.uk. We look forward to receiving it.

~ 3 ~

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.

~ 4 ~

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.

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 | | Organisation | | Total |
| OUT OF: | | 650 | | 167.5 | | 1000 |

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

Based on the SEA structure recommended by NPSA

E Mitchell & U Macleod (version 2.2: December 2012)

Appendix 3.2: Template for peer review of SEA

Significant Event Audit (SEA) of Cancer Diagnosis Peer Review Feedback Instrument

SEA submission code

Diagnosis/SEA title

Instructions for Peer Reviewers

Please use the attached tool to critically review and rate each relevant area of the SEA report. 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 doctor. Please remember that all educational feedback should be specific, informative, sensitive and directed towards improving the event analysis.

Please rate the level of evidence contained in the audit report for each of the criteria listed overleaf (using the rating scale where 1=Very Poor and 7=Outstanding).

Other points to bear in mind:

Punctuate correctly: your feedback will form part of a report that the submitter will potentially include in their appraisal folder.

Provide comments: comments that justify and explain the score awarded will be of most help to the submitting GP and are more likely to effect change. The format of saying something positive and identifying a gap/something additional for consideration works well.

Summarise in general comments: it would help the pilot's evaluation processes if you would summarise the key points you raise throughout the feedback report in the 'General Comments' box: the positives and the additional learning points and actions you have suggested.

To mark a checkbox: place the I-beam to left of the chosen box, hold down Ctrl+Shift and hit the Right Arrow key; the checkbox will be selected. Type 'x'.

SEA Peer Reviewer

Date of Review

Please place an 'x' in the appropriate box

WHAT HAPPENED?

| | 1. Very Poor | 2. Poor | 3. Fair | 4. Good | 5. Very Good | 6. Excellent | 7. Outstanding |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. The description of what actually happened: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments:

| | 1. Very Poor | 2. Poor | 3. Fair | 4. Good | 5. Very Good | 6. Excellent | 7. Outstanding |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 2. The role(s) of all individual(s) involved in the events has been described: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments:

| | 1. Very Poor | 2. Poor | 3. Fair | 4. Good | 5. Very Good | 6. Excellent | 7. Outstanding |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 3. The setting(s) where the event happened has been described: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments:

| | 1. Very Poor | 2. Poor | 3. Fair | 4. Good | 5. Very Good | 6. Excellent | 7. Outstanding | NA |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 4. The impact or potential impact of the event has been described: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments:

WHY DID IT HAPPEN?

| | 1. Very Poor | 2. Poor | 3. Fair | 4. Good | 5. Very Good | 6. Excellent | 7. Outstanding |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 5. The underlying reason(s) why the event happened has been described: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments:

REFLECTION AND LEARNING

| | 1. Very Poor | 2. Poor | 3. Fair | 4. Good | 5. Very Good | 6. Excellent | 7. Outstanding |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 6. Reflection on the event has been demonstrated: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments:

| | | | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 7. Where possible, appropriate individual(s) have been involved in the analysis of the significant event: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|

Comments:

| | | | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 8. Learning from the event has been demonstrated: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|

Comments:

APPROPRIATE ACTION TAKEN

| | 1. Very Poor | 2. Poor | 3. Fair | 4. Good | 5. Very Good | 6. Excellent | 7. Outstanding | NA |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 9. Appropriate action has been taken (where relevant or feasible): | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments:

GLOBAL RATING SCALE

| | 1. Very Poor | 2. Poor | 3. Fair | 4. Good | 5. Very Good | 6. Excellent | 7. Outstanding |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 10. Please rate the overall analysis of the significant event: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments:

PLEASE ADD ANY GENERAL COMMENTS

Appendix 4: Pilot participants

Steering Group

Vanessa Brown

Improvement Manager, Living Longer Lives, NHS Improving Quality (NHSIQ) (from October 2013)

Dr Cathy Burton

Macmillan GP Adviser, London, Anglia and South East Region (LASER) and Central South West (CSW) Region; Lambeth CCG Clinical Network Cancer and End Of Life Lead; GP Clinical Lead, Cancer Commissioning Team: West & South; representing Macmillan Cancer Support (from October 2012)

Kathy Elliott

National Lead - Prevention, Early diagnosis and Inequalities, National Cancer Action Team (NCAT), Department of Health (until October 2013)

Dr Matt Houghton

Medical Director, Clinical Innovation and Research Centre (CIRC), Royal College of General Practitioners (RCGP) (from January 2013)

Megan Lanigan

Clinical Evidence and Effectiveness Programme Manager, Clinical Innovation and Research Centre (CIRC), Royal College of General Practitioners (RCGP)

Dr Rosie Loftus

GP Cancer Lead, Medway PCT; Lead GP Advisor, Macmillan Cancer Support (until October 2012)

Professor Una Macleod

Pilot Methodological Lead; GP Cancer Lead, North East Yorkshire and Humber Clinical Alliance; Professor of Primary Care Medicine, Supportive Care, Early Diagnosis and Advanced Disease (SEDA) Research Group, Centre for Health and Population Sciences, Hull York Medical School

Virginia Manning

Clinical Evidence and Effectiveness Programme Officer, Clinical Innovation and Research Centre (CIRC), Royal College of General Practitioners (RCGP) (until June 2012)

Dr John McKay

Assistant Director GP Postgraduate Education, Quality Improvement and Performance Management, NHS Education for Scotland

Dr Liz Mitchell

Senior Research Fellow, Leeds Institute of Health Sciences, Faculty of Medicine and Health, University of Leeds

Sarah Pollet

Clinical Evidence and Effectiveness Programme Officer, Clinical Innovation and Research Centre (CIRC), Royal College of General Practitioners (RCGP) (from September 2012)

Dr Imran Rafi

Chair, Clinical Innovation and Research Centre (CIRC), Royal College of General Practitioners (RCGP) (until January 2013)

Professor Greg Rubin

Clinical Lead for Cancer, Royal College of General Practitioners (RCGP) (April 2012–March 2014); Professor of General Practice and Primary Care, School of Medicine and Health, University of Durham

Dr Alison Wint

Pilot Implementation Lead; Macmillan GP; Associate Medical Director, Avon Somerset and Wiltshire Cancer Service

Peer Reviewers – GP Cancer Network Leads

Dr Robin Armstrong

North of England Cancer Network

Dr Paul Barker

Dorset Cancer Network (until December 2012)

Dr Lionel Cartwright

Dorset Cancer Network

Dr Petula Chatterjee

Greater Manchester and Cheshire Cancer Network (GMCCN)

Dr Rob Deery

Sussex Cancer Network

Dr Jackie Dominey

Pan Birmingham Cancer Network

Dr Jeanne Fay

Thames Valley Cancer Network

Dr Praveen Gupta

Merseyside and Cheshire Cancer Network

Dr Joan Meakins

Yorkshire Cancer Network

Dr Tehmina Mubarika

North East Yorkshire and Humber Clinical Alliance

Dr Pindolia Nari

North of England Cancer Network

Dr Pawan Randev

North West London Cancer Network

Dr Vincent Rawcliffe

North East Yorkshire and Humber Clinical Alliance

Dr Phil Sawyer

Mount Vernon Cancer Network

Dr Russell Thorpe

Lancashire and South Cumbria Cancer Network

Dr Alison Wint

Avon Somerset and Wiltshire Cancer Services

Cancer Network personnel involved in project initiation

Dr Barbara Barrie

GP Lead, Thames Valley Cancer Network

Dr Rona Cruikshank

Public Health Lead and NAEDI Programme Lead, Greater Manchester and Cheshire Cancer Network (GMCCN)

Fiona Stephenson

Programme Manager, Yorkshire Cancer Network

Suzanne Thompson

Network Manager, North of England Cancer Network

Project promotion support from NAEDI personnel

Ros Bayley

Freelance journalist

Caroline Philpott

Marketing and Communications Consultant, Cancer Research UK

Appendix 5: Pilot training materials

5.1 Presentation on peer review of SEA for peer reviewers, Dr John McKay

Delivered at the training day for the pilot's prospective peer reviewers held in London on 23 May 2012. It formed part of a one-day training and was preceded by presentations from the pilot partners and insights from the National Audit of Cancer Diagnoses in Primary Care delivered by Professor Greg Rubin.

5.2 Examples of poor and better SEAs, with comments on why, for prospective submitters, Prof Greg Rubin and Dr John McKay

These example SEAs were created in the course of the pilot and are available on the RCGP website www.rcgp.org.uk/clinical-and-research/clinical-resources/cancer.aspx

With the annotations removed, they provide useful workshop examples to ask delegates to review and then compare their feedback to the annotated comments.

5.1 Presentation on peer review of SEA for peer reviewers, Dr John McKay

NHS
Education
for
Scotland

Medicine

Assessment and feedback of SEA reports

John McKay

NHS Education for Scotland (NES)
Department of Postgraduate General Practice
Glasgow, Scotland, UK

john.mckay@nes.scot.nhs.uk

Tel: 0044 (0)141 223 1462

Quality Education for a Healthier Scotland

NHS
Education
for
Scotland

Medicine

Background

- Evidence of the ability of general practitioners (GPs) to verifiably undertake SEA effectively is limited
- External peer review is one method of informing on the quality of SEA
- A voluntary model of external educational peer review is available for GPs in the west of Scotland as part of their continuing professional development

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Summary of Peer Review Model

- Defined Clinical Audit Methods
 - criterion based (quantitative)
 - significant event analysis (qualitative)
- Appropriate peer review instruments developed to support credibility of facilitated feedback
- Audit or SEA submitted in standard report formats
- Anonymised - screened for confidentiality issues
- Sent to two trained GP Peers for independent review using the appropriate assessment instrument
- Outcome & formative educational feedback collated and sent to submitting individual for their consideration

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Definition and attributes of a peer review model

*“...the evaluation of one element of an individual’s performance by **trained professional colleagues**, using a **validated review instrument** to facilitate **developmental feedback**”.*


(Bowie & Kelly, 2007)

Five desirable attributes in a review instrument

- Validity
- Reliability
- Acceptability
- Feasibility
- Educational Impact

(Van Der Vleutin CPM, 1996)

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Content Validity

- **Developmental Stage - domain identification, item generation and instrument formation.**

Informed by:
 Literature review
 Marinker's six steps to identify items and domains for SEA (REPOSE)
 Focus group work with west of Scotland peer reviewers
 Consensus generation between authors
- **Judgement-Quantification Stage - the assertion by a number of "experts" that the items are content valid and the entire instrument is content valid. (Content Validity Index)**
- **CVI sent to 10 "well-informed" individuals in SEA.**
- At least 8 out of 10 experts endorsed all 10 items listed in the proposed instrument and the overall instrument
- Indicated a statistically significant proportion of agreement regarding the content validity of the instrument (p<0.05)
- No additional items were identified for inclusion

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Aspects of reliability testing:

Calculated Reliability Co-efficients over item 10 -the global scores - for SEA reports marked using the peer review instrument (expressed with 95% CI)

| Reliability over Item 10 Global Score | GP principals 2007 | 2008 |
|---------------------------------------|--------------------|------------------|
| Overall reliability | 0.80 (0.76-0.84) | |
| Intra rater | 0.70 (0.73-0.82) | |
| Inter rater | 0.43 (0.64-0.75) | 0.96 (0.95-0.97) |

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Issues

- Content validity and reliability of the instrument are adequate.
- Instrument is suitable for use in formative assessment of sea reports submitted by GP principals and GP registrars
- Findings highlight specific areas that could improve instrument reliability with the key area being variation among peer assessors
- The moderately large G coefficient for intra-rater reliability implies a reasonable degree of instrument stability when used by individual peer reviewers to assess at different points of time.
- The lower intra-rater reliability is more likely to be related to calibration issues among the assessors rather than the robustness of the instrument
- .

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Peer Review of Significant Audit: Acceptability, Feasibility and Educational Impact

- **GP Principals**
(Bowie, McKay et al. QSHC, 2005; McKay et al., Med Ed, 2009; Murie et al., EPC, 2009):
 - Professional satisfaction and reassurance
 - Enhances validity of activity undertaken
- **GP Appraisers**
(Bowie et al. BJGP, 2009)
 - Feedback is necessary, fair and constructive; 'adds value' to Appraisal
- **GP Peer Reviewers**
(McKay et al., JECP, 2009)
 - Time, Training and calibration, Responsibility for other peoples learning, validation Issues (satisfactory/unsatisfactory)?

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Acceptability and Educational Impact for GP Principals

To investigate the acceptability and educational impact of the model, semi-structured interviews were carried out with GPs who had participated in the system.


- External peer feedback is generally acceptable to participants.
- It complimented and enhanced the appraisal process.
- The feedback had positive educational outcomes particularly in imparting technical knowledge on how to analyse significant events.
- Suggestions to enhance the educational gain from the process were given such as asking the reviewers to offering advice on how they would address the specific significant event submitted for analysis.
- There was disagreement over whether this type of feedback could or should be used as supporting evidence of the quality of doctors' work to educational and regulatory authorities.

"Appraisers might not be quite as honest and quite as frank as someone completely independent." (M1 group 3)

'stamp of approval'.

-

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Feedback: Learning and change

Some believed, however, that where there is in-depth feedback that outlines a number of learning needs, which can be perceived as 'negative' feedback, it can *"cause your hackles to raise a bit"* (M3, group 2). Indeed one interviewee (F3, group 1) had written back to the peer feedback coordinator to disagree with the reviewers' comments (a highly unusual occurrence).

"...it [feedback] would have been more useful if I hadn't done one before...The comments were more about my writing up of the SEA rather than how we could change all different things - want suggestions, not for the way you laid out SEA but for ways of improving or avoiding event happening again." (F1, group 3)

"There were points raised, you know, of dealing with things I hadn't thought of." (M2, group 2)

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Peer Review of SEA:
**Acceptability, Feasibility and Educational Impact for GP
Peer Reviewers** (McKay et al., JECP, 2009)

Six principle themes

- Purpose of feedback
- Volume and depth of written feedback
- Professional and Legal implications
- Emotional and cultural issues
- Training and calibration
- Format and content of feedback instrument

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Purpose of feedback


“This all started because we were promoting change and I am not sure at the end of the day that this is still not the driving force in terms of the mass of doctors that we want to use this exercise as a way of promoting change and their own education” (F1,M3)

“...the educators want it to be formative. I think probably the recipients would be quite happy for it to be a summative (judgement)” (F1 M1)

“Appraisal doesn’t make a decision so we should” (F2, F1)

“...we are not looking at it for satisfactory or unsatisfactory...we are looking at it to highlight areas that are weak - much more formative” (F2, M2)

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Volume and depth of written feedback

“If I submitted an ‘SEA’ that was fine and I had to read a page telling me it was fine I would be really annoyed.” (F3, F2)

“Someone may have sweated over the ‘SEA’ and are dying to hear back... what is acceptable for them may be different than for you.” (F3, M3)

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Professional and legal implications

“... you look at what conclusions have been drawn and you go whoa, whoa – you just really missed the point here.” (F3, M2)

“...it could be applied on a whole range of levels from the trivial to the massive, and the legal for instance which is something I assume we are not going to drift into - areas which might be used in court if it were to get serious.” (F3, M4)

Overall role of reviewer thought to be an important professional duty

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Medicine

Emotional and cultural issues

“...you have got to be careful about our comments; the person may want a very significant discussion about the comment.” (F1, M4)


“You sometimes feel the report you are going to give back is going to take longer than some of the poor ones take to do!” (F1, F3)

“When I started marking things I thought I am going to mark things, most people up – I feel quite sympathetic, but then I found myself thinking – what the hell did you submit this for? What was the point?” (F3, M2)

“...part of the reason we don’t give out [feedback] ‘rubbish’ is because we have a feeling for the person getting the feedback and we also have experience that says – this person has gone as far as producing this report – already they are not at the lowest end of the scale.” (F2, M1)

“...in Scotland we never say that something is outstanding!” (F3, M2)

Quality Education for a Healthier Scotland



Medicine

Training and calibration

“I think if you are taking on responsibility, you are being responsible for other people’s learning then you are duty bound to recalibrate yourself.” (F1, F3)

“...the very best thing educationally for me is when you get the feedback and you see what your co-marker has marked and you see how the comments have been collated into the final document ...without a shadow of doubt.” (F2, M2)

Quality Education for a Healthier Scotland




Medicine

Format and content of the feedback model

“It keeps us interested as part of the process and it was good to hear you acknowledge our experience and input” – general agreement (F3, M4)

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Medicine


Format of feedback and timescale

“I would rather be told something was ‘fair’ rather than a three out of seven.” (F4, group 2)

“Not sure if worth extra work [giving numerical values] – because you are looking at how to do it differently next time rather than how to get a score – nice if you get a good one you might be disappointed if you get bad one.”

(F2, group 3)

Quality Education for a Healthier Scotland



Medicine

Why GPs don't Participate in Peer Review Model

Curnock, Bowie, Pope, McKay2012 (BMC Medical Education)


- Lack of Value – Activity itself, External Review, NES model

"I cannot be bothered with all that extra bits because I don't need it...and well God ok, that is not to say I haven't looked at everything but I just haven't sat down and written it all bit by bit...but people will argue, 'well if you don't do it properly it is just sloppy, la la la la', fine, I don't need the formalisation anymore thank you very much"

- Attitudinal & Practical Influences - Mediated by Experience and Understanding

"there's a kind of core that slap each other on the backs and get together and have meetings and pontificate about how the future will be and so on and there is the bulk of people on the outside of that seeing them as some ivory tower separate organisation who comes and bothers them from time to time"

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Medicine

Feedback

van der Ridder *et al.*, (2008) argue that none of these actually 'define', but merely assert the characteristics of feedback, such as its purpose and content. By merging these concepts and characteristics the authors developed the following definition of 'feedback' in relation to medical education as, *"specific information about the comparison between a trainee's observed performance and a standard, given with the intent to improve the trainee's performance."* The term 'trainee' in this definition relates to anyone in a learning situation. The feedback provider giving the 'specific information' is defined as *"someone who can envision a standard against which to compare the trainee's performance"*.

Quality Education for a Healthier Scotland

5.2 Examples of poor and better SEAs, with comments on why, for prospective submitters, Prof Greg Rubin and Dr John McKay

5.2.1 Example of a poor SEA

~ 1 ~

| SIGNIFICANT EVENT AUDIT OF CANCER DIAGNOSIS | |
|---|----------------------------|
| Cancer SEA Report Template | |
| Diagnosis: | Cancer of head of pancreas |
| Date of diagnosis: | 15/11/12 |
| Age of patient at diagnosis: | 67 |
| Sex of patient: | F |
| Is the patient currently alive (Y/N): | Y |
| If deceased, please give date of death: | |
| Date of meeting when SEA discussed: | 29/11/12 |

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.

1/11/12: patient presents with dark urine and jaundice, abdominal pain
 2/11/12 urgent referral
 Previous consultations
 28/9/12 BP check and medication review
 14/9/12 consulted with tiredness. No cause apparent.

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).

Prompt referral at first consultation. No delay in assessment.
 USS, CT scan and ERCP done as inpatient.
 Inoperable cancer of head of pancreas, palliative treatment only.

Comment [QA1]:
 Not all relevant information appears to have been given to put the background of the SEA into context.

No information about who saw the patient on each occasion or where.

No description of negative findings, duration of symptoms/signs or exclusion of 'red flag's in earlier consultation (may not be in records).

Where/Who was the urgent referral made to?

Comment [QA2]:
 No comment on deficiencies of earlier consultations.

Specifically, the 14/09 consultation was for a symptom that could have prompted more assessment than is reported, and have been managed with safety-netting arrangements. The 28/09 consultation was an opportunity for this.

Prompt referral claimed but not defended – given there was potentially a 6 week delay in diagnosis.

Based on the SEA structure recommended by NPSA

E Mitchell & U Macleod (version 2.2: December 2012)

~ 2 ~

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:

Prompt and appropriate management.

Learning point 2:

Appropriate use of urgent referral pathway.

Comment [QA3]:
No evidence of reflection and discussion in a team meeting.

No comment on

- team working (assuming 28/09 consultation was with a nurse),
- educational needs,
- or role of guidelines versus more urgent management of patient with apparent obstructive jaundice.

No description of the assessment of symptoms of tiredness on 14/09 and any appropriate investigation or follow up.

Were other partners in agreement with management?

Did the patient perceive any delay?

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.

No changes required.

Comment [QA4]:
Could have considered:

- assessment of tiredness in the elderly,
- extent to which nurse in BP clinic should review recent consultations.

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.

Confirmed current quality of care and that guidelines for urgent referral are being adhered to.

Comment [QA5]:
A cursory SEA with no evidence of reflection.

In part due to choice of case but also failure to adequately consider events surrounding the patient's presentation.

No learning demonstrated and no actions arising.

Poor choice to benefit from 'opportunity-cost' of analysis.

SOME INFORMATION ABOUT YOUR PRACTICE *

| | | | |
|---|----------|------|--------------|
| How many registered patients are there? | | 7500 | |
| How many F.T.E. GPs are there (inc. principals, salaried GPs, trainees etc.)? | | 3.5 | |
| Is your practice a training practice? | Yes | No | |
| Does your practice teach medical students | Yes | No | |
| What were your QOF points last year? | Clinical | 650 | Organisation |
| OUT OF: | | | Total |
| | | | 1000 |

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

Based on the SEA structure recommended by NPSA

E Mitchell & U Macleod (version 2.2: December 2012)

5.2.2 Example of a better SEA

~ 1 ~

SIGNIFICANT EVENT AUDIT OF CANCER DIAGNOSIS**Cancer SEA Report Template**

| | |
|--|--------------|
| Diagnosis: | Bronchial CA |
| Date of diagnosis: | 21/08/12 |
| Age of patient at diagnosis: | 61 |
| Sex of patient: | M |
| Is the patient currently alive (Y/N): | Y |
| If deceased, please give date of death: | |
| Date of meeting when SEA discussed: | 13/09/12 |

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.

11/6/12: Patient first presented to Dr A with a 3 wk history of non-productive cough and general malaise. History of recent URTI in close family members. No weight loss or haemoptysis.

Moderate alcohol intake, stopped smoking 30 years ago.

Known to have hypertension for past 2 years, now controlled on lisinopril and bendroflumethiazide. Had CXR at time of diagnosis – reported as normal.

Physical examination - nil of note

Advised likely URTI and to return in 2 wks if no better.

25/6/12: returns to usual GP, Dr B. Cough no better, though feels a bit better generally. Thought due to lisinopril and option of stopping discussed. Switch to ARB and 2 week review.

23/7/12: Saw Dr A (Dr B on holiday) Cough still troublesome, and now some pain in upper chest, left worse than right, thinks due to coughing. Review in further 2 weeks when Dr B back.

6/8/12: Dr B. Cough no better, thinks has lost some weight in past few weeks. CXR arranged .

10/8/12: phone call from Xray department taken by Ms C, receptionist. Opacity Left upper zone, referral advised. Message left for Dr B, who is on 2 day trainers' course.

12/8/12 2WW referral made by Dr B.

Comment [QA1]:

Clear description of sequence of events with active participants identified.

In this section the submitter could also have discussed:

- impact/potential impact of the event – eg delayed diagnosis and potential effect on doctor patient relationship
- communication of 'urgent' results when doctor away or on holiday.

~ 2 ~

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).

Dr A considered viral infection most likely, and was reassured by normal CXR 2 years earlier. Nevertheless, instituted safety-netting arrangement.

Dr B places ACE-induced cough as next most likely cause, still reassured by previous CXR. Makes appropriate change to meds and makes follow up arrangement, but for a time when he is not available.

Dr A concurs with Dr B's diagnosis and makes a holding arrangement until his return, on the basis that more time needed for ACE effect to disappear. Chest pain +cough should trigger alarm by now, but lack of continuity of care also at fault.

Ms C takes report but no mechanism in practice for phoned-in results to be reviewed each day. 2WW referral delayed as a result.

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:

That a normal CXR can't be relied upon when there are persistent symptoms. Repeat if in any doubt.

Learning point 2:

The patient was an ex-smoker. At the point of attributing his cough to ACEI, this should have carried more weight.

Learning point 3:

Safety-netting ensured this man was reviewed in a timely way, but it was let down by poorly-planned continuity of care.

Learning point 4:

The practice systems for dealing with results by phone is not fit for purpose.

Comment [QA2]:

Some insights provided into thought processes at time of consultations.

Additional considerations for potential underlying reasons could include:

- Why was Dr A reassured by an X ray from 2 years previous?
- Did the practice follow current guidelines for investigation of cough?
- How quickly should ACEI cough resolve on stopping medication?
- Was the receptionist's action in breach of practice arrangements?
- Is there a training issue for the practice staff?

Comment [QA3]:

Honest analysis that ranges across all aspects of the care provided.

~ 3 ~

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.

Clinical staff reminded of the criteria for urgent CXR and 2WW referral. The prevalence and nature of ACEI-induced cough and its management is to be reviewed by Dr B and will be presented at a practice meeting.

Arrangements for planned review at time of holidays discussed. Dr going on holiday will email or discuss with others those patients he wants to be reviewed in his absence, and reasons why.

System for dealing with phoned results reviewed. All results to be reviewed and actioned by Dr on call. Audit of this planned for 3 months time, to be undertaken by practice manager.

Comment [QA4]:
 Specific, measurable actions identified.

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.

Full PHCT present, including nurses and staff for this SEA meeting, which lasted 45 minutes.

Good practice identified – use of safety netting.

Area for organisational improvement identified with criteria for audit. Areas for clinical improvement identified with specific arrangements for shared learning .

Comment [QA5]:
 Full team present.
 Good practice celebrated.
 Both actions have identified responsible individuals and timescales.

SOME INFORMATION ABOUT YOUR PRACTICE *

| | | | | | | |
|---|--|----------|--------------|-------|----|------|
| How many registered patients are there? | | | | | | 5200 |
| How many F.T.E. GPs are there (inc. principals, salaried GPs, trainees etc.)? | | | | | | 2.5 |
| Is your practice a training practice? | | | | Yes | No | |
| Does your practice teach medical students | | | | Yes | No | |
| What were your QOF points last year? | | Clinical | Organisation | Total | | |
| OUT OF: | | 650 | 167.5 | 1000 | | |

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

Appendix 6: Peer Reviewer lessons learned workshop discussion notes



Peer Reviewer lessons learned workshop

20 June 2013 12.30-4.00pm

RCGP, 30 Euston Square, London NW1 2FB

Discussion notes

Agenda

1 Drawing out the themes

Submissions/Snapshots
10.06.13
Peer Reviewer Feedback
GP Responses I & II
Peer Reviewer role
Local picture

2 Drawing on the learning

Good/bad/do differently
Future scope/model

3 Closing remarks

Papers

- 1 Cancer SEA PM Report v1 28.05.13
- 2 SEA snapshots 001-022 & 060-080
- 3 Cancer SEA Pilot Datasets v1 30.05.13

Attendees

Robin Armstrong

Jeanne Fay

Praveen Gupta

Tehmina Mubarika

Vincent Rawcliffe

Phil Sawyer

Greg Rubin

Sam Ladhani

Sarah Pollet

Apologies

Lionel Cartwright

Petula Chatterjee

Rob Deery

Jackie Dominey

Joan Meakins

Nari Pindolia

Pawan Randev

Russell Thorpe

Alison Wint

Notes of the discussion

Submissions

An analysis of the pilot will not be able to assess if there were any improvement in the quality of the SEAs submitted attributable to the feedback provided/received as only two individuals or practices submitted SEAs on more than one occasion, with a passage of time period between those submissions. All other submissions were one-off submissions.

Submissions tended to fall into two camps:

- Right spirit – good case selection and reflection.
- Missed the point – superficial/not reflective.

The submissions demonstrate that key to producing a good SEA is good case selection and an ability to identify the critical issues it raises for discussion.

Superficial SEAs

Misunderstanding?

Some seem not to have understood the objectives of the project.

Did some think they were contributing to a library of obscure cancer cases?

They raise questions about the motives for submitting (money?).

Did they think this was an easier exercise than an audit for their appraisal? The North East reviewer had promoted it on 25 practice visits as appraisal enhancing but had had no take-up, so appraisal did not seem to be a motivating factor in his opinion.

Poor status in QOF?

The superficial SEAs are worrying given the long history of SEAs for quality improvement in general practice.

It raises the question of what is the quality of the mandated SEAs submitted to QOF.

Perhaps we'll see an improvement after a few years of revalidation.

Perhaps it is connected with the low value in QOF points (two points or £400) that SEAs represent.

Practice learning skills

Practices interested in quality improvement do well/competently. Do we have an insight into why other practices do it badly?

The poor SEAs reveal that some practices do not understand how to get the practice learning from the SEA process. They stop too early and do not complete the journey. It suggests that certain settings or practice processes do not permit the level of discussion needed for the exercise. The idea of SEAs is in place (QOF) but the process of how to undertake a SEA well is not established and it will take time to influence the detail of its implementation.

The range of scores given to the SEAs reflect the 'quality' of quality improvement undertaken in GP surgeries. It would be interesting to analyse the scores against type of practice: training or not.

Was it our fault that some practices do not seem to have understood the process? They might read the instructions provided but without the education about how to reflect and write reflective notes they would not necessarily interpret them correctly.

SEA template

The question of what was the impact on the patient was often poorly answered. Tendency to focus on the medical impact and not the feelings of those involved (patient, family, GP, practice). It was recommended that the question of impact in any future such exercise become a separate and distinct question in the SEA report template to encourage submitters to reflect on it.

Low Uptake

Need for CCG involvement

Networks did best when backed by CCG encouragement, e.g. Dorset, and potentially the initiative that the Greater Manchester and Cheshire reviewer is now involved in for her CCG.

Level of detail/time required

Thames Valley ran a similar initiative on emergency admissions and received 36 practice submissions. However, they were not required to provide such detailed information. They did not have to provide the background or describe what happened. They just had to note the learning points and changes made. They did not receive an individual feedback report and it did not give the reviewers a feel for the quality of the case chosen or the practice.

Practices have to work to the business model: there needs to be a justifiable business case for spending time on something. Perhaps few could justify time spent submitting a SEA to this pilot.

Needed more central and local support

Another NAEDI initiative had three project managers to visit the practices and promote that initiative, which this one did not have.

Maybe the reviewers should have offered to help their network practices to do a SEA: sit in on their network practices' SEA meeting, particularly the non-training practices, and help them with their first SEA submission to the pilot (rather than leaving it as a suggestion for them to complete themselves following the practice visit).

When designing the pilot we thought practices would view it as a win-win opportunity. They have to complete SEAs anyway for revalidation and QOF. By participating, they would receive a feedback report to enhance their portfolio. We thought the only hurdle would be that the pilot was cancer specific. We underestimated what it would take to get practices to submit a SEA.

Networks prioritised other initiatives

Drumming up submissions for the pilot was frustrating because of the pressure on the networks. Some networks were running separate SEA initiatives simultaneously.

Retiring GPs

The high numbers of older GPs retiring and likely to retire in the next five years (e.g. 40% in Hull) was thought to be a factor in the low take-up of the initiative.

Peer reviewer experience

No local insight

As submission numbers were low for most networks, the majority of reviewers have not obtained a perspective on cancer diagnoses in their locality. Only Dorset, with 50 submissions, might have some insight into their local situation. The Greater Manchester and Cheshire reviewer is now responsible for reviewing all the SEAs submitted to her CCG.

Wonderful insight into the practice of the wider GP community

Whilst the reviewers had not gained an insight into cancer diagnoses in their locality, a major benefit of reviewing the SEAs for them was the perspective it gave them of how practices, other than their own, operate. This was new for them. It was not only interesting for them, it improved their own practice: 'with the right training, reviewing SEAs gives you a perspective on how other practices operate against which you can compare your own practice, so it improves your practice'. An excellent development experience.

Peer reviewer training and ongoing group engagement essential

The initial and ongoing training received in the course of the pilot had been essential. Half of those present (three persons) did not have a training background and, for them, reviewing the first SEAs had been challenging and outside their comfort zone. It had become a lot easier over time with the ongoing training and reassurance they received from sharing the combined feedback reports and the comments from the Quality Assurer (QA). The other half (three persons), with a training background, would not have wished to have engaged in the work without the initial training, regular discussion groups and receiving the combined feedback reports.

The reviewers emphasised how important receiving the combined feedback reports was to them: their receipt was eagerly anticipated so that they could compare their scores and comments made, with relief felt if they scored and commented similarly and learning gained from phrasing used by the other or where points discussed differed. The reviewers expressed that they had learnt to give better, more in-depth feedback over the course of the pilot as a result of reading the feedback reports.

It was noted that the majority of feedback and scores had been close per SEA. This was very good and the sharing of the feedback reports and receipt of the QA comments considered important elements of its achievement. Only on two occasions had reviewers been asked to review their scores.

It was anticipated at the pilot's outset that scoring would be more divergent. This had not proved to be the case. It was interesting to see that although reviewers might highlight different aspects of a SEA they had marked to the same grade.

Time taken

Reviewing SEAs took time

You have to think of both positive and negative comments to feedback.

A SEA cannot be reviewed in one sitting. It has to be read and returned to later, or even the next day.

The more a practice reflected in their SEA, the more the reviewer had to reflect. One reviewer noted that where a SEA's reflection was more in depth, it encouraged her to consult the National Institute for Health and Care Excellence (NICE) guidelines.

Could we have done less and still have given meaningful feedback? The consensus was no.

The work was not onerous but each case required thinking time. It took time to work out what had happened clinically versus SEA technique.

Can you confine yourself to just assessing their SEA technique?

Sometimes you do have to point out a missed clinical learning point.

QA role

The QA role was much quicker per SEA. The QA had been able to read a case quickly and not spend time digesting and reflecting on it to work out what had happened because he then read the two feedback reports that had already done that with great care. Over time he felt his role had reduced to addressing any issues of disparate scoring.

GP Evaluation I

Need to cross-analyse score awarded with submitter feedback

Submitter comments seem to be positive (the majority) or markedly negative. Analysis should examine whether this corresponds with the global score/feedback the practice received from the reviewers.

Was our feedback too robust?

One reviewer had tried to use the full range of scores available; another felt he had been softer at the outset but in response to feedback from the QA had become harder; a third felt he had become angrier over time.

If a submission had only three or four words in each box there was little a reviewer could say or be anything but robust. A practice only had to provide a reasonable narrative and address the latter part of the SEA template to get good feedback.

The QA noted that at the outset, the pilot had taken the position that there is a bit of good in everything but by the end had accepted that some are just pretty terrible and we could not be completely supportive (i.e. say something is bad if it is bad) especially as a submitter might decide to use the feedback report as part of their revalidation.

One GP submitter had expected the relevant NICE guidelines to accompany their feedback report.

GP Evaluation II: change in practice

Background

In preparation for this questionnaire, the QA had reviewed the SEAs and highlighted the measurable action points in them, e.g. establish a new process for lab reports. The submitter received a covering email containing the highlighted action points from their SEA in the body of the email and a link to the survey, in which they are asked to comment on what had been done around those action points and the outcome. This is because NCAT and Macmillan are keen to know if this exercise resulted in change and if it were measurable.

Demonstrating measurable change is very difficult

Reviewers are meant to demonstrate change in every practice visited but what you do is sow the seed; three years might pass before that practice undertakes an audit. Exercises like this plant such a seed. They move people from pre-contemplative – to contemplative – to action. It is a slow process of ‘nudges’ and ‘seeds sown’. It is difficult to demonstrate measurable change from the initial and ongoing ‘nudges’ and ‘seeds sown’.

Given the low numbers of cancers seen per practice it is very difficult for them to measure change in practice in this clinical area.

Future model: agreed premises

Need CCG backing

To increase submissions would require CCG backing.

Wider remit

To engender systematic process improvement, the model needs to be rolled out more widely. Need to expand beyond cancer and have enough reviewers.

Revise the SEA template

Revise the template to add a specific question/box/section on ‘What was the impact on those involved (patient, carer, family, GP, practice)?’ as this was often poorly addressed, with a tendency to focus on the medical impact and not on the feelings.

Present our template to QOF?

The idea of SEAs is in place (QOF) but the process and how to undertake a SEA well is not in place. Take time to influence the detail of implementation. The templates used for QOF are very basic and are probably completed by the practice manager. Not all the SEAs submitted for QOF are clinical and languish in a QOF cupboard.

Could the model be revised to one peer reviewer? – No

Opinion was that it was important for the practice to have feedback from two independent reviewers, as then the feedback was less easily dismissed by the practice.

Seeing the feedback provided by the other reviewer of the pair was a fundamental part of the learning process for the reviewers. Working alone, a reviewer would be liable to develop a blind spot.

Practices pay for peer review? – No

Given the limited take-up of this free opportunity, asking practices to pay would not work.

Business case

Practices have to work to the business model, they need a business case reason to change.

Alternatives:

- a. Make it a requirement that a RCGP peer-reviewed SEA is included in portfolios. This would drive up the number and quality of SEAs and the use of this process.
- b. Mandatory analysis of a randomly-selected SEA. Practices would do the work if Care Quality Commission (CQC) registration required it.

Future model: the suggested model

Require that one clinical QOF SEA per practice per year is randomly selected by the CCG for College-style peer review

The random selection of the SEA for peer review should drive up the quality of clinical SEAs generally as practices will not control which SEA is selected.

Would require NHS England backing as they are responsible for quality improvement.

Did the Hull SEA initiative on emergency admissions which generated 80 SEAs give the network a better handle on what was going on? The reviewer had used the learning from it in his practice visits. Practices which had participated became more proactive. The problem with self-selected participation is that only the usual suspects get involved. The challenge for quality improvement work is to involve the practices who need it most.

The benefit of randomly selecting a QOF SEA submission for peer review is that it would involve every practice. Those that do not do quality work well would have it pointed out. And they would need to improve all their SEAs as they would not know which would be selected.

It would generate the 'nudge' across the board towards reflective thinking and quality improvement.

Protection needs to be built into the model to ensure it remains a quality improvement exercise and not a performance management one.

Broaden the remit to reflect the new Domains and CCG local-focus interest.

Link up with admission in hospitals. Could tweak to an end-of-life focus from the beginning to the end of a patient's care pathway. Make it more about end-of-life than diagnosis. May identify more problems in palliative situations. This could work well for the College which has appointed a new End-of Life Clinical Champion, Peter Nightingale, and seeks more join-up between its initiatives. Could tweak to cover Domains 1 and 2: preventing premature death and enhancing quality of life for people with long-term conditions. CCGs would want a locality focus and interpretation.

Online automated administrative solution

To be sustainable, the model's administrative processes would need to be overhauled as it has been onerous to process even 95 SEAs. When a SEA is submitted, someone has to 1) identify the own-patch reviewer and the next random reviewer on the list (so that reviewing is shared out equitably); identify the timeline for that SEA, i.e. when the peer reviewers need to return the SEA, when the QA will have to return the SEA, etc. to meet the 15-working day deadline, and log the details of the SEA and these process dates in a spreadsheet (and in their calendar so that they are able to send out a reminder to the reviewers and QA if they do not send their reports back in time). Then contact the two prospective reviewers to ask if they are available to review that SEA by the identified deadline for their part of the process. Monitor their replies. Issue the documents if they say yes or find another reviewer. As a result of the reminder in their calendar, when it alerts them that the peer reviewer or QA deadline is approaching, they need to check if they have received both reports and send a reminder where appropriate. Collate the reports into a combined report: this involves cutting and pasting from the two individual reports into a new combined template. This is open to human error.

A technology solution is required so that practices complete an online form, and an automated system selects reviewers, identifies deadlines, sends reminders and enables peer reviewers to complete online feedback forms, which are automatically combined into anonymised feedback reports.

There is a consultation currently out on what CCGs want from the strategic clinical networks. Need to feed into that consultation. The strategic network wants on the ground work devolved to the CCGs.

Could NHS IQ build a common online system that could be rolled out to all CCGs? An online tool with a multiplicity of locality-focused outcomes?

To be for the benefit of the CCGs and via them CQC and NHS England, the model needs to be locality-focused, underpinned by a common administrative system. Once in existence, the system could be used to analyse specific circumstances of note for a locality, a current hot topic, e.g. with the current questions being asked about accident and emergency (A&E) services, one response could have been to ask practices to submit two SEAs on A&E attendance. This would harness enthusiasm and provide a rich big picture on a particular issue.

Reviewers: trainers and associate trainers

Reviewers should be trainers and associate trainers (as associate trainers have less to do than trainers), to have enough appropriately qualified people to make it possible.

e.g. 77 practices in Durham. If it was required that two of their 12 QOF SEAs had to be peer reviewed, that would be 154 SEAs per year. If a third of available trainers agreed to be SEA peer reviewers, that would be 100 reviewers. If 20 of those were secured as reviewers, that would be roughly one per month for them to review (two reviewers per SEA: $154/10$ pairs = 15.4 SEAs each), which is on a par with what the majority of reviewers of this project have had to do; it is not an onerous task: it is a positive, rewarding experience; and the feedback reports the reviewers contribute to are invaluable for their own appraisal.

The hurdle: the value of SEAs in QOF

QOF SEAs are worth two points or £400 to the practice. This is not much. Will practices in the future choose not to complete this element because it is not worth much money to them? It costs a practice £400 to get the whole practice together to undertake the SEA, as they need a locum to cover them all. So they effectively would not earn anything by completing this QOF indicator. Can this be changed?

Input from peer reviewers unable to attend Lessons Learned Event

Peer Reviewer contributions I and II were received ahead of the event and provided to attending delegates on the day.

Peer Reviewer contribution I

Reflection on the SEA Pilot Project:

- I think that most will agree that the SEA pilot has overall been a success. A wide range of cancer diagnoses has been included and all but one of the pilot sites has contributed.
- A few of the SEAs have been outstanding, quite exemplary.
- The learning has been implemented as the project has progressed leading to improvements over the period of the pilot.
- The difference between reviewers has narrowed as familiarity with the scoring process has developed and through comparison with others' scores.

- A few submitters appear not to have grasped the need to identify learning rather than just record the event.
- Also feedback has not always been welcomed/valued.
- Administratively, personally, there have been occasions when a batch of SEAs have been fed back on simultaneously, resulting in confusion as to which feedback report from that reviewer applied to which SEA. Similarly, there has been one example when the text in the combined feedback report was not that submitted for that SEA but rather another. This highlights the need for Admin support and scrutiny of reports.

(The reports for SEA085 and 086 were returned by the reviewer in the same email. The feedback content for SEA086 was pasted into the combined report for SEA085, issued to the QA, and then to the submitter with the QA's comments. I've been responsible for similar, and I think it shows that everything needs to be double checked, or independently scrutinised.)

Recommendations

Although a final feedback meeting and summary report is yet to be held/written, I would suggest that any region intending to roll out SEAs should consider the following:

- Peer review training and comparison of scoring between reviewers is an essential pre-requisite.
- Preparation and teaching for practices taking part will improve uptake and learning from the SEA.
- Administrative support and co-ordination is essential.

Peer Reviewer contribution II

Should peer review of a SEA feedback only on SEA technique and not on clinical practice?

This question arose in the course of reviewing SEA083 (see below) and the reviewer felt it would be useful for everyone present to discuss.

SEA083 DIFFUSE B-CELL LYMPHOMA

Diagnosed: 10 July 2012; Patient: Male, 70, alive; SEA meeting: 30 April 2013

Combined report was issued to the peer reviewer with the QA comment:

'Good feedback that identifies areas for improvement as well as applauding a good SEA. Worth remembering that it's the SEA technique that is being assessed, and not the clinical practice, though both very good.'

The peer reviewer asked:

'Can you please confirm that in future SEA reviews I undertake I should solely concentrate on the SEA technique and not make any comments beyond the SEA process?'

The QA responded:

'The evaluation form is designed around the process of SEA and the primary aim of the pilot has been to give practices an opportunity to get feedback on their technique. I think this is made clear in the information to practices.'

Feedback on clinical practice is to some extent unavoidable, though we haven't set out to specifically judge practices on this. In some cases it has been particularly appropriate, if only from a patient safety perspective.'

Appendix 7: Finance report

Income

| | Macmillan Cancer Support | National Cancer Action Team | RCGP | Total |
|--|--------------------------|--|-------------------------------|---------|
| As agreed in the PID, project costs were to be allocated as: | Peer review assessments | Project administration, steering group meetings, workshops | In-kind staff time commitment | |
| | £10,000 | £10,000 | £10,000 | £30,000 |

Outgoings

| | Macmillan Cancer Support | National Cancer Action Network | RCGP | Total |
|---|--------------------------|--------------------------------|----------------|----------------|
| Peer Review Assessments | | | | |
| Paid (182 invoices @ £37.50 for 45 mins) | £6,825.00 | | | |
| Peer Review Workshops | | | | |
| 2 workshops (Training May 2012 & Lessons Learned June 2013) | £1,658.04 | | | |
| Workshop travel | £1,516.96 | £1,298.92 | | |
| Steering Group Meetings | | | | |
| Held (5) | | £170.19 | | |
| Paid Steering Group travel (Clinical Lead) | | £600.45 | | |
| Project Administration | | | | |
| | | £7,930.44 | £10,000.00 | |
| Total expenditure | £10,000 | £10,000 | £10,000 | £30,000 |

| Category expenditure | |
|--------------------------|------------|
| Peer Review Assessments: | £6,825.00 |
| Peer Review Workshops: | £4,473.92 |
| Steering Group meetings: | £770.64 |
| Project Administration: | £17,930.44 |
| | £30,000 |

Peer reviewer remuneration was agreed from the project's outset to be based on the sessional rate of £200/4 hours (£50/hour). It was initially assumed that a review would take 15 minutes (@£12.50 per peer reviewer). However, peer reviewer evaluation in the course of the project consistently found that a review took on average 45 minutes, not including its associated administration. It was also found that time per SEA did not reduce with experience as each case required individual reflection to think through the situation presented and consideration of how to word the feedback.

97 SEAs reviewed, including a resubmission, with two invoices received per SEA. A total of 194 invoices were expected. Received 182 invoices with 12 not submitted because one peer reviewer chose not to charge for their time (8) and others chose not to charge when the SEA was not a cancer case (2) or did not submit their invoice in time (2).

The above were the chargeable costs to the project. Much additional in-kind time was given by participants:

The Quality Assurer role (to review the SEAs and their peer assessments; and lead meetings, webinars and workshops) was performed in his role as Clinical Lead and the analysis work for the final report funded by NCAT.

Peer reviewers attended the workshops and webinars; participated in the quarterly evaluation; promoted the opportunity; and undertook the associated administrative work of managing the peer review requests in their role as Cancer GP Leads and Macmillan GPs.

Steering group members participated in the workshops; steering group meetings; and analysis (in and out of session) with the support of their respective organisations.

RCGP contributed additional staff time and webinar costs.

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