

Electronic Safety Netting (E-SN) Toolkit Quality Improvement Report

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February 2020

Bringing together hospital trusts, GPs, health service commissioners, local authorities and patients in north central London to transform cancer care.

www.nclcanceralliance.nhs.uk

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ACKNOWLEDGEMENTS

The Alliance would like to thank the many individuals and teams that have supported this project right from its inception and throughout its evolution.

Kathy Pritchard-Jones, the Chief Medical Officer for the Alliance at the start of this project, who supported and encouraged the development of this project.

Sharon Cavanagh, the programme lead, who saw this project as a valuable part of the work stream. Vanessa Ponnusamy, the primary care project manager who was in charge of the operational aspects of this project's delivery and whose support has been vital to complete the latter half of the project work stream.

Naser Turabi, the Alliance programme director, for his leadership, support and steer in propelling this project forward.

Anthony Cunliffe and Rosie Loftus have been key figures in Macmillan Cancer Support whose clinical leadership, advocacy and support have been absolutely pivotal in taking the project forward strategically. Their ongoing support to promote this toolkit to the Macmillan GP group has meant widespread utility of the toolkit.

GP Cancer leads in the Clinical Commissioning Groups (CCGs) and the Transforming Cancer Services Team (TCST) who provided a range of input into this project throughout its development. In particular, Ishani Patel and Pawan Randev who were key GP clinical leads at TCST in the early stages of this project.

The Cancer Research UK facilitator team for helping to promote this toolkit on their GP visits.

Pilot GP practices in Barnet, Barking & Dagenham, Camden, Havering, Islington, Tower Hamlets and Waltham Forest who became part of the early adopter sites to really test and shape this toolkit.

Rob Walter and Emma Coulson at EMIS Web who have been the clinical and technical leads, who saw the value and purpose of the toolkit and made it the final and completed product within EMIS Web that it is today.

INTRODUCTION

This report details the drivers and processes behind the development and implementation of the E-SN toolkit. We will highlight evaluation data from pilot practices and share our recommendations and plans for further mobilisation. The report is primarily targeted for Cancer Alliance colleagues, primary care colleagues including clinical and non-clinical leaders, providers and commissioners and voluntary sector partners of cancer care improvement (e.g. Macmillan and CRUK).

The NCL Cancer Alliance formally came into being in April 2020. Prior to this, we were the NCEL Cancer Alliance and covered the north-east London footprint as well. The project was carried out by the primary care team within the organisation.

The now NCL Cancer Alliance brings together hospital trusts, GPs, health service commissioners, local authorities and patients across North Central London to improve cancer care for patients in the region. Working with stakeholders, its mission is to achieve world-leading patient outcomes and experience for its local population. The NCL CA is a nationally mandated programme and reports to the national cancer team.

The E-SN toolkit is now nationally available on EMIS Web (the electronic health record system provider - EHRs) as of June 2018.

EXECUTIVE SUMMARY

Safety netting in primary care is central to how clinicians and GP practices manage risk and patient safety in daily practice, especially in the context of cancer care provision. Yet, safety netting is not uniformly understood and applied in a variable manner across primary care.

In the cancer field, safety netting has been advocated to improve earlier cancer detection, which reduces the time to diagnosis and ultimately improves patient outcomes and experience. Reviews of missed opportunities in the early diagnosis of cancer highlight the intricate steps in the diagnostic field, from assessment to testing to follow up. High quality safety netting systems could mitigate risk uniformly.

The Alliance has innovated, tested and deployed a toolkit within EMIS Web that is user friendly, auditable, proactive, and robust that offers a system based approach of applying high quality safety netting to clinical events in primary care.

The improvement methodology has been multi-faceted. The development and testing phases were direct and active with high levels of GP engagement to feed into the product evolution. There was strong clinical and stakeholder engagement, which enabled mobilization of the product strategically. There was an appreciation that having a product that was 'free and available' within a system alone, would not guarantee widespread adoption and usage in primary care. In response, resources and investments were allocated to publicise and communicate the products purpose and value and an educational package was produced to support implementation.

The improvement journey and resulting service evaluation has shown that the toolkit is acceptable and user friendly in primary care. It has made positive improvements to safety netting processes in practices with the potential to reduce misses and delays in referral or diagnostics test, which in turn reduces time to diagnosis. Practices have used the system to track urgent suspected cancer referrals and direct access investigations (e.g. Blood test to Ultrasound referrals) to ensure patients attend and

their results are received by the practice. The toolkit has also been used to track persistent concerning cases despite a 'normal' investigation e.g. A chest XR that is normal could still pose a risk of lung cancer and ongoing symptoms would require ongoing re-appraisal of patient symptoms or escalation.

The wider learning covers the complex nature of promoting a new way of working in primary care and the operational aspects of trying to do so, without commissioning or contractual (top down) levers. The experiences reflect impact on a non- incentivised and then incentivised approach in implementing change. The product has had a lot of appeal due to the simple and integrated model and wider applicability beyond cancer tracking. Practices could see the clear benefits of adopting this change without an incentive. But payments were necessary for the return of evaluation data. Finally, successful adoption of this system way of working required whole practice engagement with administrative and clinical ownership and leadership. Implementation training would need to be come with explicit instruction that some practices may need to work differently with regards to a shift in administrative work from clinical staff to administrative staff.

Safety netting: a quality issue in relation to cancer ¹²³⁴⁵⁶⁷⁸

Safety netting is a pivotal part of clinical care and is said to be best practice and yet there is a huge variation on how it is understood and applied.

Safety netting is a strategy to help manage diagnostic uncertainty. It helps ensure patients undergoing investigations for, or presenting with, symptoms which could indicate serious disease, are followed up in a timely and appropriate manner. The aim is to ensure patients do not drop out of the primary care net but are 'monitored' until their

¹ <https://www.bmj.com/content/355/bmj.i5515?sso=>

² <https://www.nature.com/articles/bjc201547>

³ <https://bjgp.org/content/68/666/e63>

⁴ <https://europepmc.org/articles/pmc5916080#b10>

⁵ <https://bmjopen.bmj.com/content/7/11/e018210.full?ijkey=vzq1XeONUNLsR2y&keytype=ref>

⁶ <https://www.ncbi.nlm.nih.gov/pubmed/25734393>

⁷ <https://europepmc.org/articles/PMC3529291/>

⁸ <https://annals.org/aim/fullarticle/1656430/patient-safety-strategies-targeted-diagnostic-errors-systematic-review>

symptoms have been explained or resolved. Good safety netting is dependent on good patient communication and shared planning, good record keeping and clinical systems.

The diagnosis of cancer is complex and often has multiple steps. This is because many cancers will present with vague or non-specific symptoms (e.g. fatigue), which may be shared with other non-cancerous conditions. The clinical consequences for cancers with vague symptoms have been delays in diagnosis and/or multiple consultations. It is known from various large scale audits, including the National cancer diagnosis audit (NCDA) and significant event audit, that inadequate safety netting has been associated with delays in diagnosing cancer.

Medical Defence unions like the Medical Protection Society Ltd (MPS) have written about the importance of stringent safety netting systems.

Technology-based interventions and alerting could potentially help to improve safety netting processes and be an effective approach to ensuring timely diagnosis.

National drivers for cancer safety netting in primary care

In 2015, NICE published ‘suspected cancer: recognition and referral’ (NG12)⁹ and made the following recommendations for safety netting:

- 1.15.1 Ensure that the results of investigations are reviewed and acted upon appropriately, with the healthcare professional who ordered the investigation taking or explicitly passing on responsibility for this. Be aware of the possibility of false negative results for chest X-rays and tests for occult blood in faeces*
- 1.15.2 Consider a review for people with any symptom that is associated with an increased risk of cancer, but who do not meet the criteria for referral or other investigative action. The review may be:*

⁹ <https://www.nice.org.uk/guidance/ng12>

- *planned within a time frame agreed with the person or*
- *patient initiated if new symptoms develop, the person continues to be concerned, or their symptoms recur, persist or worsen.*

Also in 2015, ACHIEVING WORLD-CLASS CANCER OUTCOMES, A STRATEGY FOR ENGLAND, 2015-2020, a report of the Independent Cancer Taskforce (ICT)¹⁰ made recommendations on safety netting in primary care:

It is important that GP practices continue to monitor those patients sent for an investigative test. This will ensure test results are reported and communicated, and that any abnormal results are followed up appropriately. This is especially the case if symptoms persist despite a negative test, as further testing or follow up may be required.

And the report goes on to recommend that:

NHS England should incentivise the establishment of processes by GP practices to ensure ‘safety-netting’ of patients, including adequate support for training.

Cancer Alliance led work on safety netting

Primary care plays a vital role in the diagnosis of cancer and it is essential that they have safety netting processes in place to ensure patients are referred through the system to provide a timely diagnosis, high quality experience and ongoing support after a cancer diagnosis.

Safety netting in primary care is a set of steps and actions that can be taken during a GP-patient consultation and within the primary care practice systems. These ensure patients are monitored until their symptoms and signs are explained and results acted upon.

In 2015, the Alliance produced a guide to help GPs improve the quality of their coding

¹⁰ <https://www.england.nhs.uk/publication/achieving-world-class-cancer-outcomes/>

and safety netting¹¹. This was the precursor work to the E-SN toolkit. The guide sets out in detail the importance of high quality coding and safety netting in primary care that has important clinical implications on cancer work from early diagnosis to supporting people living with and beyond cancer.

The guide was then developed into an online educational module for GPs with support from Macmillan to host it on their LearnZone site¹²

Image 1: Safety netting process map in primary care¹²



It is useful to reflect on some key aspects of the NG12 clinical recommendations which were based on primary care data. NG12 advised a reduction in the threshold that triggers an urgent suspected cancer referral (positive predictive value from above 5 to 3%). NG12 was also crucial in linking the significance of vague symptoms to earlier cancer diagnosis and recommending more timely/urgent GP direct access tests. The NG12 recommendations were enacted over the years after its publication, with direct access pathways commissioned across NCEL.

Background scoping work with our local GP practices had revealed an appetite for a practical solution to help them with safety netting.

In primary care, there are a number of key cancer related clinical scenarios that would benefit from stringent safety netting processes. Some examples are listed below:

- *Patients on an urgent suspected cancer referral pathway*
- *Direct access diagnostics where serious conditions are suspected e.g. qFIT*

¹¹ https://www.uclh.nhs.uk/OurServices/ServiceA-Z/Cancer/NCV/MICa/Documents/Guide-to-coding-and-safety-netting-in-cancer-by-Dr-A-Bhuiya_V5-Feb-17%201.pdf.

¹² <http://learnzone.org.uk/courses/course.php?id=323>

test to ultrasound

- *Vague symptoms where there is diagnostic uncertainty and patient/clinician concern e.g. appetite loss*
- *Active monitoring of patients who you wish to review in an agreed time frame to re-evaluate their risk of cancer/serious pathology*
- *Patients who have negative/reassuring results but continue to have symptoms*
- *Stratified follow up for prostate cancer patients*
- *Longitudinal follow up e.g. bone density scan*

Aims at the start of the project

- To create a safety netting solution for primary care that would sit in EMIS Web that captured all the desirable aspects of a high quality electronic safety netting solution and be practical to deploy.
- To test its feasibility and understand the desirable aspects, as well as the challenges, for practices in implementing and using this solution.

Phase 1: Developing a product to support the high quality safety netting

The origins of the toolkit concept were conceived in collaboration with the Transforming Cancer Services Team for London (TCST).

The toolkit was based on functionalities within the existing electronic health record system (EHRS) - EMIS Web.

The Alliance then went on to develop this product in-house, and to test, pilot, evaluate and publish with EMIS Web centrally to sit as a national product for all practices to access. EMIS Web was the selected EHRS as this was the system that was the majority provider for practices in NCEL as well as the system that Dr Afsana Bhuiya, the creator of the toolkit, understood and used.

Developing a toolkit from existing functionalities meant it was easier to build internally without external resources. It was also much easier to spread the innovation as no external software or operability or additional purchase budgets were required.

The Intervention: The Electronic Safety Netting (E-SN) Toolkit

What is it and how is it best used in practice?

The toolkit is an electronic method of tracking patients of high to low concern within your surgery using functionalities within EMIS Web. As the toolkit used existing functionality in EMIS Web, there was no additional fee or additional software needed.

The toolkit aims to provide GP surgeries with a robust, auditable, pro-active approach to safety netting their patients and is wholly designed to be used by the practice team as a 'system' with administrative staff taking the lead on tracking/proactive follow up. It should replace existing verbal or manual/paper methods of safety netting and as such offers a centralised, more efficient approach to tracking.

It requires clinicians to use the template interface and an administrative member of practice staff to lead on the tracking aspects. This can be a new way of working for some surgeries so will require leadership advocacy in order for this to work smoothly. The template has read coded events tagged to diary entries which are time reminders for an action set. These reminders are there to ensure the events such as referrals or tests requested are followed up. All open reminders will show up on the regular run searches and also will have pop up reminders when the patient record is accessed.

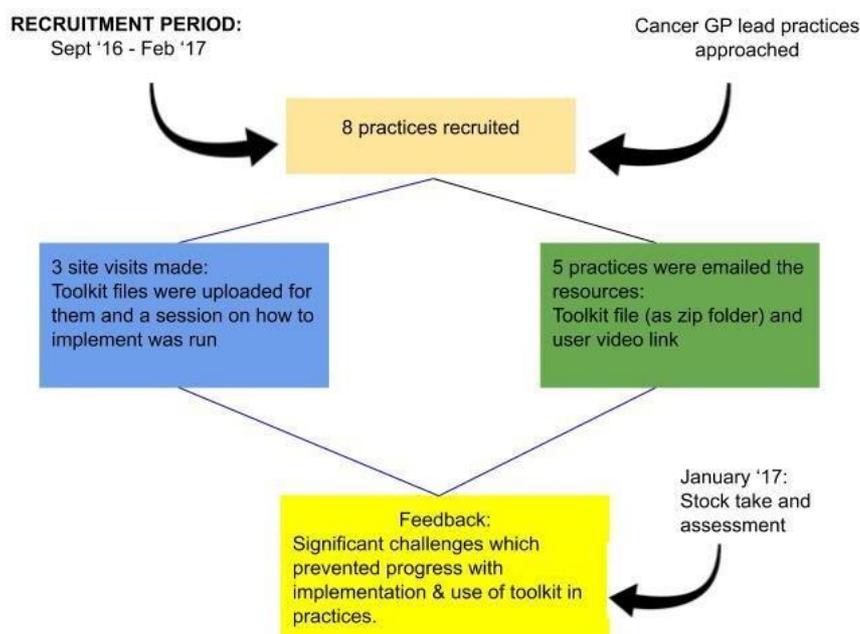
Image 2: Overview of the E-SN functionalities



Phase 2: Feasibility amongst GP Cancer lead practices

The GP cancer leads in the NCEL geography were approached to test and pilot this toolkit. The toolkit was saved as a zip file and a basic 'home made' YouTube video user guide was created to support its implementation at this stage.

Image 3: The feasibility pilot



It was clear from the early stages that the project plan had to be revised. The feedback can be summarised as:

- Set-up (IT) challenges and implementation/understanding
- The self-starters were unable to progress with loading the files to EMIS Web and those who did had not fully grasped how to use it in the intended way
- Those who were supported with uploading of the files found they could not progress with the educational support material we had.

The conclusion was that offering a new intervention itself was not enough to implement change at a practice level. The tool had to be easily accessible, ready to use and that support material and leadership had to be in place to enable implementation and follow through.

The next steps were having a dedicated project manager (PM) to support this project and enable phase 3.

Phase 3: Improvement project - Pilot in NCEL

The PM was trained on all aspects of the project including EMIS Web functionalities and the toolkit operation. Their role was to recruit and support GP practices on a NCEL wide E-SN pilot. Cancer GP leads and CRUK facilitators helped publicise this quality improvement offering and identified 'early adopter' GP pilot sites. The PM was then able to make practice level contact and book in for site visits to enrol practices to the QI pilot.

Project stages:

Pilot recruitment: The site visits involved uploading the required files to EMIS Web first, then leading a training session for the clinicians and admin team on how to use the toolkit effectively. These site visits evolved as the practice teams' experience and confidence with the tool improved so too did the response to the challenges proposed by the PM during this training visit.

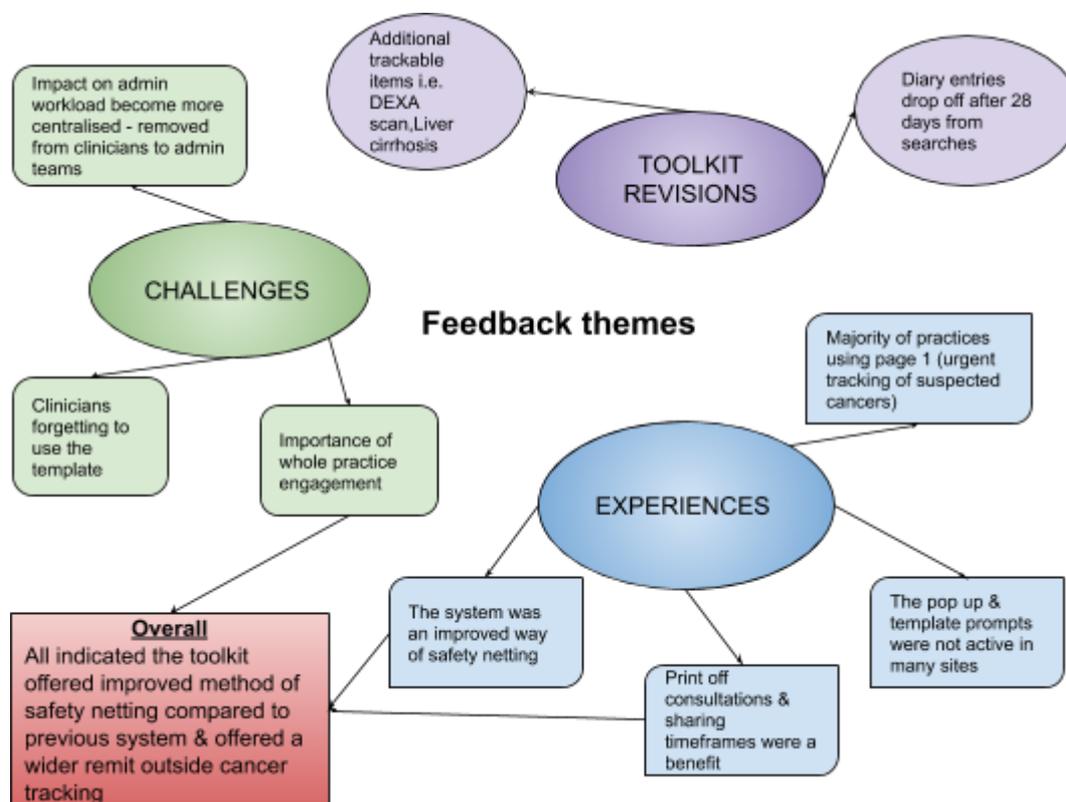
Improvement: The original toolkit went on to have several adaptations and improvements as pilots sites fed back on real time issues and improvement options. New versions of the toolkits were labelled consecutively (e.g. Version 1/2/3 etc.) and rolled out to new recruits.

Study expansion: The NCEL pilot had recruited 21 practices voluntarily and a service evaluation of a qualitative nature was planned.

Evaluation: The PM had left post before any formal evaluation could be collected. This was a significant risk to the project and stalled the evaluation. However, the PM had captured informal feedback from pilot sites in real time on Trello (project management software).

Feedback: Informal feedback summary

Image 4: Feedback themes



Quotations from pilot site user GPs:

" I love it - it makes my job so much easier!"

" We have a dedicated administrator who runs a search once a week, which highlights all the alerts for either 2ww referrals or monitoring due - she follows these up and/or informs a clinician"

Reflections: Despite the incomplete formal evaluation, the feedback was informative and insightful. These early adopters allowed us to learn a lot about the toolkit and the revisions needed. The pilot was labour intensive and it was difficult to ensure practices had the added features of the toolkit.

The strategy for wider implementation needed to be multifaceted, sufficiently resourced and ultimately required the toolkit to be incorporated into EMIS Web.

Strategic aspects of the project

There was a realisation of the importance and potential of this project for primary care from different arenas.

Macmillan Cancer Support were fully supportive of this product and very keen to have their Macmillan GPs informed, but also have this product more accessible to all. Macmillan had established links with all the primary care EHRS providers and linkage was made with the clinical lead for EMIS Web to discuss the potential of a central product. Working with EMIS Web the functionalities of the final product were mapped and finalised.

The CRUK facilitator team were highly supportive of this work. The Alliance had led sessions to train the facilitators on the toolkit and its functionalities. They were then able to publicise this toolkit and help with recruitment to the pilot.

There were CCG-level variations on implementation, from adapting the toolkit template to commissioning this locally e.g. City and Hackney.

TCST mobilised a Once for London Safety Netting Steering Group in order to advocate for similar responses from the other major EHRS systems like [Vision](#) and [SystemOne](#). This did not continue for a variety of reasons. A SystemOne project was initiated by a cancer GP lead in the east Midlands' cancer alliance and is led locally. The toolkit was available nationally on EMIS Web from **June 2018** which meant that any practice choosing to use it could do so very easily. This was by far a crucial enabler for wider dissemination of the toolkit.

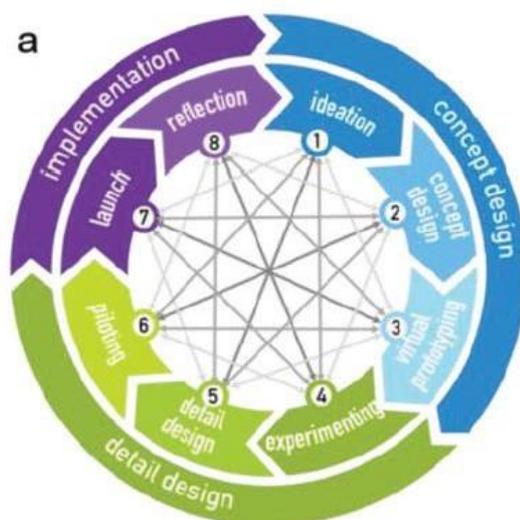
Aims for phase 4

- To understand what strategies were needed to communicate and implement a potentially new way of working with primary care in an area the size of NCEL or wider
- To measure and quantify successful implementation and early change in the quality of tracking in primary care.
- To consider the wider implications and sustainability of such a project in primary care

Phase 4: Wider implementation and strategy

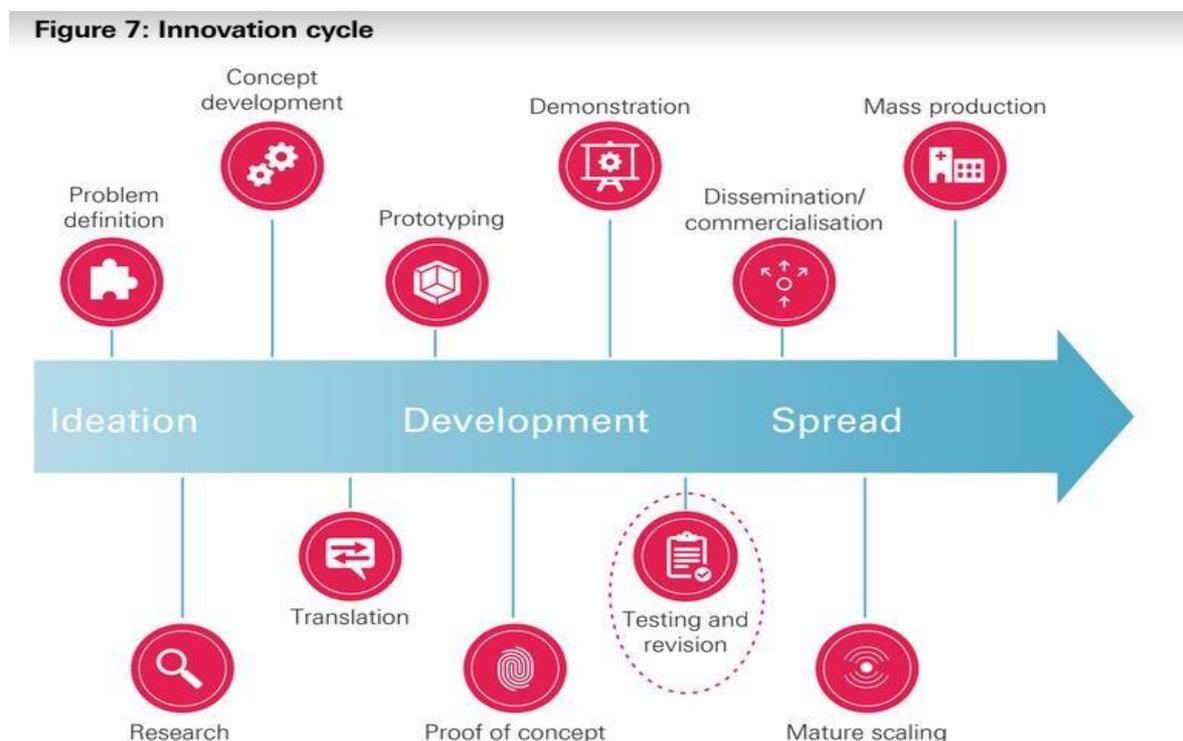
Learning and strategy planning was key so referring to the business model theory helped especially when understanding the aspects of launching and reflection. The Health Foundation’s report ‘*Spread the challenge*’ looking at supporting successful improvements in the health care system, also provided useful steps to reflect on.

Image 5: Cambridge business model innovation¹³



¹³ <https://www.sciencedirect.com/science/article/pii/S2351978917300392?via%3Dihub>

Image 6: The innovation cycle¹⁴



Educational support material

Production of high quality educational support material was an obvious requirement for this project. The Alliance produced a professional user video guide¹⁵ and PDF user guides for clinicians¹⁶ and administrative staff¹⁷ and finally short guides on how to locate the toolkit files within EMIS Web¹⁸. All the information was available on a public domain, the Alliance website.

¹⁴ <https://www.health.org.uk/sites/default/files/upload/publications/2018/The-spread-challenge.pdf>

¹⁵ <https://www.youtube.com/watch?v=U4byHZwOZv8&feature=youtu.be>

¹⁶ <https://www.uclh.nhs.uk/OurServices/ServiceA-/Cancer/NCV/MICa/Documents/UCLH%20ESafety%20toolkit%204.pdf>

¹⁷ <https://www.uclh.nhs.uk/OurServices/ServiceA-Z/Cancer/NCV/MICa/Documents/UCLHCC%20E-SN%20Guidance%20for%20ADMIN%20staff%20using%20the%20toolkit.pdf>

¹⁸ <https://www.uclh.nhs.uk/OurServices/ServiceA-Z/Cancer/NCV/MICa/Pages/Primarycareimprovement.aspx>

Communication plan

A communication strategy was defined and the structure sought to ensure all the relevant primary care stakeholders had been captured and connections made with them.

Image 7: Levels of communication in primary care

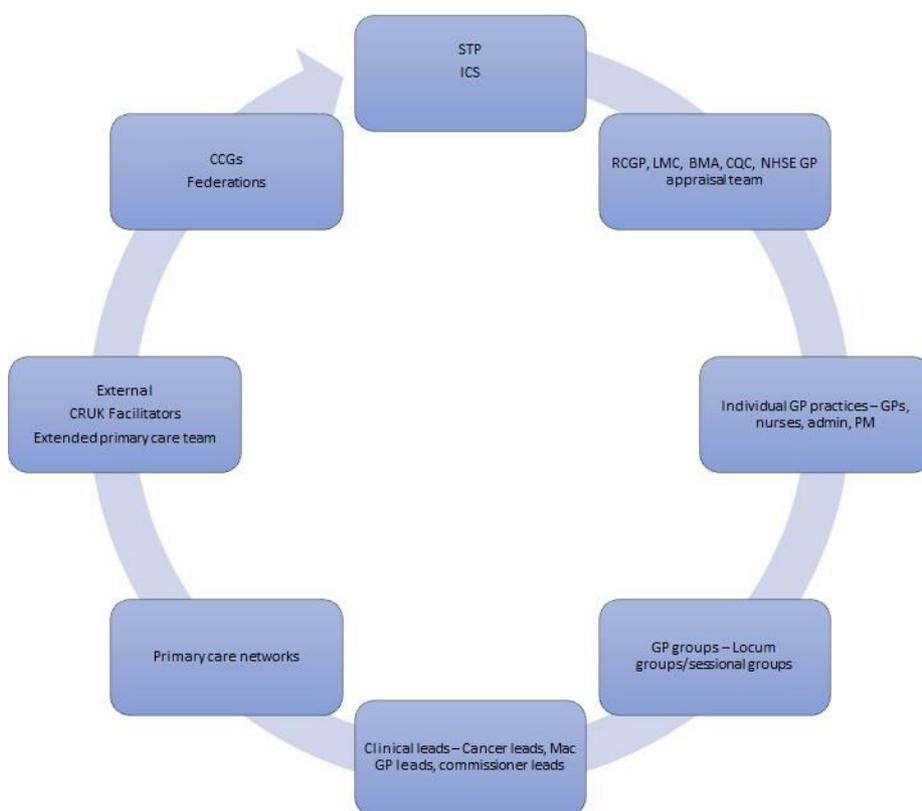
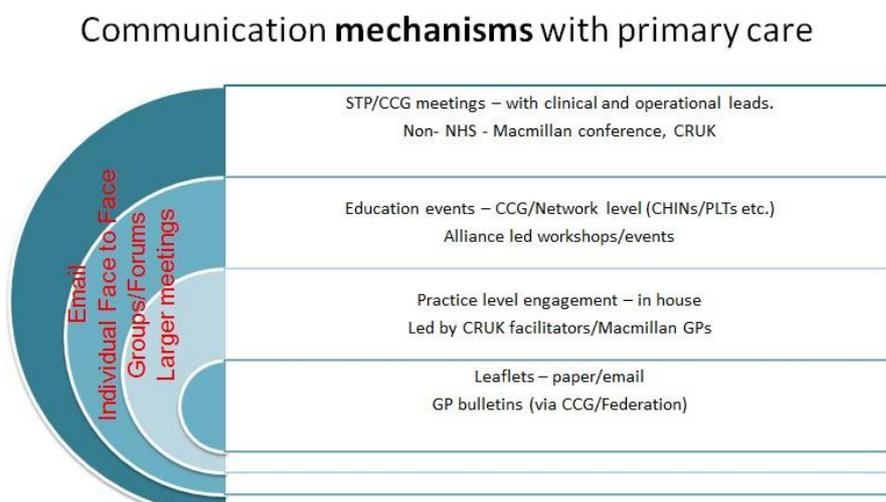


Image 8: Communication mechanisms in primary care



The details of the communication work:

- Showcasing the toolkit at protected learning time sessions for GPs, GP education events, GP network events, practice manager events & National Macmillan GP Conference.
- Articles in GP bulletins/newsletter: Each CCG has a GP bulletin that goes out to the practices (weekly/biweekly) and we had advertised the workshop events through the bulletin in all 12 CCGs in the alliance patch.
- Communications to Cancer Leads & Macmillan GPs: The cancer lead GPs and the Macmillan GPs were consulted with at the onset of this project to discuss its feasibility and were kept updated on the various stages of the project evolution. They helped with advocacy and information dissemination.
- CRUK facilitators: Training and education was shared with our CRUK facilitator colleagues, who understood the value of the toolkit. They provided the invaluable resource of helping to promote awareness and implementation of the toolkit during their routine practice visits. There was constant contact and support from the Alliance's primary care team. Through this networking, the reach of this project has extended with practices and facilitators making contact with us from the west and south west of London up to the north west of England.

- Commissioning and Cancer Board meetings: The toolkit was presented at the cancer commissioning meetings. These presentations also allowed for any concerns that GPs, commissioners and cancer leads had to be aired and addressed by the Alliance's primary care team.
- GP appraisers (appraiser conference presentation): GP appraisers meet at regular conference style meetings to have updates. The toolkit was showcased to this group. The appraisers have opportunities to spread this QI project when they carry out appraisals.
- Internal meetings: Within the Alliance, opportunities were identified to align particular projects, e.g. the toolkit offers a method of call and recall that benefits the Prostate Stratified Follow up roll out in the north central London area. The project managers and project leads of these projects were furnished with resources and training for the toolkit which they could then disseminate to the various stakeholders and healthcare professionals with whom they interacted.
- One to one interactions: The team took every opportunity to promote and discuss the toolkit with GPs, commissioners, primary care managers and other primary care health professionals that they met.

The training model – workshops

A workshop model for training practices was decided upon. Practice visits were resource and time intensive and not sustainable. The workshops could be delivered over fewer sessions and reach a larger number of practices.

Three small scale 'starter' workshops were held in March 2018 and as they were received well, this formed the approach going forward.

Once the resources were in place to support further larger workshops and the toolkit was published nationally, further seven workshops were delivered through an incentivised route (see Table 1 & Chart 1).

The incentivised route was chosen to give the implementation a kick-start and to

ensure that practices were resourced to provide evaluation data for the project. The workshop sign up was restricted to terms and conditions (see appendix C). Practice payments were agreed through memorandums of understanding (MOU) via the STPs (see appendix B). The workshop sites were across venues in NCEL to ensure a fair offering to both north central and north east colleagues.

Table 1: The number of practices that attended and the total number of people who attended each workshop

Workshop attendance	GP practice attendance (GP + admin lead)	GP practice attendance (GP + admin lead)	External attendees	Total attendees (GP, admin & external)
Date	NCL	NEL		
15 Nov 18	5	0	0	10
20 Nov 18	0	6	0	11
13 Dec 18	3	3	0	12
10 Jan 19	9	1	0	23
17 Jan 19	3	10	0	26
25 Apr 19	10	0	0	23
02 May 19	0	12	4	30
Total attendees				133
Total GP practices in workshops	30	32		62

Chart 1: Pie chart showing the CCG representation of attendees at the commissioned workshops

Nov 18 to May 19

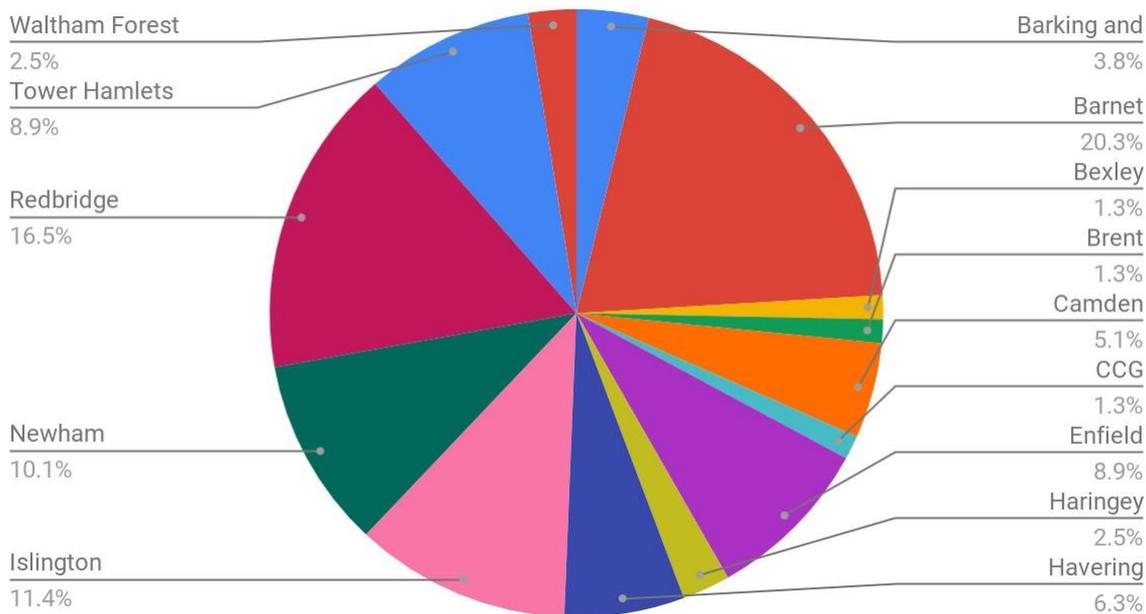
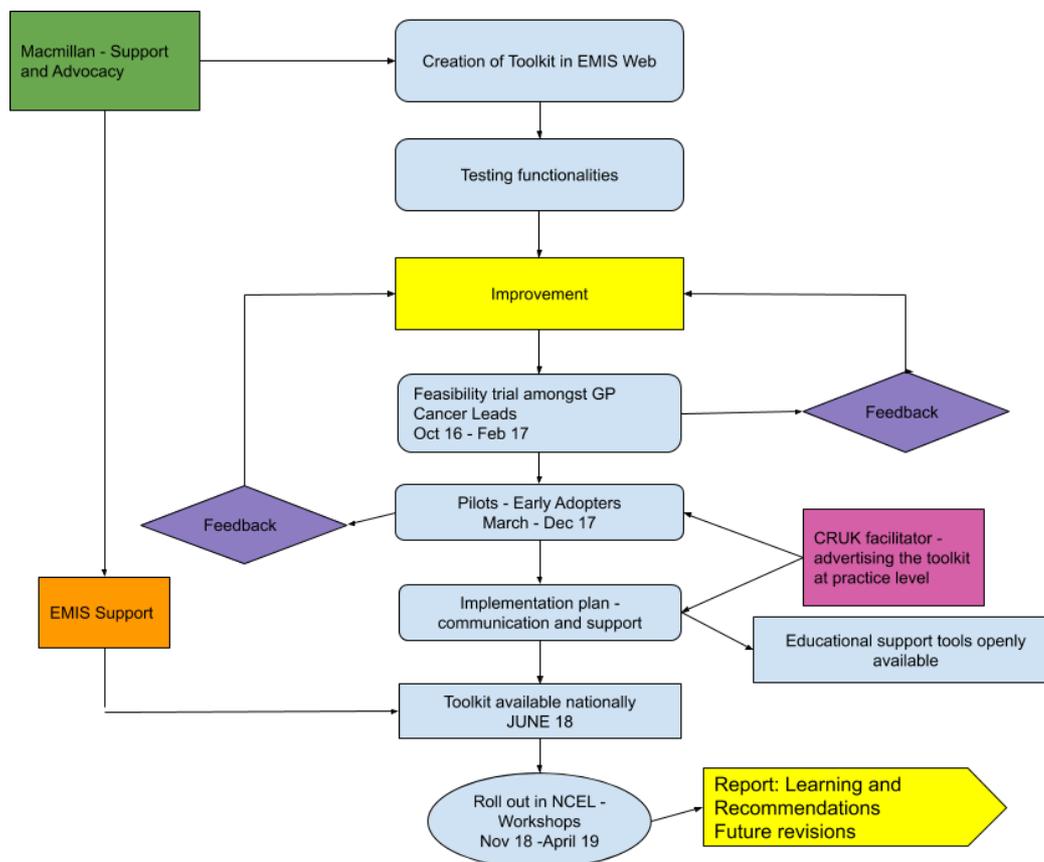


Image 9: Summary of the Improvement journey



Evaluation of phase 4

Feedback was collected straight after the workshop and then at four to six months after the workshop.

The four month period was chosen to align with the project manager's contract period and funding for the Alliance which was determined on an annual basis. The relatively short time frame of data collection determined the data that was collected. Of note, the user video guide had over 2 400 views by February 2020 and the webpages with the guides had been visited 1,754 times between January 2018 and July 2019.

Methods

- 1) The post workshop evaluation questionnaire asked questions around learner satisfaction, learning outcomes and behaviour change. (See appendix item E)
- 2) The 4-6 month data consisted of:
 - a) Quantitative coded data on how often practices were activating the templates and how the template was being used in practice. (See appendix item D)
 - b) Questionnaire for the lead GP and admin lead to complete. The format of the questionnaire was based on Kirkpatrick's model of evaluation¹⁹ It followed themes to understand practice level experiences and challenges, impact on the work level, patient feedback and overall sustainability.

Data Analysis - Thematic analysis of quantitative and qualitative data

Data completeness

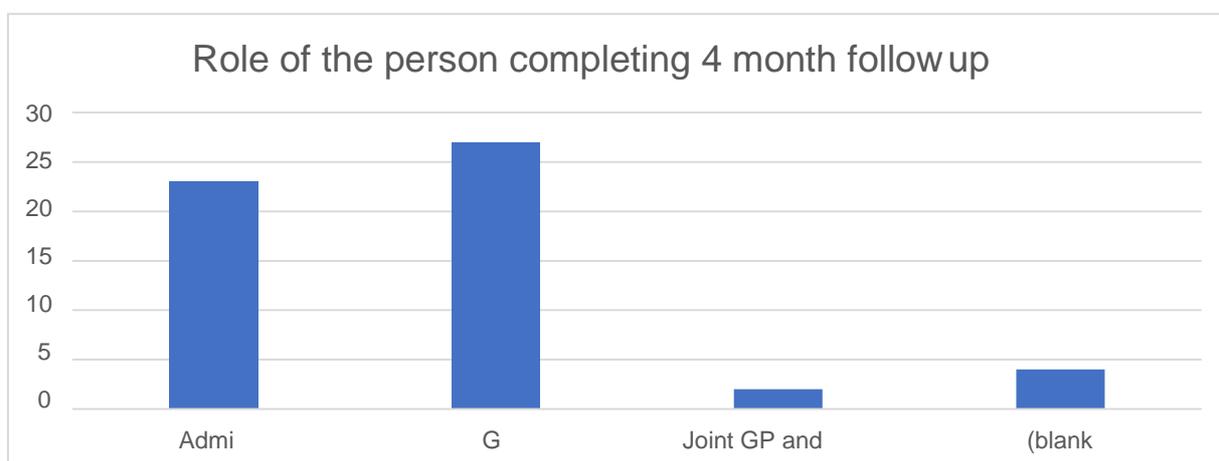
As has been set out earlier in this report, 62 practices sent participants (One GP and One administrative lead) to the initial training workshop.

The follow up questionnaire (method 2, b) had 56 respondents (mixture of GPs and administrative leads who were generally Practice Managers).

¹⁹ <https://www.mindtools.com/pages/article/kirkpatrick.htm>

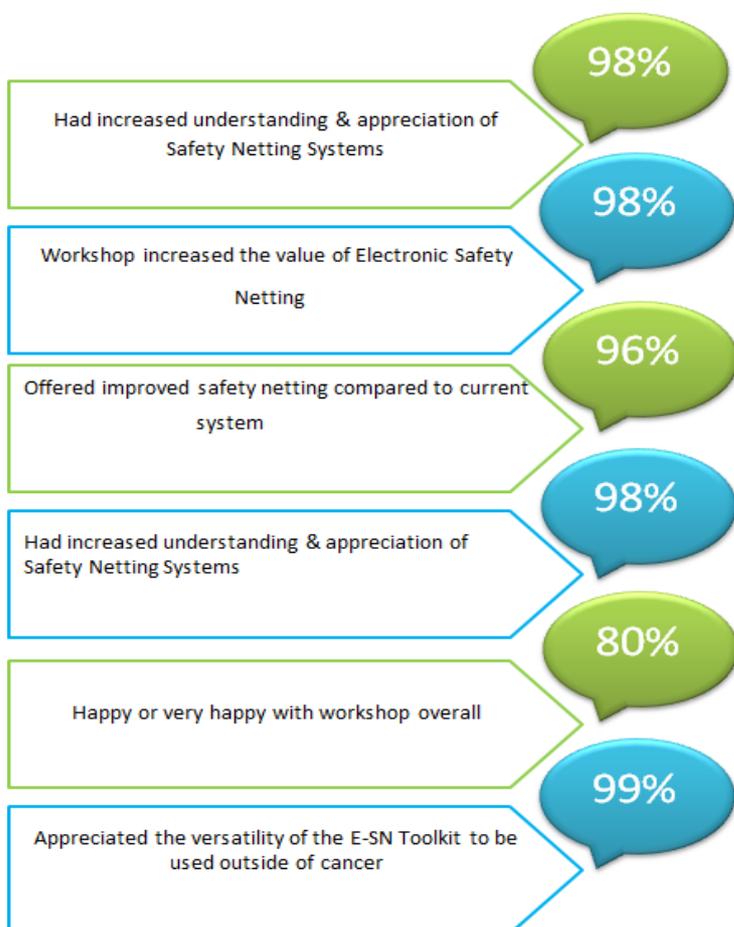
This evaluation also makes use of data from 32 practices who submitted data on their use of the tool (method 2, a) over varying periods of time (detailed further below). The last cohort in May had low rates of data return.

Chart 2: Showing the different roles of the people who completed the 4 to 6 month follow up survey on behalf of a practice.



The image below highlights the key feedback from the workshops (method 1)

Image 10: Workshop feedback - learner satisfaction and learning outcomes



Data on usage

Practices started using the toolkit in different months reflecting the dates they attended the different workshops. The data provided by practices also covered different lengths of time, which suggests there was a lag between workshop attendance and practice implementation.

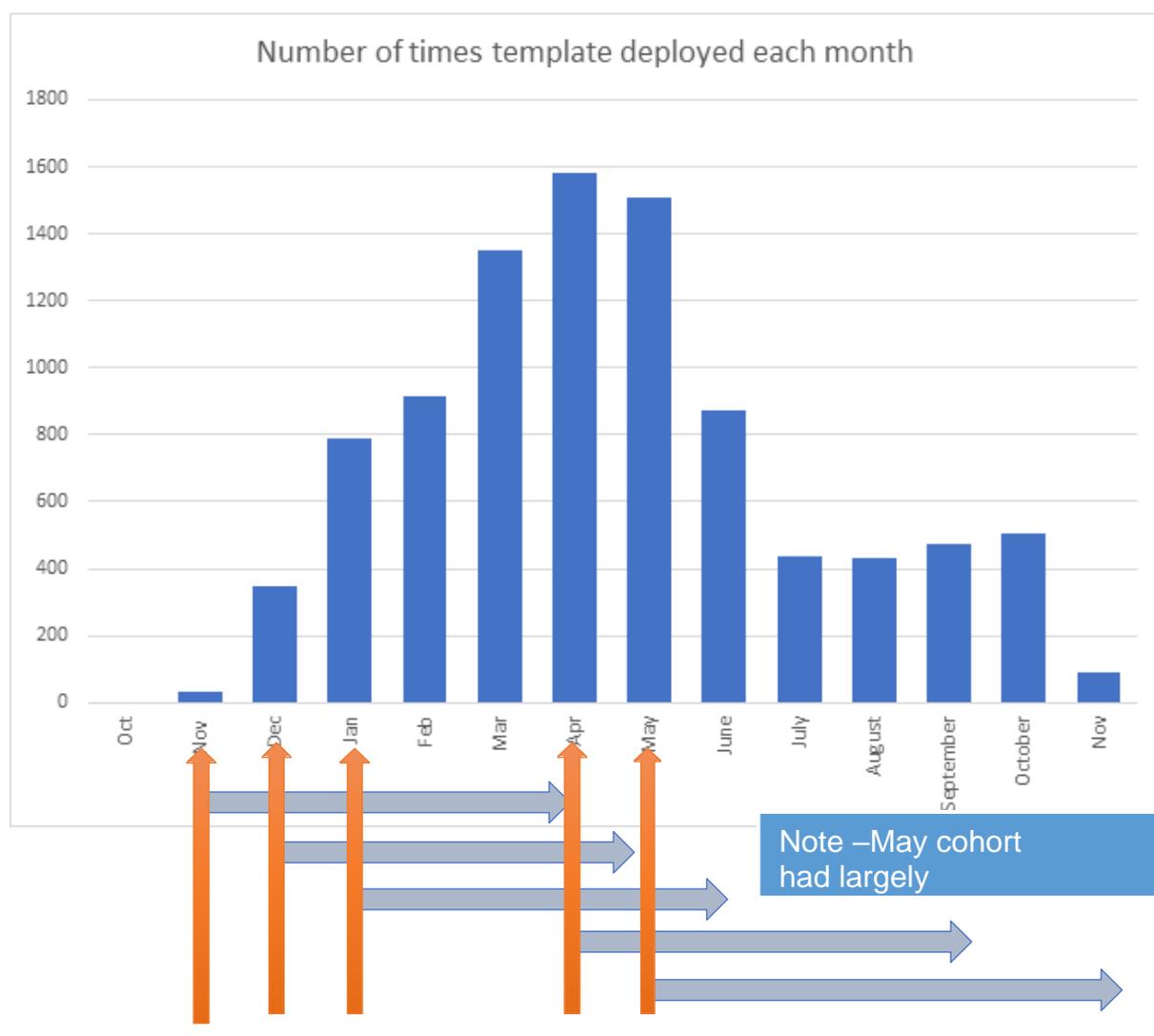
Table 2: The table below shows the number of practices who provided data by the number of months provided

No. of months of data provided	2	3	4	5	6
No. of practices	2	3	5	17	5

Template deployment was looked at by practices. Chart 3 sets out the overall picture of template deployment mapped to workshop cohort months and data availability.

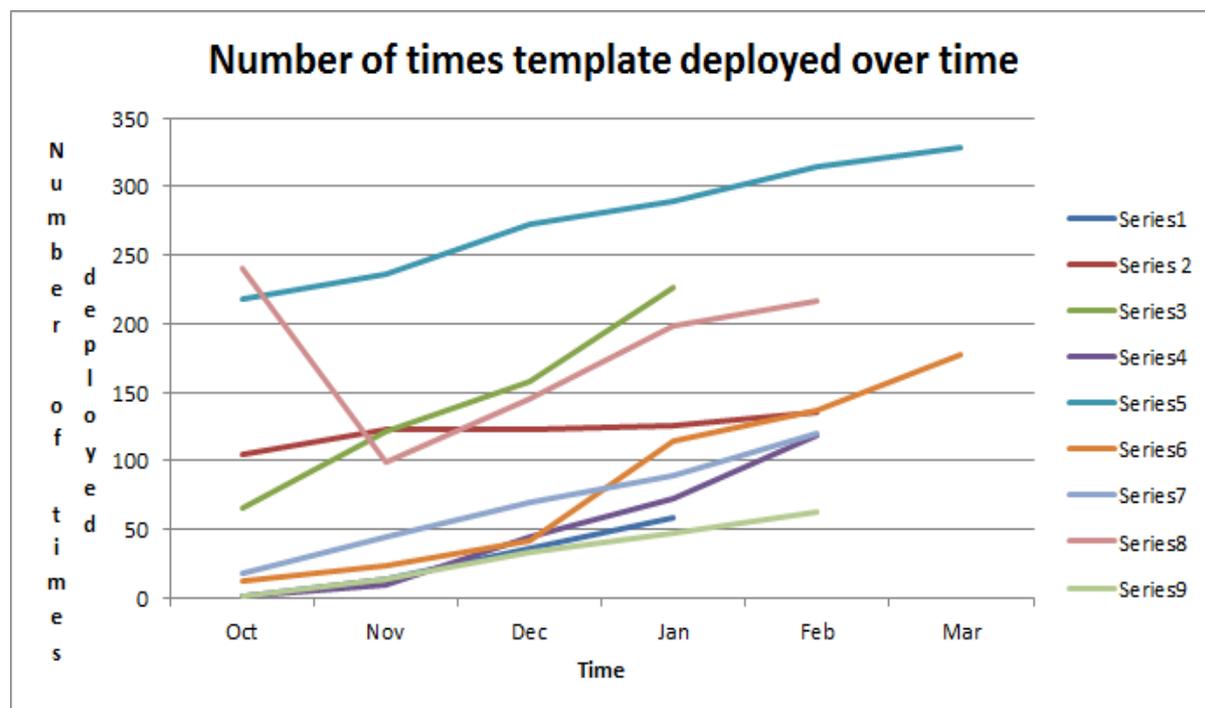
Chart 3: Shows the number of times the template was deployed during each month for all practices

The red vertical arrow signifies the month that workshops were held to recruit practices. The blue horizontal arrows signify duration of data capture (average 5 months) by that cohort of practices.



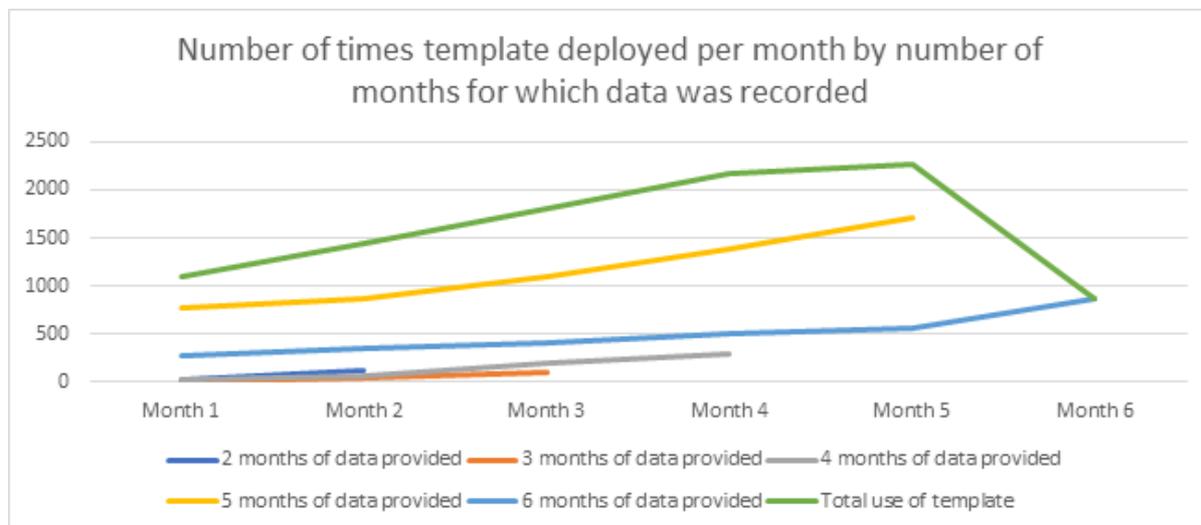
A cohort of the early practices were taken, to review their template activation rates over the period of their data collection. An increased template activation was seen over time.

Chart 4: Use of template over time (sample of the total cohort)



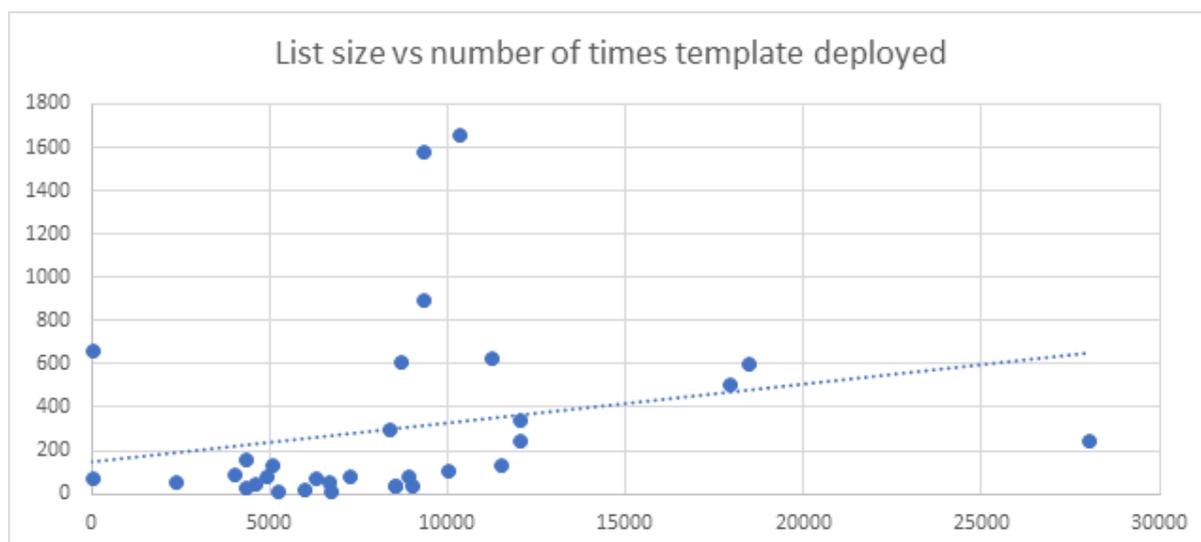
Account was taken for the variations in numbers of practices using the toolkit and time periods over which data was captured. In chart 5 below, the time periods were aligned to show how the number of times the template was used, changed over months for which data was captured. The green line represents the total use and rises each month before falling at six months. The fall is explained by the reduction in data from the practices. The chart also shows that for each of the groups of practices, the number of times the template was deployed increased each month. The increase in deployment could relate to a wider usage by more clinicians in the practice over time, as well as individual users realising the benefits and applicability of the toolkit over time.

Chart 5: Shows the number of times the template was deployed per month by the number of months for which data was recorded



Consideration was given to the extent to which the size of practices impacted upon the number of times the template was deployed. The scatter plot (chart 6) below shows the list size set against the number of times the template was deployed. It shows a slight positive correlation between size of practice and the number of times the template was deployed. However, there are clear outliers which perhaps suggests that practice size is not the only factor in how frequently templates were deployed.

Chart 6: Plots practice list size vs number of times template deployed



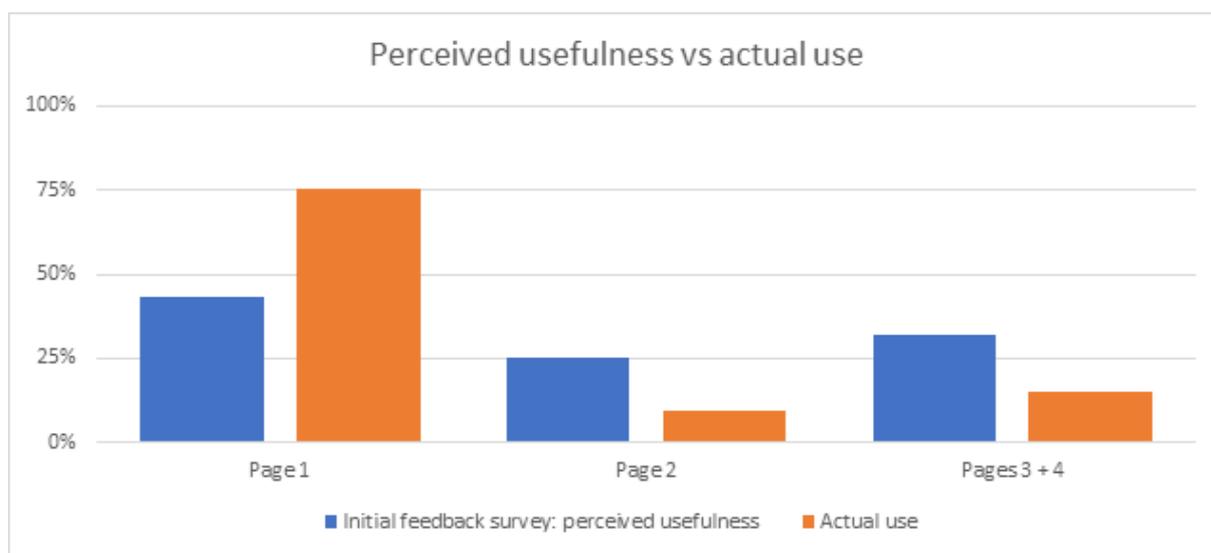
Data of Page Usage within the template

As part of the initial feedback survey following training, participants were asked which pages from the template they thought would be most useful. This was an open response question and the qualitative responses have been coded to provide a picture of the pages that were most frequently cited by respondents to the question as being ‘most useful’.

Page 1 of the template (fast track referrals) was most commonly thought to be the ‘most useful’, followed by pages 3 & 4 (safety netting low risk symptoms & cancer or pre-cancerous monitoring).

Data on the actual usage shows that page 1, utilised for fast track referrals, was the most commonly used by some distance with 499 items tracked, accounting for 75% of total usage. Pages 3 and 4 accounted for 15% of use while page 2 (investigations) accounted for 9%.

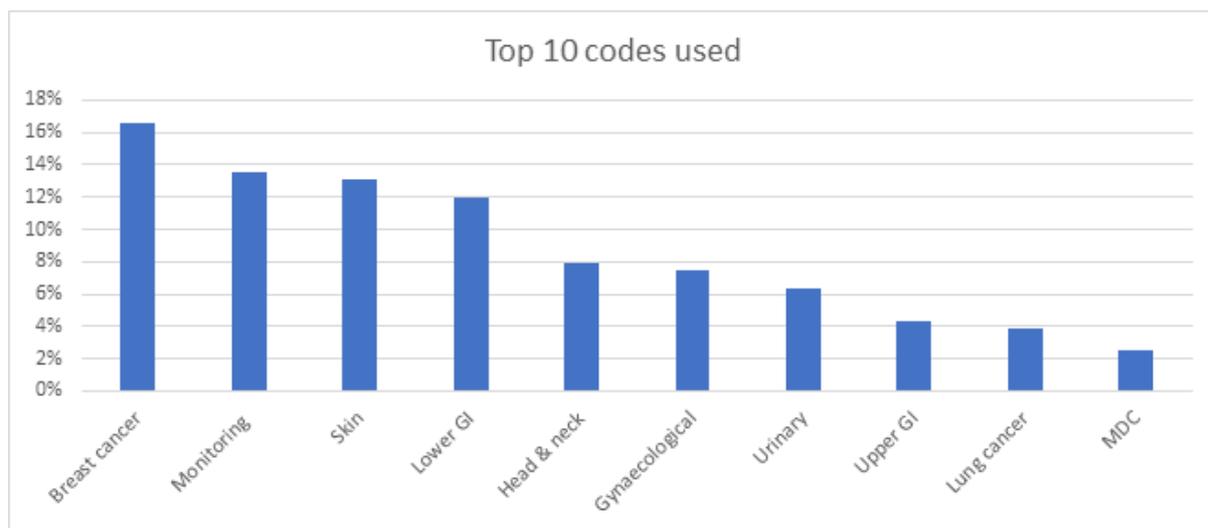
Chart 7: Showing practice perceived usefulness of each template page versus actual template page usage



The usage of the read codes (now SNOMED codes) used was reviewed. The top 10 codes used were found on page 1, with the exception of ‘monitoring of patient’ which appears on page 3 of the template and accounted for 84% of all views on pages 3 and 4 and was the second most commonly used code. ‘Fast track referral for suspected breast cancer’ was the most commonly used code accounting for 17% of

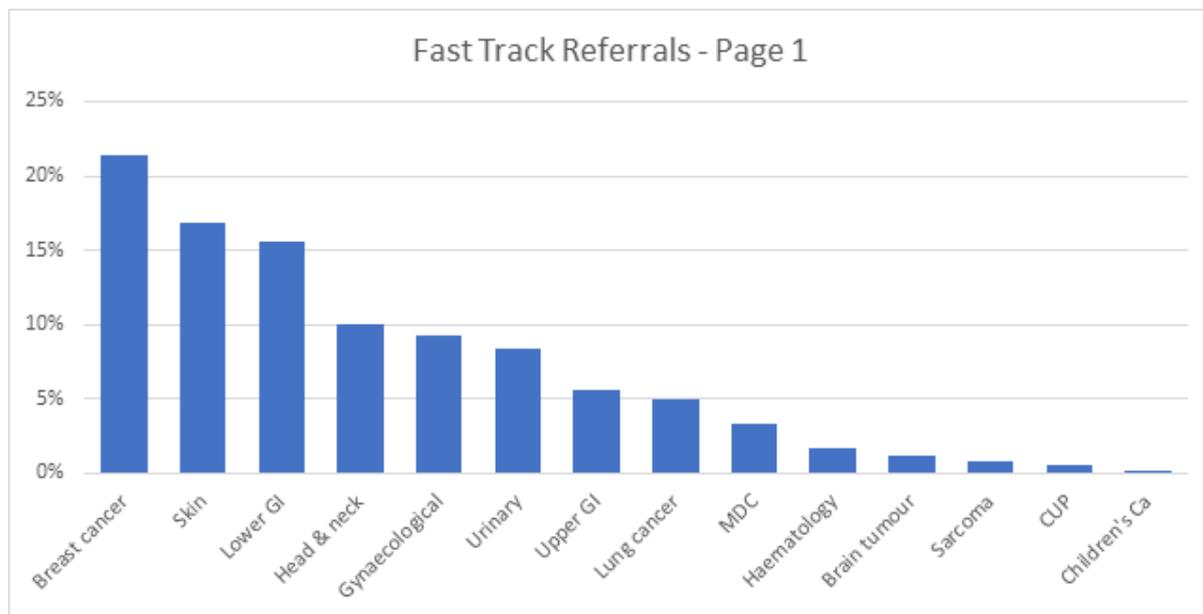
all usage across all pages, followed by 'monitoring of patient', 'fast track referral for suspected skin cancer' and 'fast track referral for suspected lower GI cancer'.

Chart 8: Showing top 10 codes used by pilot practices



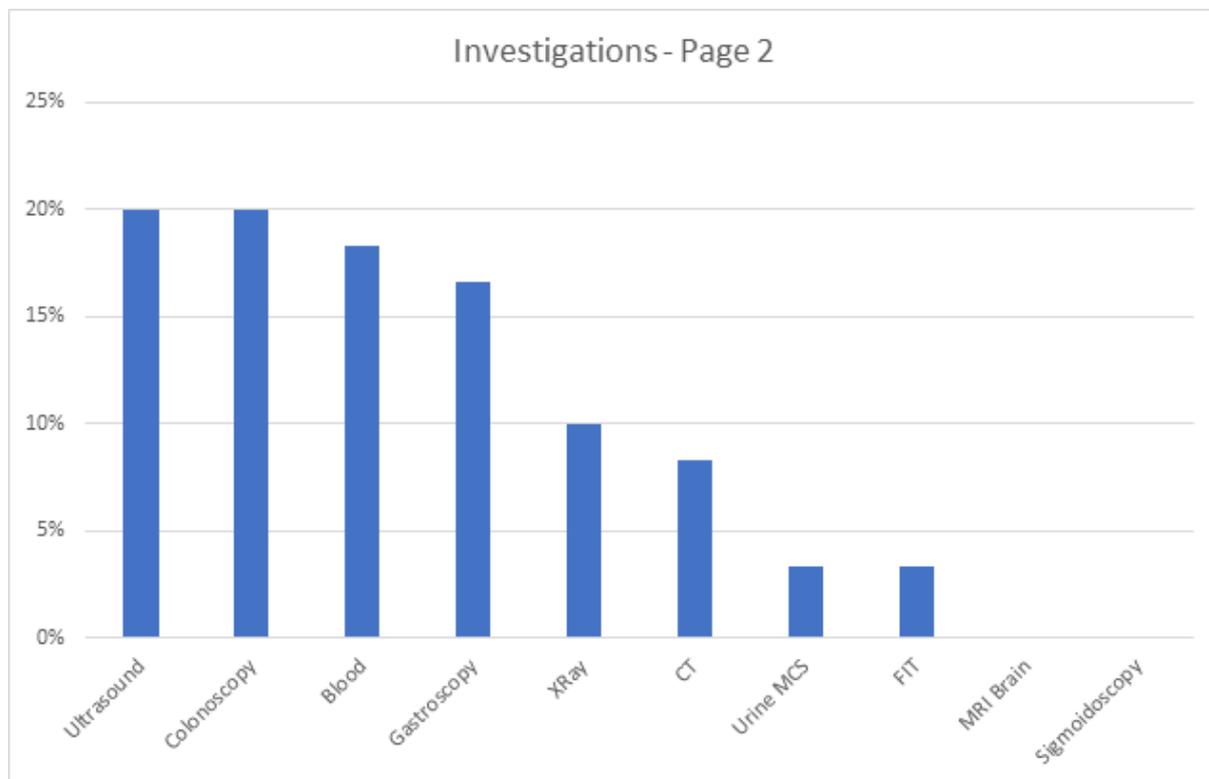
Looking specifically at page 1 of the template, it was notable that all the codes on the page were utilised. The pattern is reflective of the incidence of the referrals made to the particular sites.

Chart 9: Showing percentage of codes utilised on page 1 of the template



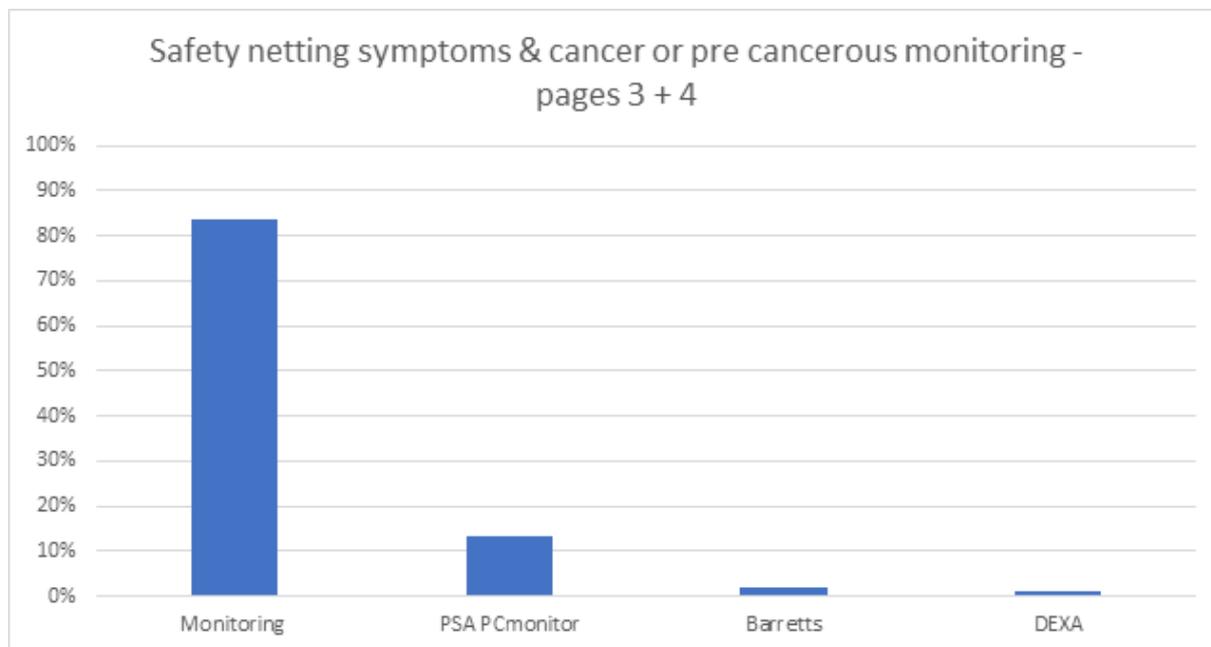
On page 2 of the template, all the codes were used expect for 'refer for MRI' and 'refer for sigmoidoscopy'.

Chart 10: Showing percentage of codes utilised on page 2 of the template



When looking at data on read codes for pages 3 and 4, clear skewing to the use of 'monitoring of patient' code, is observed. This code accounts for 84% (used in 82 instances) whereas the next most used code on page 4 is 'PSA (prostate specific antigen) monitored in primary care' which is used 13 times.

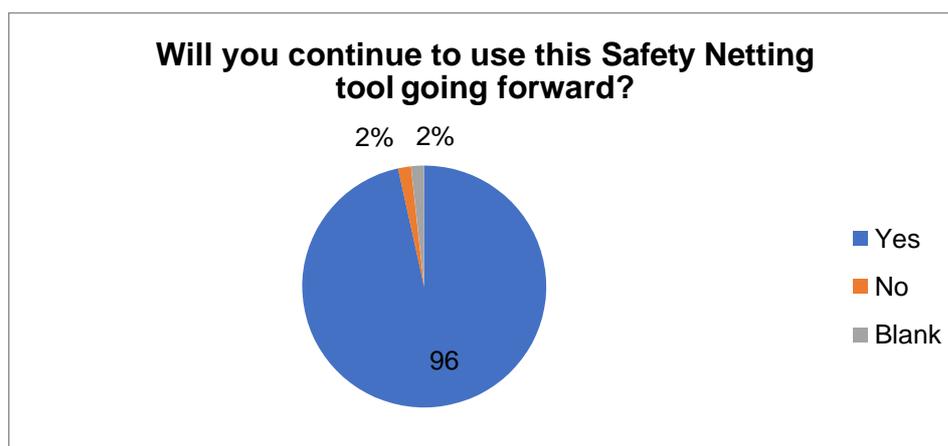
Chart 11: Showing percentage of codes utilised on pages 3 and 4



Sustainability

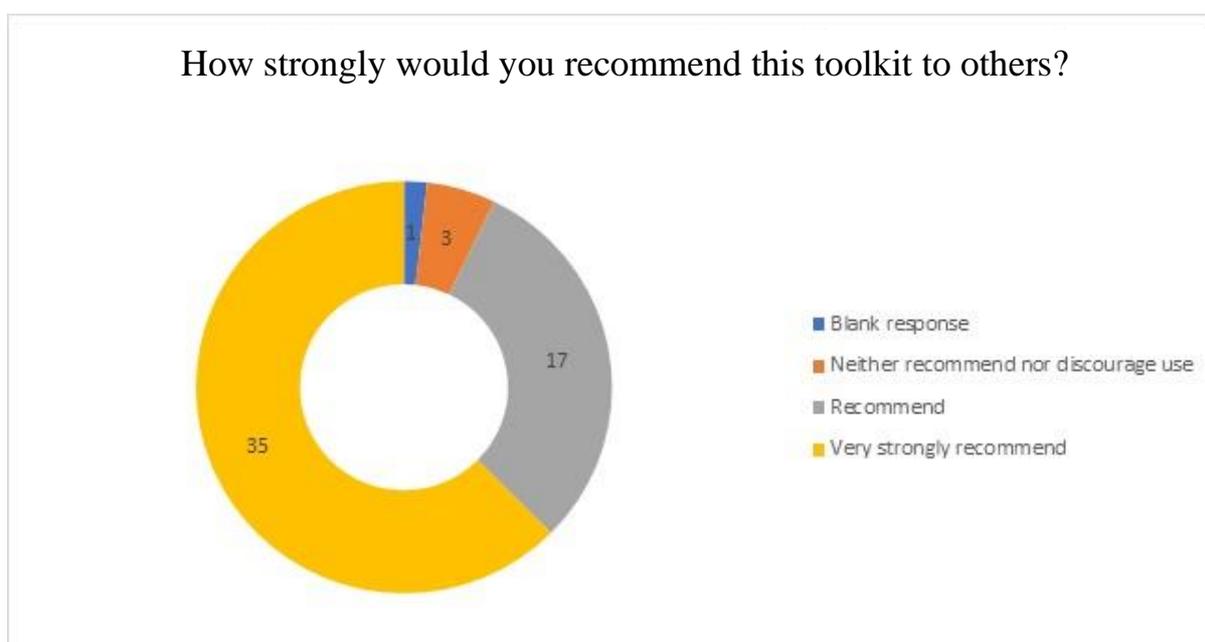
Responses from the follow up questionnaire showed that participants overwhelmingly indicated their intention to make continued use of the tool.

Chart 12: Continued use of the E-SN toolkit



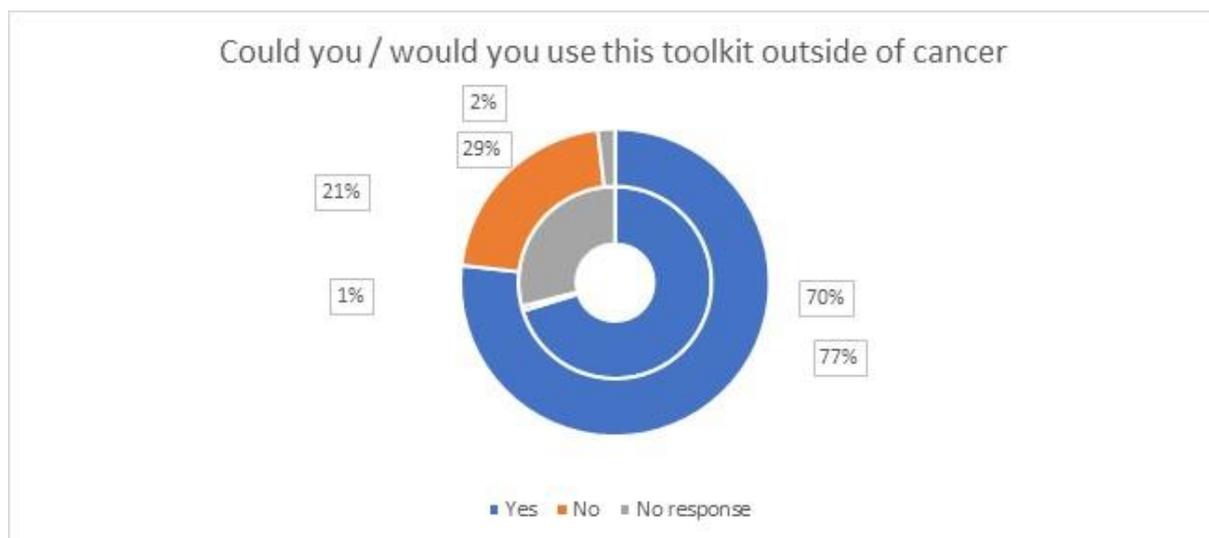
Moreover, respondents indicated that they would recommend the tool to others. None of the responses provided indicated that they would discourage or strongly discourage. 53 of the 56 responses indicated that they would either recommend or very strongly recommend the use of the tool.

Chart 13: Showing how strongly respondents would recommend the toolkit



Participants were also asked about potential use of the toolkit outside cancer both at the initial feedback stage and in the follow up questionnaire. The percentage of respondents suggesting that they would consider use of the toolkit outside cancer increased slightly in the follow up period, from around 70% saying they could see a use outside cancer after the initial feedback survey to around 77% saying that they would use the toolkit outside cancer.

Chart 14: The doughnut chart shows the inner ring representing responses to the initial feedback survey and the outer ring representing responses to the follow up questionnaire



When asked how this tool could be used beyond cancer, answers in the follow up questionnaire were similar to answers following the initial training, with *follow up of investigations, monitoring of at risk patients and chronic disease management* again featuring as themes through qualitative responses in both surveys.

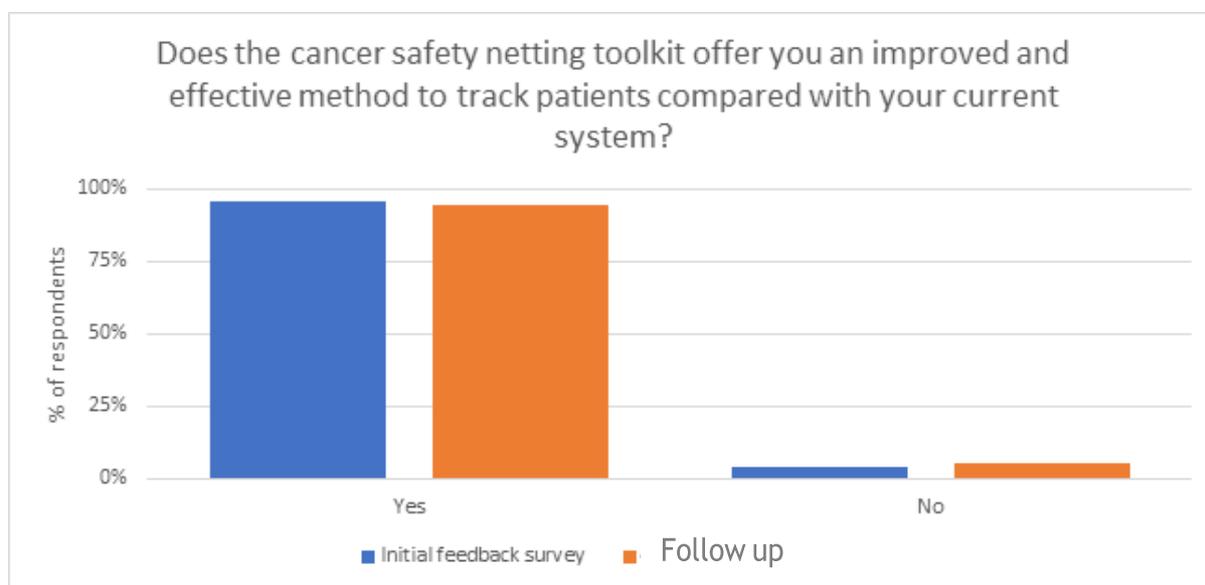
Impact on safety

Participants were asked if they felt that the electronic safety netting toolkit offered an improved method to track patients compared with their current systems and 95% indicated that it did provide an improvement.

Participants were also asked how the safety netting toolkit offers an improved method to track patients compared with current systems responses. A number of key themes emerged from qualitative responses including:

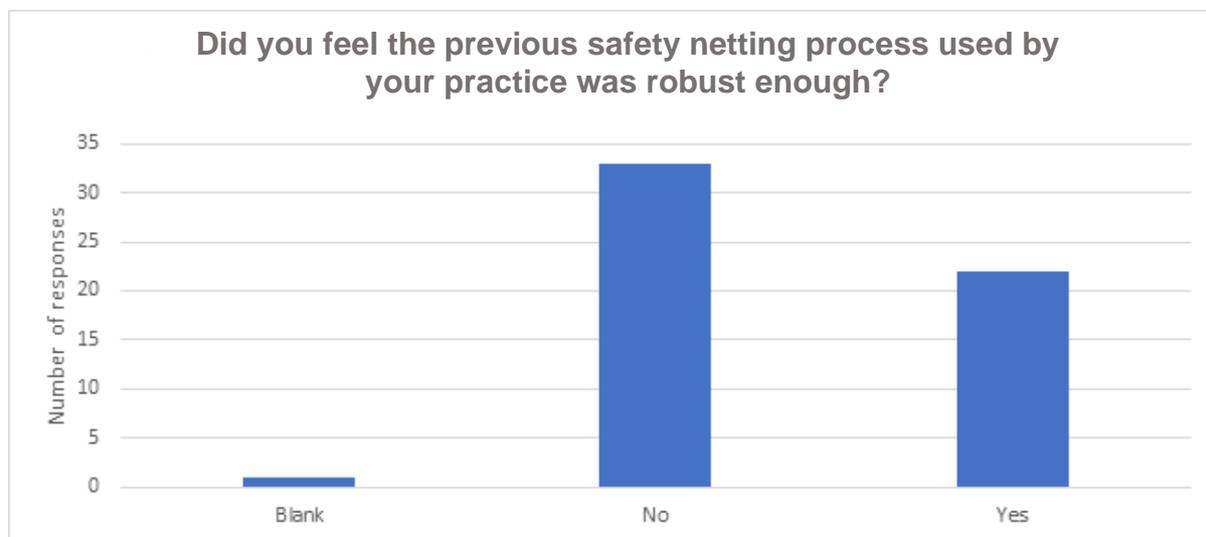
- The provision of an electronic system which allowed people to move away from paper systems or use of Excel
- Easier to track and monitor patients
- The system was thought by several participants to be more auditable and easier to monitor facilitating better tracking of patients
- Through making required follow up more visible
- Ease of use of the toolkit
- implementation of more standardised processes
- The ability to make use of searches
- As the template works with existing systems that are used within teams it was thought to be less dependent on any one individual

Chart 15: Showing responses to the question on whether the E-SN toolkit offers an improvement to current systems (from post workshop survey and follow up questionnaire)



Participants were asked whether they felt previous safety netting processes were robust. The majority of respondents to follow up questionnaire did not think their previous processes were robust enough. When asked to elaborate, the most common theme was that there was no previous process or at least no consistent previous process. The next most common theme was the use of manual processes. Interestingly, a substantial proportion did believe their previous systems to be sufficiently robust and they had cited manual processes in place which they previously perceived were robust enough.

Chart 16: Responses in absolute numbers to whether previous safety netting measures were robust enough



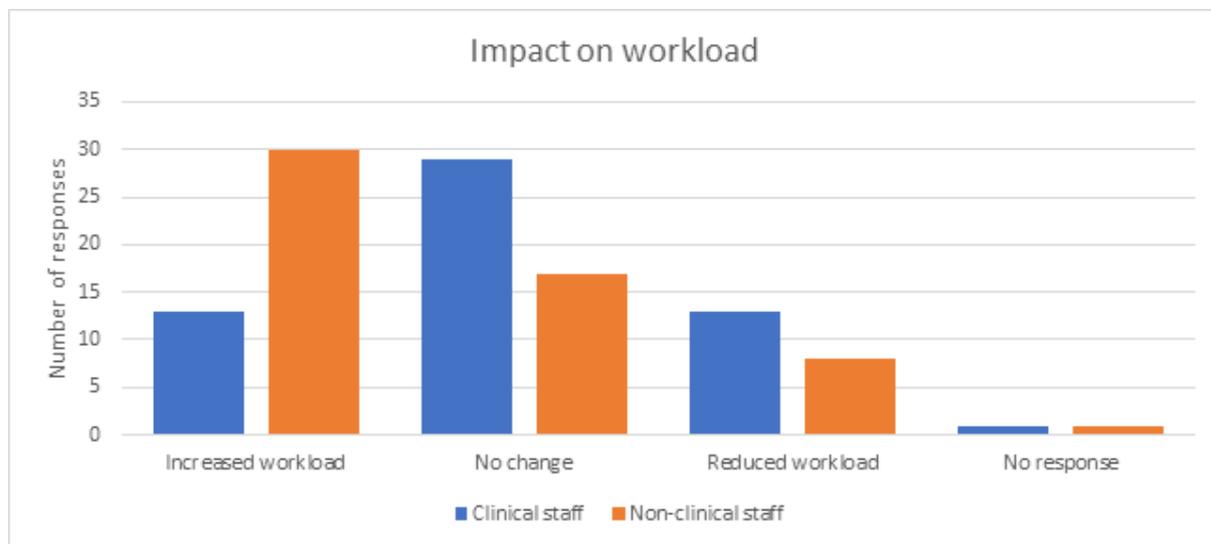
Impact on workload

The follow up questionnaire explored the impact of use of the toolkit on workloads for both clinical and non-clinical staff. Responses showed a mixed picture, with an equal number of respondents suggesting that use of the tool increased clinical workload (13) and reduced clinical workload (13). The most frequent response was that use of the tool had no impact on workload (29). When asked to provide reasoning for their answer, three respondents indicated that though using the toolkit increased workload it was more effective than their previous way of working and two respondents suggested that although the toolkit led to an initial increase in workload they hoped it would save time in the long run.

Among respondents who indicated no change to workload, the most common reason provided (by 11 respondents) was that the use of the toolkit had simply replaced a previous system. Four responses reported that it was too early to assess the impact on workload with any certainty.

The impact on the workload of non-clinical staff did show a clearer picture, with the majority of respondents reporting an increase. When asked how workload had increased the most common responses related to increased time to run searches and reports and follow up with patients.

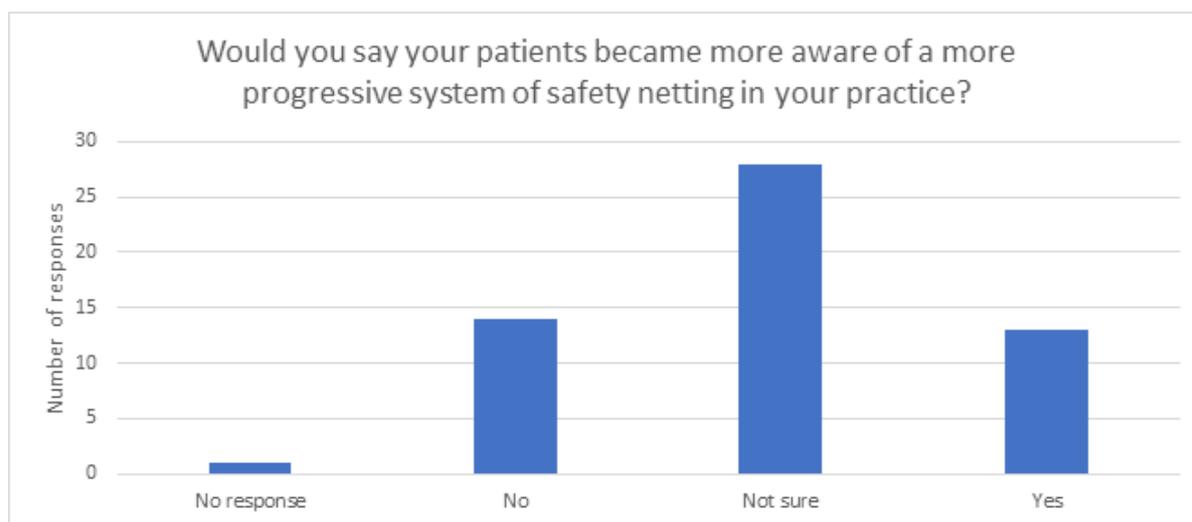
Chart 17: Impact on workload for clinical and non-clinical staff



Impact on patients

Participants were asked if patients were more aware of safety netting being used in the practice. Half of the respondents (28 of 56) responded that they were not sure if this was the case. There was an almost equal split of respondents who thought that patients were not more aware (14) and who thought patients were more aware (13).

Chart 18: Reponses to patient awareness on the E-SN toolkit implementation in practice



Practices were also asked if they had received any feedback from patients as a result of using the safety netting system. The most common response was that patient feedback had not been received although nine responses did state that they had received feedback. Of those who had not received patient feedback, four respondents suggested that patients were followed up in a similar way as part of their previous system and so it would not be noticed as a recognisable change. Those who did report receiving feedback said this was positive with patients stating that they either appreciated follow up and / or were pleased to be reminded of appointments. A small number of responses to the survey were unclear as to whether feedback had been received or not.

Table 3: Coded responses to open response question on patient feedback

Theme	Quote
Patients appreciated the call	<i>“Yes the patient who apparently DNA'ed her 2WW dermatology appointment was pleased we contacted her as she claimed never to receive an appointment letter”</i>
Patients were pleased to be reminded	<i>“Patients are happy that we contacted them especially when they forgot to attend and needed help”</i>
This was nothing new for our practice	<i>“No they are not aware as we were doing this but using a manual system”</i>

Suggestions for improvement

Suggestions for improvement provided in responses to the follow up questionnaire were diverse and no clear themes emerged. However, a number suggested an increased use or improvement of automated processes, for example automating e-mails, running of reports, automatic subsequent recall diary entries or for recalls and recalls only to appear in searches when due.

SUMMARY of Analysis

In summary almost 95% of practices who had implemented this system reported that it improved their ability to track patients compared to their current systems. The data shows that the longer the system is in use in a practice the more frequently it is used each month. Page 1 of the template was the most frequently used by a wide margin however, the monitoring code on page 3 of the template is the second most use individual code suggesting demand for the ability to use code to track patients. Practice size is likely not the only factor in the frequency of use of the template in a practice. Practices indicated that they found the tool easy to use, would continue to use the tool and would and a large majority suggested they would consider using the tool outside of cancer. Use of the tool does clearly result in an increased workload for non-clinical roles but the impact on clinical workload showed more inconclusive picture. Overall, it appears from the data that the tool is perceived to be user friendly and have made positive improvements to safety netting processes and to have been welcomed by patients.

Next Steps and Recommendations

This report has shown that this electronic method of safety netting has been an acceptable and sustainable way of working in primary care. Practices had stated their current methods of safety netting could be more robust and they felt this solution was not just better, but high quality.

Some of the benefits of the toolkit from the practices perspective included the ease of use, the centralization of administration, reduction in administrative burden of clinicians and being electronic it was a robust call - recall system. This in turn led to clinicians and patients reporting good experiences with its use.

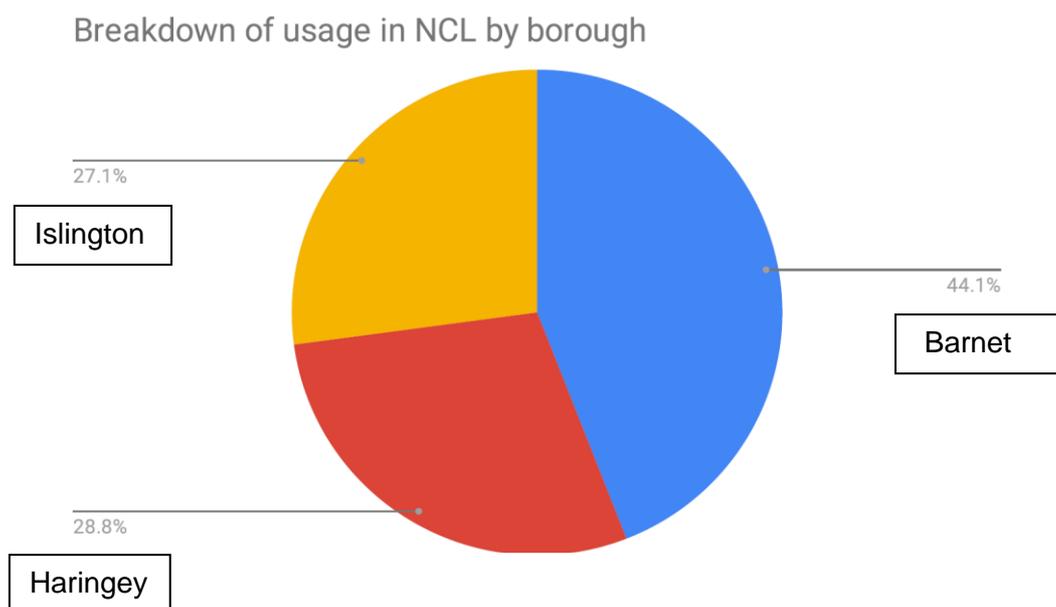
There are a number of potential wider benefits to having practices using this system. The robust tracking could mean reduced lost follow ups and reduced non-attendance on the cancer pathway. This in turn could result in cost savings and reduction in the primary care interval. It sets up practices to deal with higher risk clinical pathways, such roll out of qFit for high risk patients and cancer stratified follow up in primary care.

Indisputably for improvements in healthcare such as this, support is needed for those implementing the changes. The Alliance continues to support implementation in its geography and wider.

The Alliance has collaborated with the Nuffield Department of Primary Care Health Sciences, University of Oxford team to study the longer term outcomes of implementing the toolkit in naïve practices, through a CRUK funded randomised control trial. The protocol has been published on BMJ open (add hyperlink). The study is currently running and the protocol for the study has been published on [BMJ open](#).

Feedback on the toolkit is important as its usage spreads more widely. Since publication the toolkit has been updated and expanded. The relationship with EMIS Web is important to enable continued improvements.

Through local data collection we were able ascertain 118 practices were deploying the template in NCL in December 2019. We were unable to gather coded data from Enfield and Camden at this time. As we update this document in 2021 we endeavor to gather data across the NCL CCG.



The Alliance recommendations would be to continue to support the implementation of the toolkit within NCL and wider. Practices that are armed with this level of patient tracking are better placed to deliver higher quality cancer related activities. This also gives the various stakeholders and partner reassurance that commissioned work in primary care related to cancer can be delivered safely. Practices would be expected to be using this system or equivalent if they were embarking on high risk qFit test requests to stratified follow up of cancer patients in primary care.

The Alliance would advocate a Pan London approach/National approach (via alliances) to safety netting and influence non EMIS Web systems to take on the task of delivering equivalent systems. To support this endeavor, a systemic description of electronic safety netting is helpful. In appendix G, the electronic safety netting system requirements have been set out.

Covid-19 Impacts, comments and updates (from Jan 2020)

Since the completion of the report, the covid-19 pandemic had begun and its far reaching significant impacts on the healthcare system and wider society is history in the making.

The E-SN toolkit was updated through EMIS Web, to allow for commentary on tracking urgent suspected cancer referrals.

The oxford led research trial has been impacted in terms of the pace of practice recruitment but covid-19 impact metrics have been factored into the outcomes data. The trial has now recommenced with recruitment.

The need for robust safety netting systems in primary care has become ever more pressing in the covid era and the Alliance has been supporting general practice in implementing this system. A series of webinars were delivered from May to July 2020 and an E-SN [SOP](#) was created.

The primary care contract for the 20/21 PCN cancer early diagnosis DES identifies safety netting as a key deliverable and this system has been promoted for usage to fulfil the DES requirements.

There has been country wide requests for supporting E-SN roll out and the YouTube user video has had over 5,200 views (on 12/1/21).

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APPENDICES:

A: The E-SN toolkit template - screenshots

B: Memorandums of understanding between Cancer Alliance & STPs (e.g.

NEL) - anonymised

C: Advert for the workshop which was on Eventbrite

D: The commissioned pilot evaluation - part A and part B

E: The workshop evaluation feedback forms

F: The Educational material (screenshots/hyperlinks)

G: Electronic safety netting set of requirements/deliverables

Appendix A

Page 1: Suspected cancer referrals diary entries

Safety Netting Template UCLH-CC V9

Pages

- Suspected cancer referrals
- Direct access diagnostics
- Safety netting symptoms
- Cancer/Pre-cancer Monitoring

Suspected cancer referral diary entries

This section is to track urgent cancer referrals made and outcomes from the referrals.

- Safety Net Template used
- Fast track referral for suspected breast cancer Follow Up
- Fast track referral for suspected upper GI cancer Follow Up
- Fast track referral for suspected lower GI cancer Follow Up
- Fast track referral for suspected lung cancer Follow Up
- Fast track referral for suspected skin cancer Follow Up
- Fast track referral for suspected gynaecological cancer Follow Up
- Fast track referral for suspected urological cancer Follow Up
- Fast track referral for suspected haematological cancer Follow Up
- Fast track referral for suspected

ATOMIC NAME | NHS Web Health Care System - Sharnley Practice 1 - 22498

Summary Consultations Medication Problems Investigations Care History Diary Documents Referrals New Consultation

Save Cancel Split Search

Template

Text Summary - 1 - GP208 - 29 (28) Medicine Management - 1 (1) Respiration - 36 (32) Lab Results - 9 - Tests - 19 (18)

Active ATOMIC, Neil (Dr) Item: 01-Sep-1972 (45y) Gender: Male Ref No: 491 015 2249 Usual GP: HARDING, Brian (Dr)

Safety Netting template UCLH-CC V9

Pages

- Suspected cancer referrals
- Direct access diagnostics
- Safety netting symptoms
- Cancer/Pre-cancer Monitoring

Suspected cancer referral diary entries

This section is to track urgent cancer referrals made and outcomes from the referrals.

- Safety Net Template used
- Fast track referral for suspected breast cancer Follow Up 03-Apr-2018 No previous entry
- Fast track referral for suspected upper GI cancer Follow Up 03-Apr-2018 No previous entry
- Fast track referral for suspected lower GI cancer Follow Up 03-Apr-2018 No previous entry
- Fast track referral for suspected lung cancer Follow Up 03-Apr-2018 No previous entry
- Fast track referral for suspected skin cancer Follow Up 03-Apr-2018 No previous entry
- Fast track referral for suspected gynaecological cancer Follow Up 03-Apr-2018 No previous entry
- Fast track referral for suspected urological cancer Follow Up 03-Apr-2018 No previous entry
- Fast track referral for suspected haematological cancer Follow Up 03-Apr-2018 No previous entry
- Fast track referral for suspected head and neck cancer Follow Up 03-Apr-2018 No previous entry
- Fast track referral for suspected childrens cancer Follow Up 03-Apr-2018 No previous entry
- Fast track referral for suspected brain/ONS cancer Follow Up 03-Apr-2018 No previous entry
- Fast track referral for suspected sarcoma Follow Up 03-Apr-2018 No previous entry
- Fast track referral for suspected ophthalmology cancer Follow Up 03-Apr-2018 No previous entry
- Referral to cancer of unknown primary (CUP) service Follow Up 03-Apr-2018 No previous entry
- Referred to multi-disciplinary diagnostic centre (MDC) Follow Up 03-Apr-2018 No previous entry

Possible cancer diagnosis has been

Page 2: Direct access investigations

Diagnosics (direct access) diary entries

This section is to track direct access investigations and general test requests. There is variability in access to direct diagnostics. Please be familiar with what is available in your locality. (Direct access - when a test is performed and primary care retain clinical responsibility throughout, including acting on the results.)

Test	Follow Up	Previous Entry
Refer for X-ray	03-Apr-2018	No previous entry
Refer for ultrasound investigation	03-Apr-2018	No previous entry
Refer for CT scan	03-Apr-2018	No previous entry
Refer for MRI Brain	03-Apr-2018	No previous entry
Referral for gastroscopy	03-Apr-2018	No previous entry
Referral for colonoscopy	03-Apr-2018	No previous entry
Refer for sigmoidoscopy	03-Apr-2018	No previous entry
Referred for blood test/s	03-Apr-2018	No previous entry
Referred for urine HCS	03-Apr-2018	No previous entry
Referred for quantitative faecal immunochemical test (qFIT)	03-Apr-2018	No previous entry

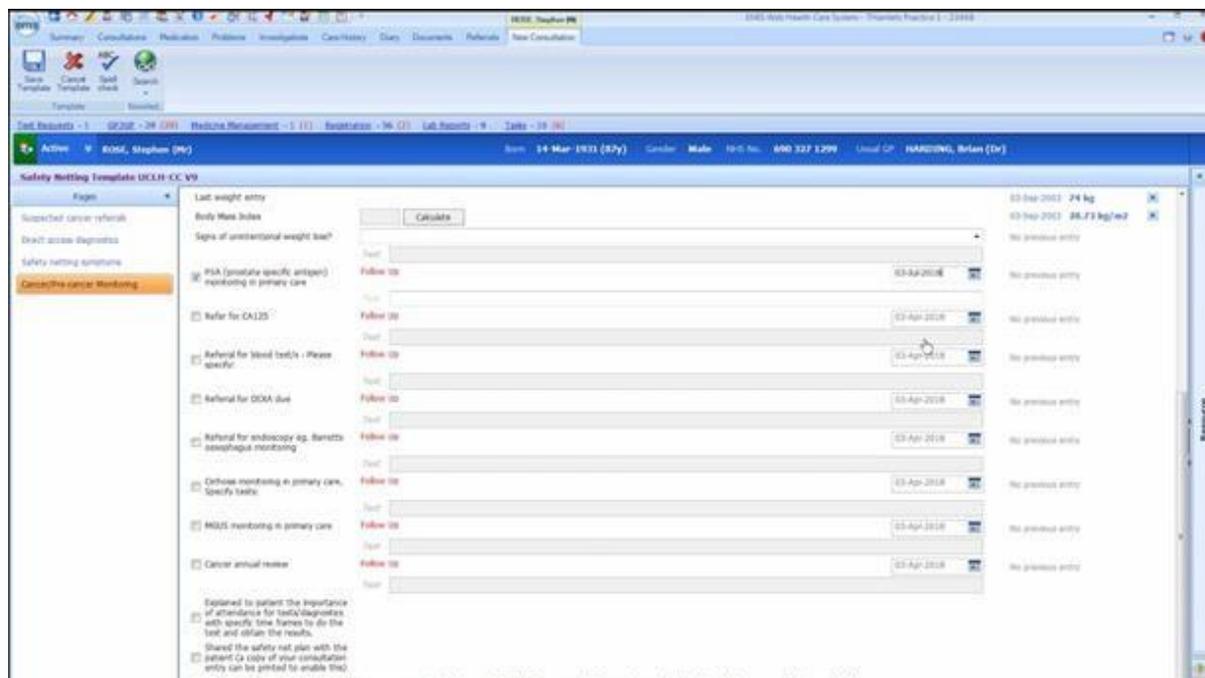
Page 3: Active monitoring of patients

Diagnosics (direct access) diary entries

This section is to track direct access investigations and general test requests. There is variability in access to direct diagnostics. Please be familiar with what is available in your locality. (Direct access - when a test is performed and primary care retain clinical responsibility throughout, including acting on the results.)

Test	Follow Up	Previous Entry
Refer for X-ray	03-Apr-2018	No previous entry
Refer for ultrasound investigation	03-Apr-2018	No previous entry
Refer for CT scan	03-Apr-2018	No previous entry
Refer for MRI Brain	03-Apr-2018	No previous entry
Referral for gastroscopy	03-Apr-2018	No previous entry
Referral for colonoscopy	03-Apr-2018	No previous entry
Refer for sigmoidoscopy	03-Apr-2018	No previous entry
Referred for blood test/s	03-Apr-2018	No previous entry
Referred for urine HCS	03-Apr-2018	No previous entry
Referred for quantitative faecal immunochemical test (qFIT)	03-Apr-2018	No previous entry

Page 4: Monitoring of patients who have had cancer or those who have had pre-cancerous conditions



Appendix B

Memorandum of Understanding

Between

UCLH Cancer Collaborative (UCLH CC)

and

[insert name of organisation]

UCLH CC personnel details:

Programme Lead -

Project Lead -

Project manager -

MICa primary care team

UCLH Cancer Collaborative

This Memorandum of Understanding (MOU) sets out the terms and understanding between UCLH CC and the [organisation name] to deliver general practice training for implementation of Electronic safety netting (E-SN). UCLH CC has transformation funding to deliver this project by March 2019 subject to the terms and conditions outlined in this MOU being met.

The total funding allocated for E-SN over this period amounts to XXX and half will go to North Central London (NCL) and half to North East London (NEL) - (XX).

Background to the project

The Cancer Task Force and NG 12 NICE guidelines 'Suspected cancer: suspected cancer recognition' (2015) highlighted the need for rigorous safety netting. Early diagnosis of cancer can be aided by systematic use of safety netting and symptom monitoring.

Safety netting is a strategy to help manage diagnostic uncertainty. The aim is to ensure that patients do not drop out of the primary care net but are monitored until

their symptoms have resolved or been explained.

The E-safety netting toolkit

The electronic safety netting toolkit for EMIS Web offers a solution to safety net in primary care far more effectively. It enables users to pro-actively track patients of high or low concern in a systematic and robust way.

The toolkit has undergone a feasibility trial and now several Plan Do Study Act (PDSA) cycles as part of our wider London pilot to help form the final version. UCLH CC has led on the development of this version of the EMIS Web E-SN solution and it is now available nationwide on EMIS Web.

The toolkit is designed to be used by the practice team as a whole. The toolkit comprises of a 4 page comprehensive template that the clinicians would use for their patients in various cancer related scenarios. For example, 'tracking fast track cancer referrals' or 'direct access diagnostics'. Each trackable event will have a diary entry created by clinicians through the template, which acts as a time reminder and when the event is due or expired, it can then be found through a search. A search is a way to retrieve the coded information in the template and this would be run regularly by the administrative lead at the practice who would then review these outstanding events. The toolkit has additional functions like the Alert flags which pop up in the records to signal an incomplete safety net event and Template Trigger that helps remind users to use the template.

This system provides a centralised and efficient safety netting approach that will replace existing verbal and paper methods in participating practices. For some General Practitioner (GP) practices, this is a new way of working therefore requires leadership advocacy in order for this to be implemented and run smoothly.

There is a pan-London safety netting group led by Transforming Cancer Services Team (TCST) aiming to roll out similar tools for other systems (System One and Vision). These tools are currently in pilot or production phases. TCST with the North West of London have recently started to incentivise workshops to implement electronic safety netting for their GP practices.

Proposal for E-SN workshops in NCEL

UCLH CC will fund training for implementation of the E-SN toolkit project to help accelerate embedding across GP practices in NCEL. As requested by NEL and NCL STPs, content of the workshops will also include cancer updates. The cancer topics will include: FIT, HPV, direct access and MDCs.

Five to seven workshops will be held in total to cover practices across the NCEL footprint. The workshop sessions last between 2.5 - 3 hours long.

- Two or four large workshops with capacity for approximately 46 people in each (23 GPs and 23 administrative personnel) - one in an NEL location and the other in an NCL location.

- Three smaller workshops with capacity for approximately 20 people each (10 GPs and 10 administrative personnel) to be held at the NEL CSU at Clifton House.

We have capacity to deliver funded training for 76 NCEL practices in total and we will offer the places on a first come first served basis. The workshops will be advertised on Eventbrite.

Reporting and monitoring

Reporting will be conducted by the UCLH CC team. Attendance and evaluation will be recorded and monitored. UCLHCC will notify the STP finance team within 14 days of the workshop providing both the names of attendees and their practice details after which payments will be issued.

In addition to the reporting and monitoring responsibilities outlined above, UCLH CC will also undertake the following activities:

- Advertise the workshop spaces through Eventbrite
- Eventbrite will clearly state all the relevant information about the workshops including locations and details of the incentivisation scheme.
- Eventbrite's functions will be used to ensure practices in NCEL attend only once and previous attendees do not re-attend
- Organise and carry out the workshops
- Ensure registrants complete a post workshop evaluation which will evidence attendance for the whole workshop
- Send confirmation of attendance to the STP finance team
- Send reminders to practice (within 4 months of attendance) to return their evaluation of the tool
- Ensure all the practices receive the E-SN evaluation pack and have instructions on how to complete
- Send confirmation to relevant CCGs that the evaluation has been received and that payment two can be issued.

The STP finance team for NEL will:

- Make the first payment to back fill the GP practice once confirmation is

received that both GP and senior administrative staff member have attended the workshop

- Make a second payment once confirmation that the GP evaluation has been received by the UCLH CC team - approximately 4 month after attending the workshop

UCLH CC will use an Excel spreadsheet to monitor the activities outlined above. This is a top level example of the spreadsheet:

Practice information						Workshops				Evaluation		
Registration No.	Surname	Name	Designation	Contact details	Practice Name	ETD	Workshop date	Workshop time	Register	Evaluation Date sent to ETG	Payment 1	Payment 2

Payments

UCLH CC will transfer XX of transformation fund to the [organisation name] to provide the 2 payments detailed below.

A compulsory requirement will be that a GP and 1 senior member of administrative staff from each practice attend one workshop. Both the GP and the senior administrator have to attend for the practice to receive this payment as effective use of the E-SN relies on both clinicians and administrative staff working in tandem.

Practice participants who attended in March 2018 workshops will not be able to register (they were paid backfill to attend at that time).

We recommend 2 payments are made to GP practices:

Payment 1: XX after the GP and the senior administrator have attended one workshop

Payment 2: 4-5 months after attending the workshops, the practice will be asked to complete the E-SN evaluation pack. This comprises a GP- led reflective qualitative questionnaire and a report that includes downloaded results of pre-written searches. The completed questionnaire and report will be sent back to the UCLH CC team (anonymised data). XX will be issued on receipt of the completed evaluation pack.

UCLH CC Conditions of funding

1. If actual project costs were to exceed the funding allocation, UCLH CC will be under no obligation to fund any overspent amounts. In this eventuality, you are advised to escalate to us at the earliest available opportunity with details of overspend.
2. Funding is to only be used for eligible project costs.
3. The data captured from this project will be kept by UCLH CC and nominated third-party supplier may or may not be contracted to evaluate the data for UCLH CC.
4. When communicating with the media, the STPs or any other individuals involved with the project should reasonably promote UCLH CC and acknowledge the Funding received from cancer transformation funding and the importance of the Funding to the overall project.
5. A signed copy of this agreement by the STP lead and finance team lead is returned to the UCLH CC.

We hereby agree to abide by the terms and conditions stated above and acknowledge that failure to comply with these may result in funding to be withheld by UCLH CC.

Signed by

Insert name, Programme Director

UCLH Cancer Collaborative

Signed by

[organisation name] lead

[organisation name] finance lead

Contact Information

University College Hospital London Cancer Collaborative

Name of Programme Lead

Add address here

E-mail:

[organisation name]

Insert name

Commissioning Director-Cancer [area]

Add address here

E-mail:

Appendix C:

E-Safety netting toolkit and Cancer Updates for general practice in the NCEL area - Funded workshop

Dear Colleagues;

The UCLH cancer collaborative (UCLH CC) are holding further cancer electronic safety netting (E-SN) workshops to support implementation of our toolkit into GP practices in North-Central and North-East London (NCEL). Please note we will be funding this training so please read fully all the information below before booking.

Electronic safety netting toolkit for cancer for GPs:

We have created an electronic safety netting toolkit for cancer that can be used by GPs faced with various 'cancer related' clinical situations. The toolkit gives GP practices a template/form that schedules diary reminders in their system and reminds and alerts practice staff to follow up at a later date. EMIS Web have made our solution nationally available on their system, meaning that all GP practices using EMIS Web can now access this toolkit.

In these workshops we will also aim to cover crucial cancer updates relevant for primary care such as FIT testing, HPV testing, direct access diagnostics and MDCs.

Please see our website for further information on the toolkit:

<https://www.uclh.nhs.uk/OurServices/ServiceA-Z/Cancer/NCV/MICa/Pages/Primarycareimprovement.aspx>

And our E-SN video user guide:

<https://www.youtube.com/watch?v=U4byHZwOZv8>

Workshop Contents:

Part 1: Cancer E-SN toolkit

- Background - National drivers for safety netting and the toolkit narrative
- Explain the purpose of the toolkit - Case studies building on the need for E-SN.
- Implementing and using it in GP practices - Case studies exemplifying operation
- The toolkit components and optimising use in practice i.e. Administrative leadership
- Enable opportunity to trial the toolkit on EMIS enabled PC's (CSU site ONLY)

Break: Refreshments

Part 2: Cancer updates for GPs

- FIT testing
- Screening – primary HPV and FIT in screening
- MDCs
- Urgent Direct Access services (availability mapping in NCEL)
- Cancer Care Reviews - Showcase UCLH CC package and need for high quality CCRs
- Signpost to GatewayC (online cancer education platform) and BMJ on Examination early diagnosis of cancer.

This training is incentivised and places are offered on a first come first served basis and you may only attend one workshop.

Who should attend: One GP and One senior/lead administrative staff member (e.g. reception manager or practice manager) from the same practice.

Dates and Locations of E-SN workshops:

Thursday, 13 December 2018 at 9.30 - 12.30

at CSU, IT Training Suite, Basement, NEL Commissioning Support Unit, Clifton House, 75-77 Worship Street,

London, EC2A 2DU.

Thursday, 10 January 2019 at 9.30 - 12.30

at WEC Lecture Room 7, The Education Centre at The Whittington Hospital, Magdala Avenue, London, N19 5NF.

Thursday 17 January 2019 at 09:30 - 12:30

at Room US 4.15, University of East London, Stratford Campus, Water Ln, London E15 4LZ

Capacity:

Each event has a limited capacity - see each event ticket site for numbers.

We have set out the terms for the incentivisation and these will need to be complied with to obtain payments so please do read fully.

TERMS OF INCENTIVISATION:

1. The first payment is made for attending the workshop and amounts to **£250**. To obtain this payment one GP (preferably a partner) will need to attend with one senior/lead administrative staff member (e.g. reception manager or practice manager) from their practice. The administrative staff member is free to leave after part 1 if they choose to do so.
2. To obtain the second payment of **£250** we would ask the practice to complete an evaluation pack four months after attending the workshop. The pack contains an evaluation questionnaire and some EMIS Web reports that would need downloading from your system. We will provide you with the reports and prompt you when these are due. To get the second payment the practice would need to have implemented the toolkit into their practice (action from the workshop) and returned the evaluation to us.
3. You must be in practice within our sectors CCGs (NCEL includes: Barking & Dagenham | Barnet | Camden | City & Hackney | Enfield | Haringey | Havering | Islington | Newham | Redbridge | Tower Hamlets | Waltham Forest).

How to claim your payment:

Please sign in on arrival and complete the evaluation form at the very end of the session as this would confirm your attendance and your first payment will be processed.

Your second payment will be processed once your evaluation of the tool has been sent to us 4 months post workshops.

To book a place on one of the training dates please register yourself using the tickets below and make note of the different locations which are highlighted on the tickets. You are welcome to book as a pair at any site that is convenient for both of you.

For further information on course aims/content: vanessaponnusamy@nhs.net

For assistance with registering onto the course: daisy.doncaster@nhs.net

If you are a network of practices looking for onsite training we are able to visit you at your site - please inform us of your interest by email to vanessaponnusamy@nhs.net.

Looking forward to seeing you there.

Dr Afsana Bhuiya

Macmillan GP Improvement Lead

UCLH Cancer Collaborative | 47 Wimpole Street | London | W1G 8SE

Website www.uclh.nhs.uk/cancercollaborative

Blog www.uclh.nhs.uk/cancerblog

Appendix D

Cancer Electronic Safety Netting (E-SN) toolkit for EMIS Web

PART 2 - Evaluation

The E-SN toolkit would have had to be implemented in your practice post the workshop in order for you to complete this evaluation package.

Once the evaluation is completed and returned to the UCLH Cancer Collaborative, the second incentive (£ 250) will be issued to your practice.

This pack contains an evaluation questionnaire and some EMIS Web reports that would need downloading from your system.

Your feedback is anonymised and will be used collectively to evaluate the qualitative aspect of the E-SN toolkit.

Dr Afsana Bhuiya

GP Lead

UCLH Cancer Collaborative

A - Evaluation questionnaire

The questions are set out in 6 sections:

Section 1: Practice information

Section 2: Previous safety netting in practice

Section 3: Your experience and improvements from using the E-SN toolkit

Section 4: Challenges in implementing and use of the toolkit in your practice

Section 5: Patient feedback and participation

Section 6: Overall review of the toolkit

Please click the smartsurvey link to complete the questionnaire:

<https://www.smartsurvey.co.uk/s/ElectronicSafetyNetting/>

B - EMIS Web report activities on E-SN toolkit usage

There is just one search in the pack we have sent for you to import.

We require you to carry out 2 search activities.

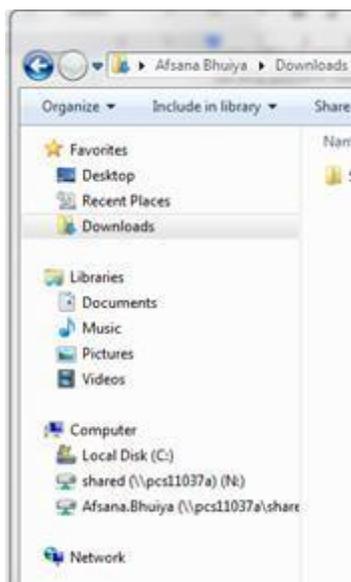
The first activity relates to looking at the number of times the template was deployed over a period of time. The second activity is running the safety netting search that you normally use, on the day you are doing this activity and downloading this as an example of activity in your practice in relation to E-SN.

The next few pages takes you through a step by step guide of importing the search and running the search in order to obtain the required information.

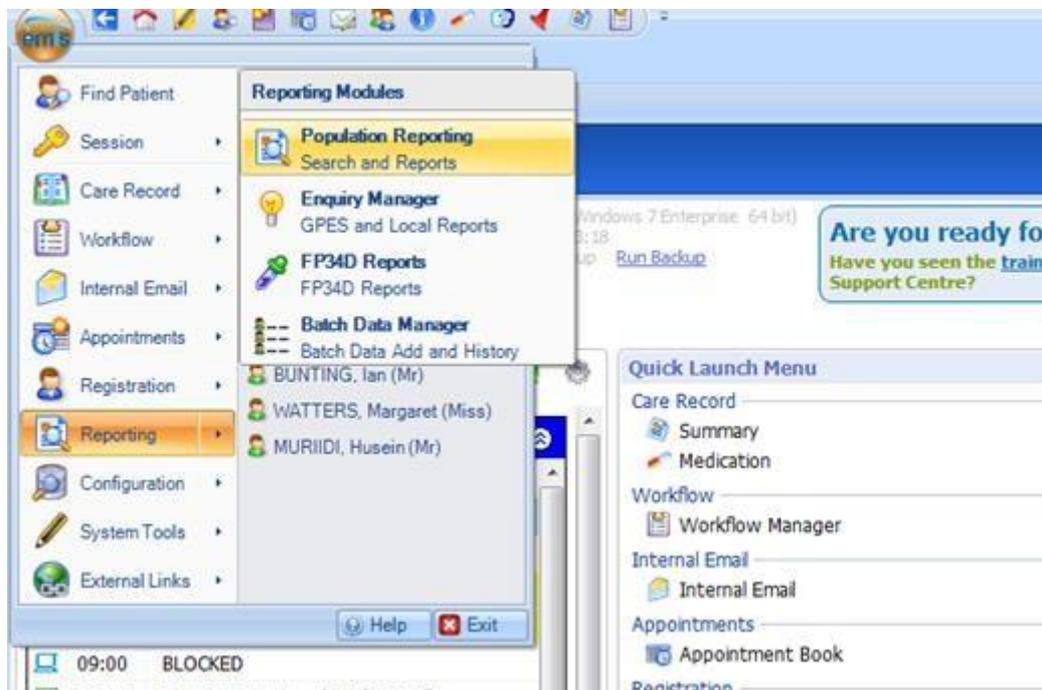
The reports should **NOT** include any patient identifiable data so please ensure you remove the patient ID columns.

DOWNLOAD THE EMIS SEARCH AND IMPORT TO EMIS WEB:

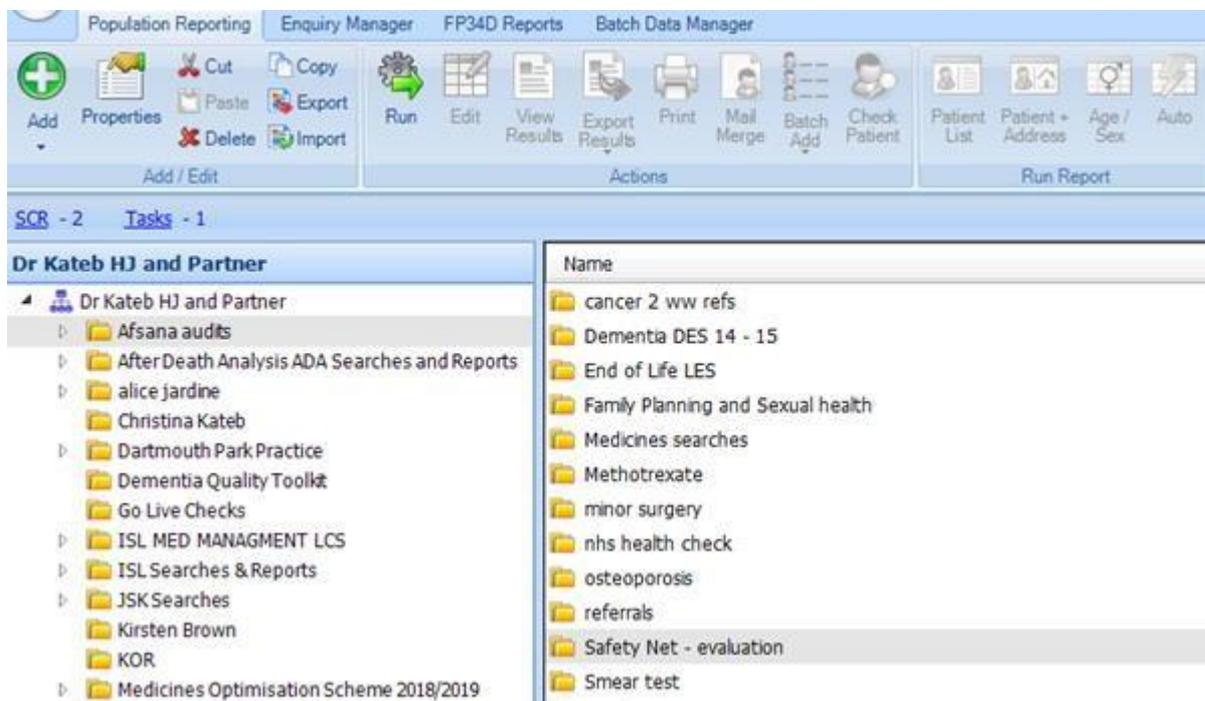
In the email you received, besides from this PDF guide, there was an xml file labelled 'SN template usage search for evaluation'. Please ensure you download this file to your downloads folder too.



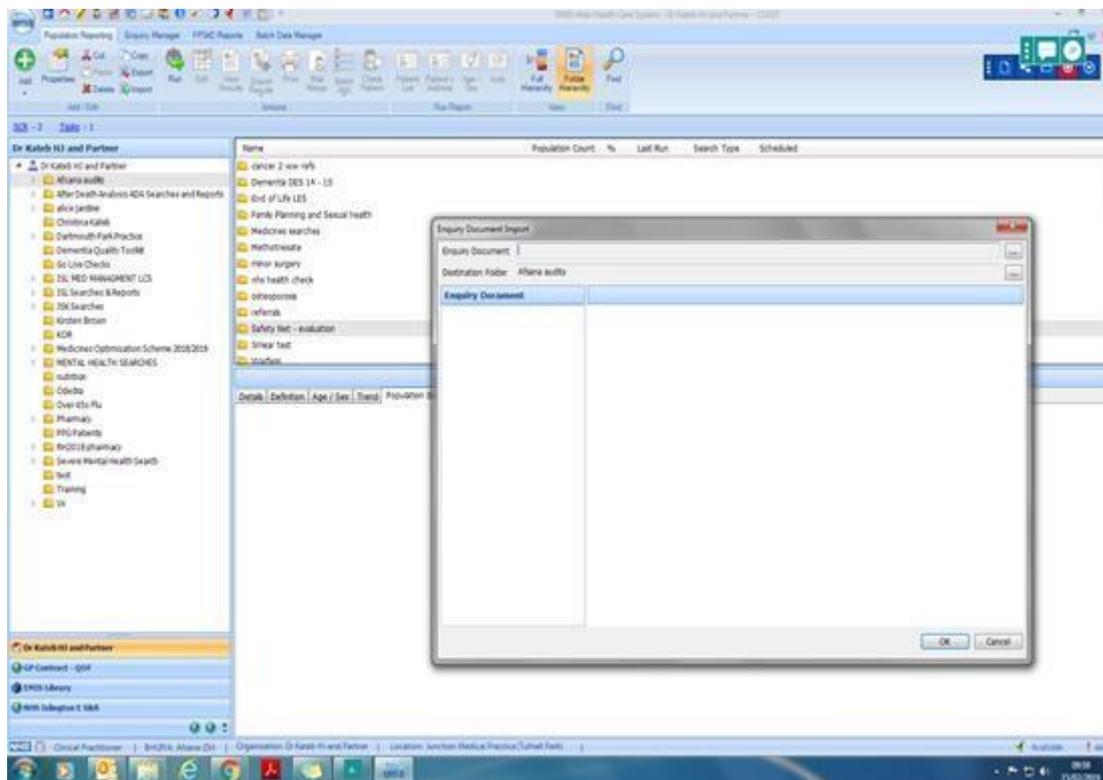
In EMIS Web - Go to top EMIS button and find 'reporting' - then 'population reporting'



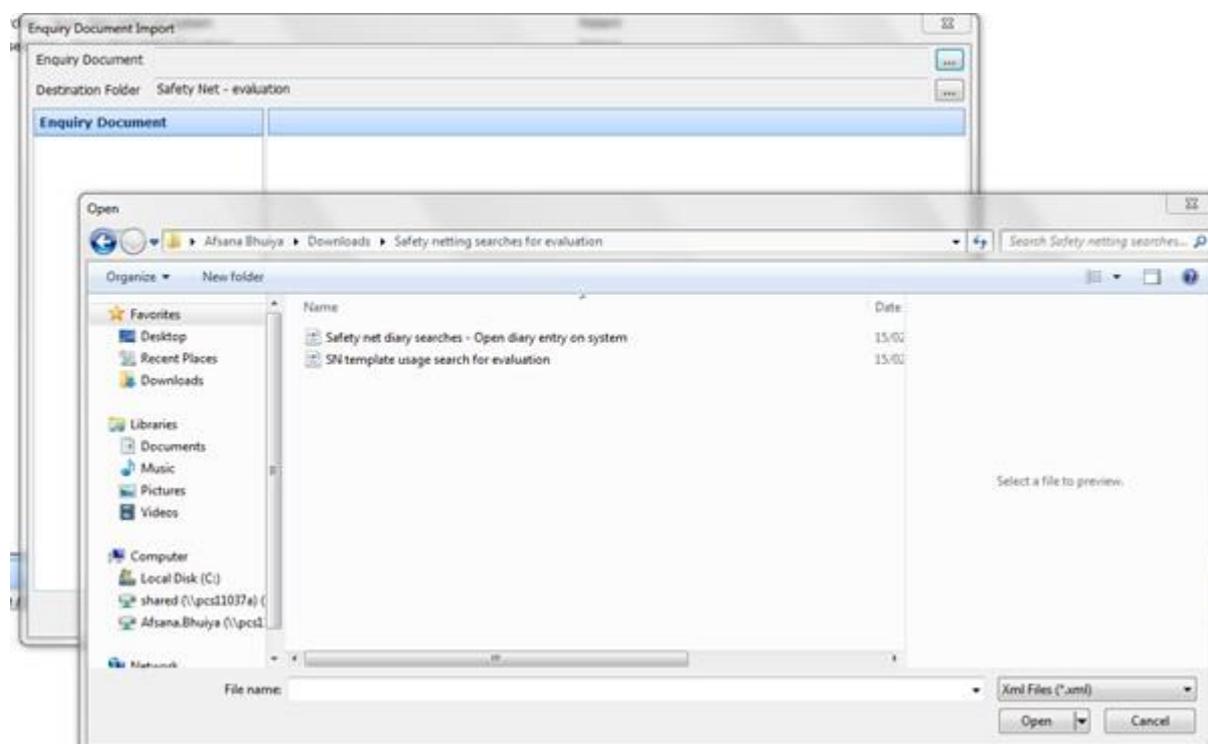
Then choose where within population reporting, you would like to import the files to. Below is an example from my own practice:



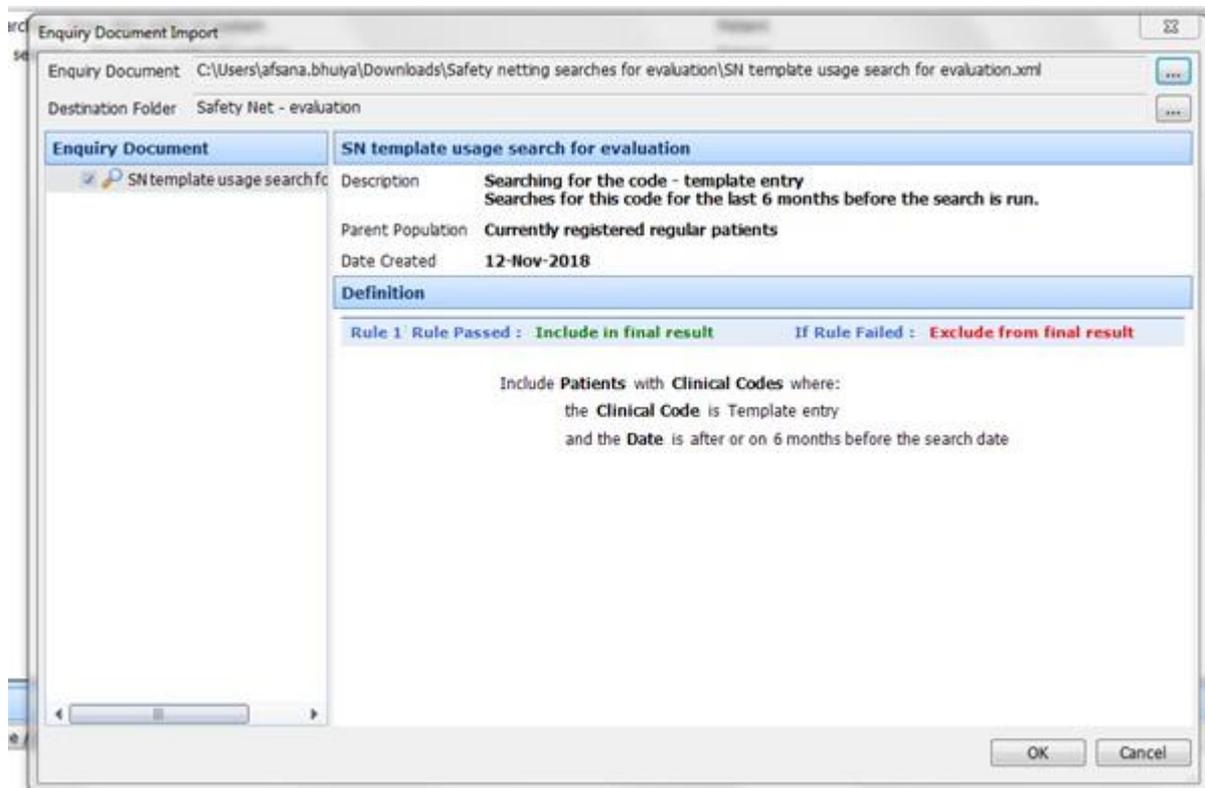
Then click on the import button to import the search file. This will open up a document finder:



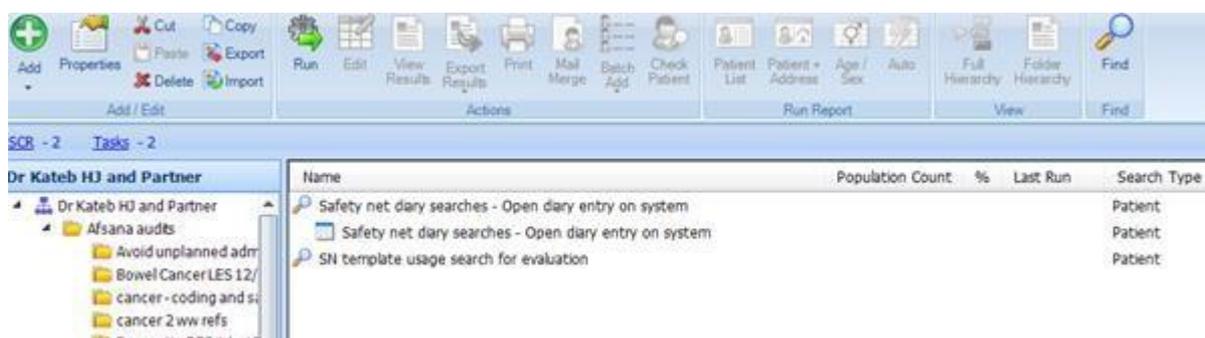
Locate the 'SN template usage search for evaluation' folder in the Downloads folder:



And import it:



Once imported - the search will sit in your allocated folder:

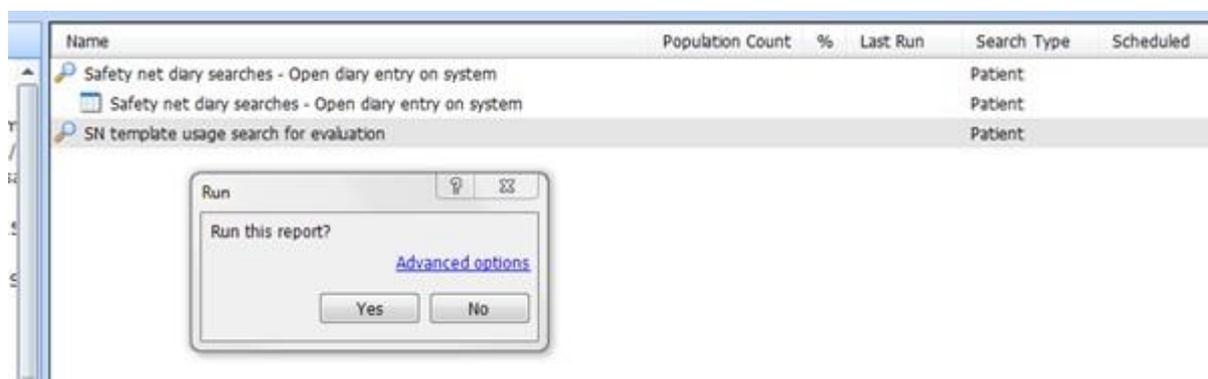


RUNNING THE SEARCHES:

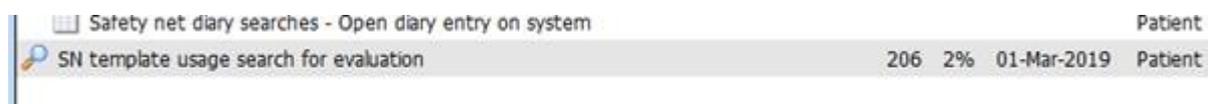
SN template usage search:

We need you to run this search several times over different relative dates, so we can see if there are any trends from when your practice started using the toolkit.

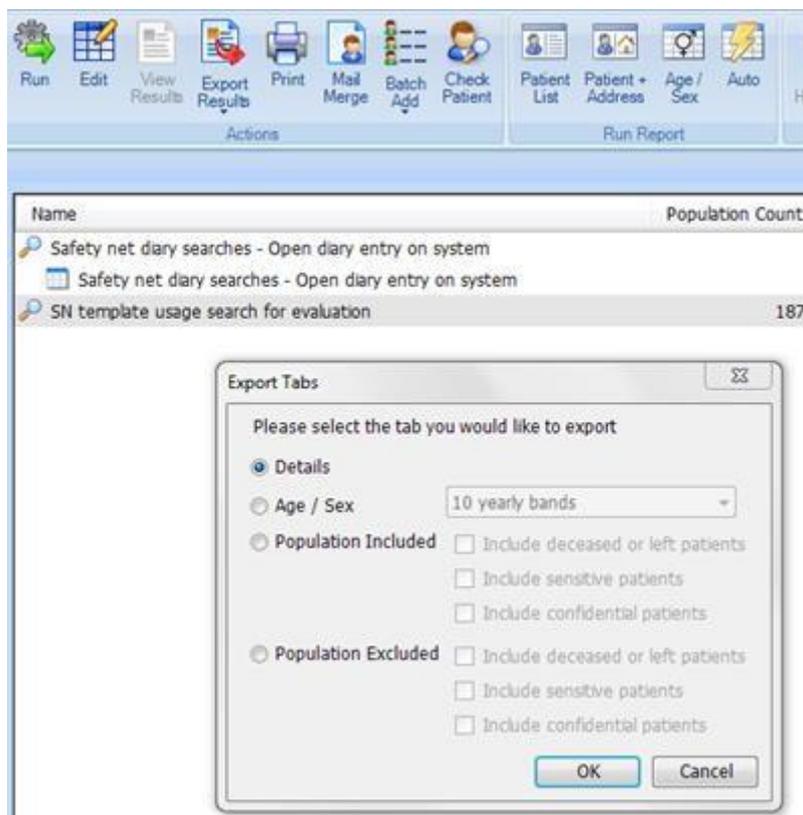
Highlight the SN template usage search and then press run which will give today's number of template runs.



After running a number will be shown as exemplified below:

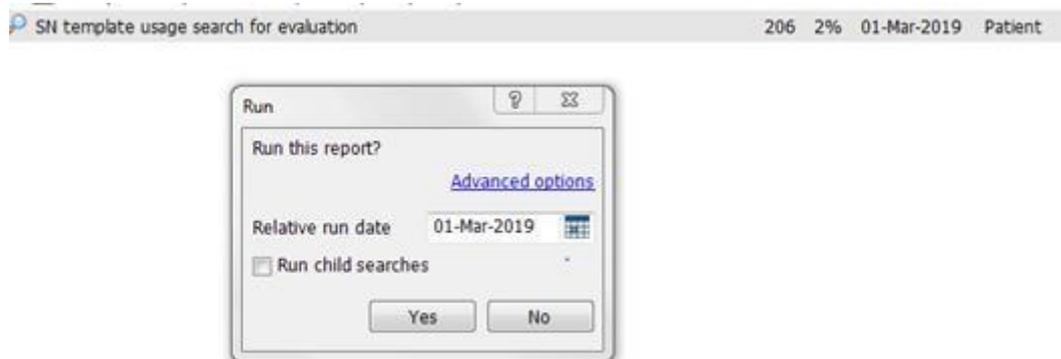


Then download this report as an excel file to your downloads folder. To do this press export results and save as an excel file. Please name and date saved file along the lines of 'SN search - March 19'.



Next we want to see the number of template runs each month going back in time.

So next, press run again, then on the box press 'advanced options' to reveal:



The relative run date is what we need you to change for the next set of runs. So in this case you want to change the date to one month back and then run again (i.e. 1st feb) so show results of the search relative to the new date.



You will now get a new reading for this search (187, previously was 206)



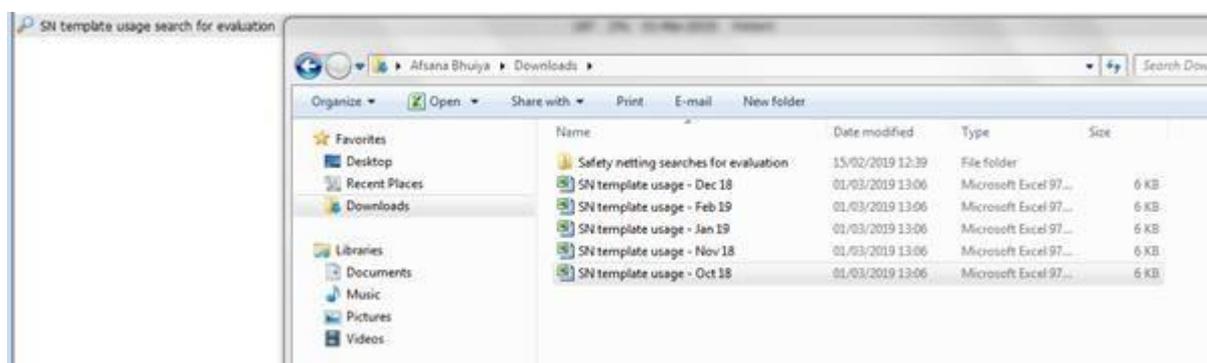
Repeating this method, keep going back monthly, below exemplifies the next month back (i.e. 1st of Jan):



Again, download the new report and label accordingly.

We require you to repeat the relative runs to look back at the last 5 months please.

At the end of the process you should have excel report saved and labelled appropriately to send back to our team:



This will give us the sequential template usage per month at your practice.

Safety net diary searches

The second search is the search that is part of the toolkit that you run regularly as part of tracking your safety net events. All you need to do here is just run it on the day you do this evaluation and then view results.

The report example below has been modified so the columns representing patient identifiable details has been blocked out.

Safety net diary searches - Open diary entry on system

Parent Population: Safety net diary searches - Open diary entry on system
 Exit Row: 15-Feb-2019 11:55 Relative Date: 15-Feb-2019 11:54

Population Count	Males	Females
28	10	18

Patient Details			Diary Entries			
EMIS Number	Full Name	Usual GP's Surname	Date	Code Term	Associated Text	User Details: Full Name
			05-Feb-2019	Fast track referral for suspected lower GI cancer		
			12-Feb-2019	Monitoring of patient NOS		
			23-Jan-2019	Monitoring of patient NOS	ENT UCLH URGENT referral - share outcome, was he seen?	
			15-Feb-2019	Fast track referral for suspected lower GI cancer		
			13-Feb-2019	Monitoring of patient NOS	Raised PSA - to ensure has been seen by GP and assess referral pathway after discussion with pt	
			05-Feb-2019	Fast track referral for suspected breast cancer		
			05-Feb-2019	Monitoring of patient NOS		
			21-Jan-2019	Refer for ultrasound investiga		
			20-Jan-2019	Monitoring of patient NOS		
			30-Jan-2019	Refer for ultrasound investiga		
			11-Feb-2019	Monitoring of patient NOS		
			31-Jan-2019	Refer for CAT scanning	Specify CT site: Abdomen @ UCLH - check report is back - let me know	
			30-Jan-2019	Fast track referral for suspected breast cancer		
			13-Feb-2019	Fast track referral for suspected upper GI cancer		
			13-Feb-2019	Monitoring of patient NOS		
			13-Feb-2019	Refer for ultrasound investiga	USS neck	
			13-Feb-2019	Fast track referral for suspected skin cancer		
			31-Jan-2019	Fast track referral for suspected breast cancer		

You would then export this excel file and save to your downloads folder (name and date the file).

Once saved it can be open and at this point you can edit the file to delete the columns related to patient identifiable details (EMIS number, patient details, GP/User details) - see below:

Report Name: Safety net diary searches - Open diary entry on system
 Parent Population: Safety net diary searches - Open diary entry on system
 Last Run: 15-Feb-2019 11:55
 Relative Date: 15-Feb-2019 11:54
 Population Count: 28
 Males: 10
 Females: 18

Patient Details		Diary Entries				
EMIS Number	Full Name	Home GP's Surname	Date	Code Terms	Associated Text	Details Full Name
			02-Feb-2019	Fast track referral for suspected lower GI cancer		
			12-Feb-2019	Monitoring of patient NGS		
			23-Jan-2019	Monitoring of patient NGS	ENT UCLH URGENT referral - chase outcome, was he seen?	
			16-Feb-2019	Fast track referral for suspected lower GI cancer		
			13-Feb-2019	Monitoring of patient NGS	Raised PSA, to ensure has been seen by GP and assess referral pathway after	
			06-Feb-2019	Fast track referral for suspected breast cancer		
			06-Feb-2019	Monitoring of patient NGS		
			21-Jan-2019	Refer for ultrasound investign.		
			30-Jan-2019	Monitoring of patient NGS		
			30-Jan-2019	Refer for ultrasound investign.		
			15-Feb-2019	Monitoring of patient NGS		

REMEMBER

- Please send back all the reports back to vanessaponnusamy@nhs.net
- Ensure that all patient and GP details in searches are removed
- Please can you enclose the Full address of your practice including the postcode in your email containing the completed evaluation.

Thank you very much for attending the workshop and completing this evaluation.

Appendix E:

Workshop Evaluation questionnaire

E-Safety netting toolkit and Cancer Updates for general practice in the NCEL area - Funded workshops

Category/s: Screening/Primary Prevention/ED/Supportive Care/LWBC

Geography: NCEL GP practices

Training delivery by:

Target group: GPs and GP admin lead staff

ATTENDEE JOB TITLE:

DATE of WORKSHOP:

Learner satisfaction:

1. How did you hear about this workshop?

2. What made you attend?

3. How happy were you with the workshop overall ?

Not happy at all	Unhap py	Neutral	Happy	Very happy
1	2	3	4	5

4. How happy were you with the session aims?

Not happy at all	Unhap py	Neutral	Happy	Very happy
1	2	3	4	5

5. Are you happy that the venue to meet your training needs?

Not happy at all	Unhap py	Neutral	Happy	Very happy
1	2	3	4	5

Learning outcomes:

6. Has the session increased your understanding of safety netting and the systems used to deploy effective safety netting?

Yes No

7. Has the session increased the value of electronic safety netting systems for you?

Of no value at all	Not valuab le	Neutral	Valuab le	Most valuab le
1	2	3	4	5

8. Do you feel the electronic safety netting toolkit offers you an improved method to track patients compared with your current system?

1. Yes - if yes how?

2. No – if no, why not?

9. How confident do you feel to use it on a personal level?

Not confident at all	Unconfi dent	Neutr al	Confid ent	Very confid ent
1	2	3	4	5

10. How confident do you feel to take your learning back to train the rest of your practice team on using the E-SN toolkit?

Not confident at all	Unconfi dent	Neutr al	Confid ent	Very confid ent
1	2	3	4	5

Behaviour change:

11. As you know this is a commissioned activity with the second payment related to completing evaluation related to having implemented and used the E-SN in your practice. Do you intend to submit evaluation data as per part 2?

1. Yes

2. No - if no, why not?

12. Which page/s of the toolkit would be most useful to you for your clinical practice? Please state:

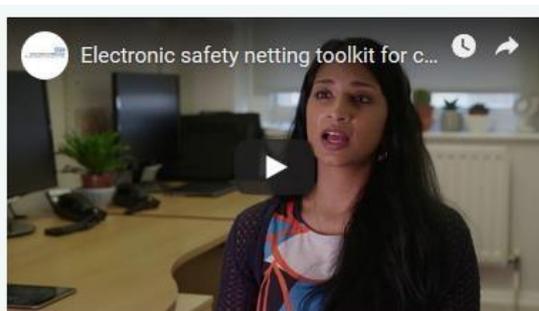
13. Could you see use of the toolkit for safety netting outside cancer? Yes/No

Example/s:

14. Any further comments/feedback?

Appendix F:

- To support GP practices implement the toolkit we have produced a video user guide: <https://youtu.be/U4byHZwOZv8>
- and PDF user guide for clinicians: <https://www.nclcanceralliance.nhs.uk/wp-content/uploads/2021/01/E-SN-Guidance-for-clinicians.pdf>
- And guide for administrative staff: <https://www.nclcanceralliance.nhs.uk/wp-content/uploads/2021/01/E-SN-Guidance-for-admin-staff-using-the-toolkit.pdf>
- And a guide on where to find the toolkit in EMIS Web: <https://www.nclcanceralliance.nhs.uk/wp-content/uploads/2021/01/Location-of-toolkit-in-EMIS-web.pdf>



As well as a PDF user guide.



And a user guide for administrative staff in GP practices.



Appendix G:

The electronic safety netting set of requirements:

1. Practice or network agrees on a system led way to safety netting e.g. back office and clinical leadership to ensure accountability and sustainability
2. Appropriately coded actions/events (READ and soon SNOMED)* for target patients† and set date by which actions should be completed
3. Completed actions/events should be closed or recorded (e.g. diary entries completed vs coding of an event)
4. Embed a search capability to retrieve the recorded codes/events that have expired and are due to be reviewed for completion or not. These searches should be run regularly (e.g. weekly)
5. The search output should be clearly led on by admin staff named person and sub delegated as per resources. The aim of the search output is to ensure actions are completed.
If completed – event closed
If not completed – clear actions arising from each type of event – see next step
6. Have a process in place for contacting patients or hospitals to ensure actions completed
7. Unclear or unresolved events should be followed by communicating with the clinician setting the event or senior clinician if they are not available
8. Monitoring delivery of safety netting processes to assure quality and identify ways in which these could be improved