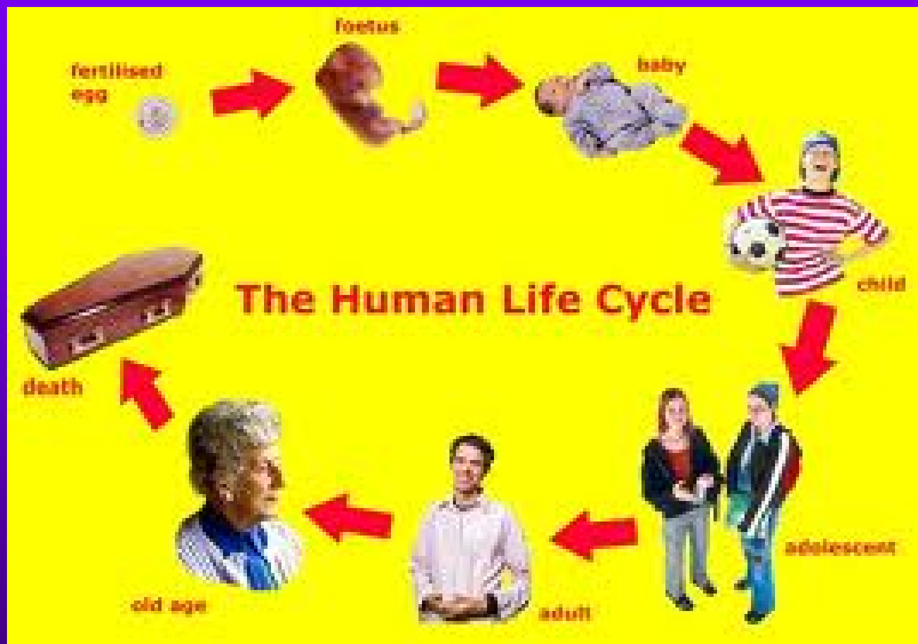
Circle of life

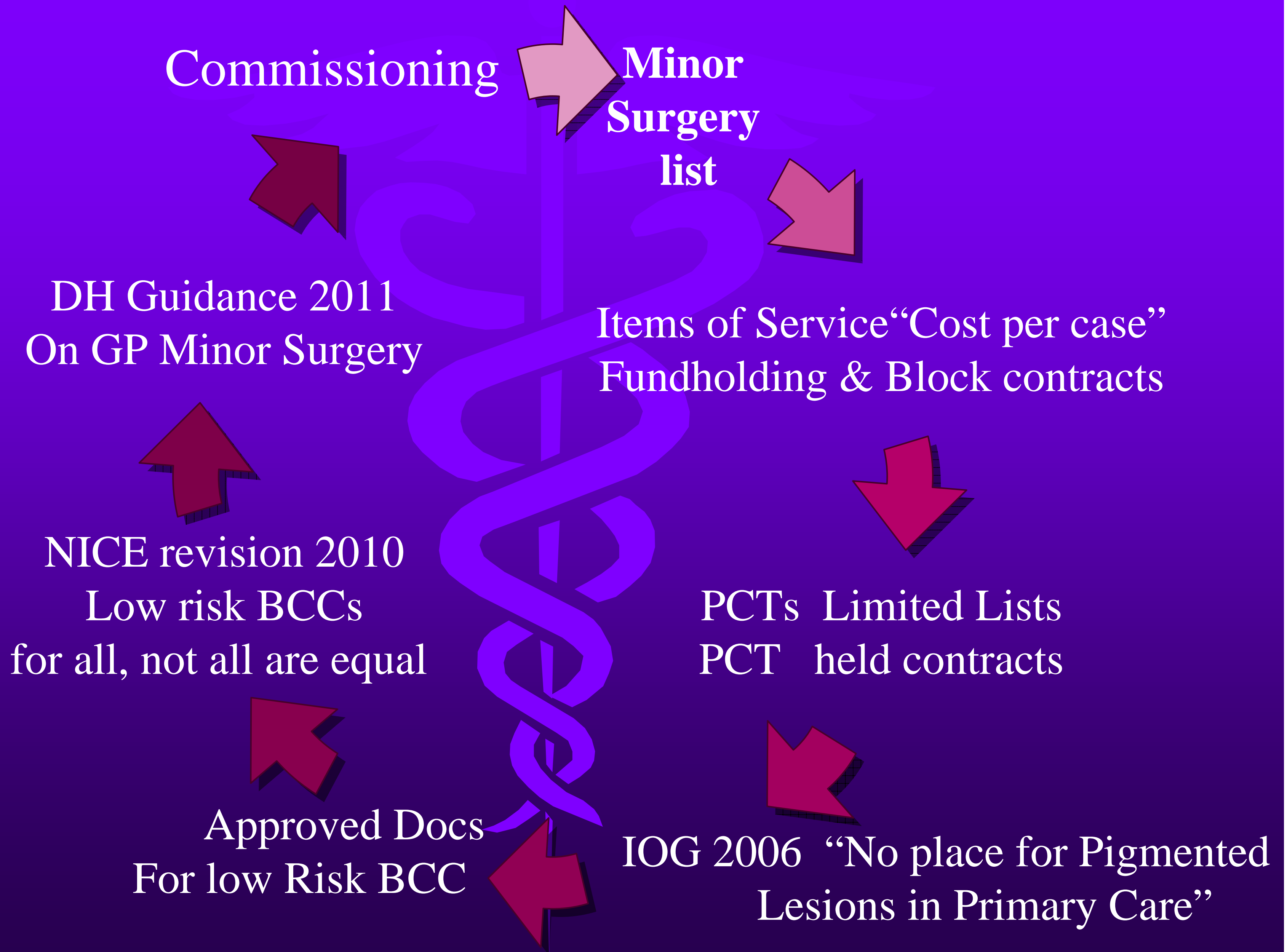
Dr Jonathan Botting
RCGP Clinical Champion for Minor Surgery
Author PG Diploma in Minor Surgery

Circle of Life, as we know it



- How we got here
- Where here is
- Where are we going
- How do we get there

The Minor Surgery Cycle



The Cycle

NHS

National Institute for Health and Clinical Excellence

Guidance on Cancer Services

Improving Outcomes for People with Skin Tumours including Melanoma

The Manual

Recommendations and text relating to the management of low-risk basal cell carcinomas in the community (in the 'Key recommendations', 'Organisation of skin cancer services', 'Initial investigation, diagnosis, staging and management' and 'Glossary of terms' sections of this document) have been removed and replaced by:

Improving outcomes for people with skin tumours including melanoma (update): the management of low-risk basal cell carcinomas in the community. NICE guidance on cancer services (2010). Available from www.nice.org.uk/CSGSTIM

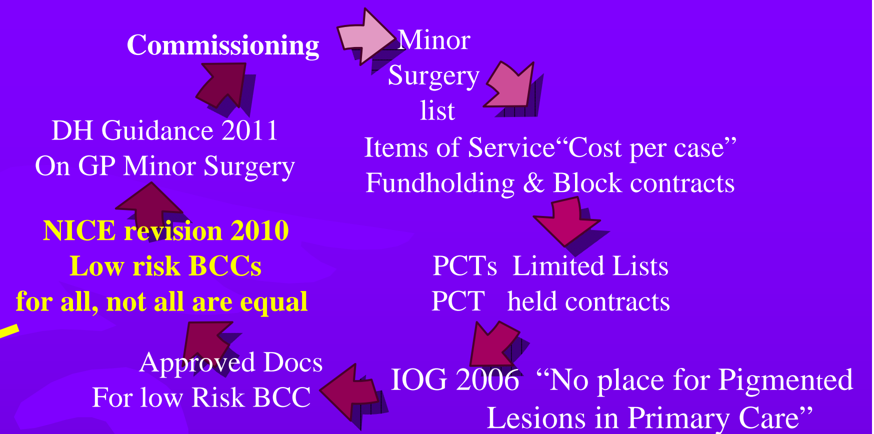
The updated guidance contains details of the methods and evidence used to develop the updated recommendations and text.

February 2006

Developed by the National Collaborating Centre for Cancer

- Written by 2ndary Care
- For 2ndary Care
- 2 week wait Cancer rules
- GPs Diagnose
- "Experts" treat
- GPwSI limited role
- BCCs not 2 ww

The Response

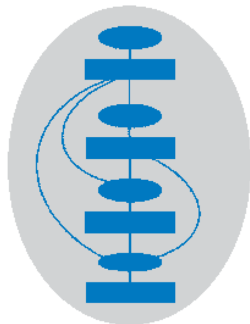


NHS
National Institute for
Health and Clinical Excellence

Guidance on cancer services

Improving outcomes for people with skin tumours including melanoma (update)

The management of low-risk basal cell carcinomas in the community

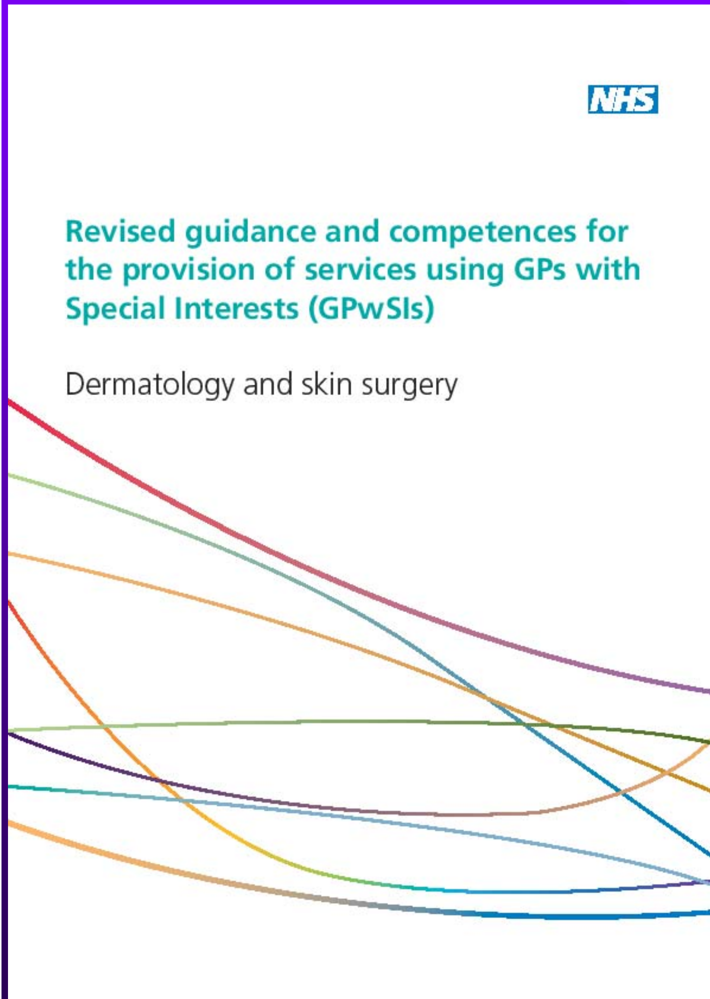


May 2010

Developed by the National Collaborating Centre for Cancer

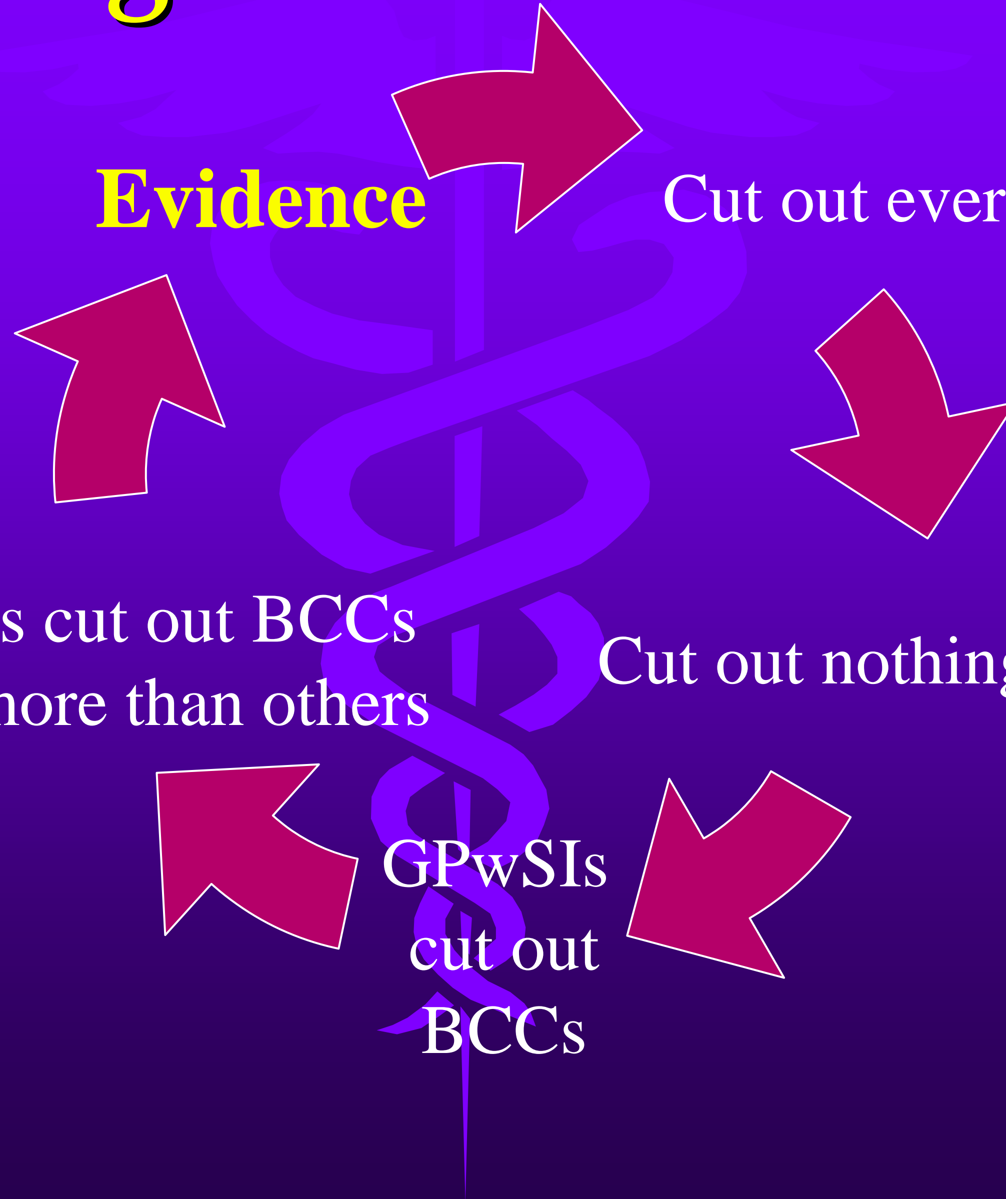
- BCCs back in
- Low risk relates to training
- But reduced commissioning:
  - Adverse evidence,
  - adverse publicity,
  - adverse finances

The Latest



- Guidance for all GPs
- Evidence of Quality:
  - From activity (audit)
  - From observation (DOPs)
- Advice to commissioners

Next Stage



Evidence

Primary excision of cutaneous melanoma:

does the location of excision matter?

Peter Murchie, Erika Sinclair and Amanda J Lee

ABSTRACT

Melanoma is diagnosed more quickly if primarily excised in primary care, but current guidelines discourage this. The reports of all melanomas excised in north-east Scotland between 1991 and 2007 were analysed for adequacy of excision. Reports were analysed blinded as to source. Of primary biopsies performed in primary care, 72.5% were reported as completely excised, compared with 69.7% of those performed in secondary care ($P<0.612$). The difference remained non-significant following adjustment for important confounders.

Keywords

cancer; melanoma; primary health care; skin neoplasms; surgical procedures, minor.

INTRODUCTION

The incidence of melanoma in the UK has quadrupled since 1970.[1] By 2025 an estimated 15 500 cases of melanoma will be diagnosed annually.[1] Melanoma is curable if diagnosed and excised early.[1] Existing guidelines discourage primary care excision of suspected melanoma,[2] but evidence is contradictory.[3–7] Furthermore, two studies demonstrate that melanoma is diagnosed more quickly following primary care excision.[7,8] Consequently, definitively elucidating the relative quality of primary versus secondary care excision is very important, since current melanoma guidelines may not support the optimal diagnostic pathway. This is explored in this report, in melanomas diagnosed in north-east Scotland between 1991 and 2007.

METHOD

Setting, subjects, and data collection

All melanoma pathology reports, issued from Aberdeen Royal Infirmary between January 1991 and July 2007, were scrutinised by a single observer, blinded to the location of excision and clinician submitting the specimen. They were assessed for: type of biopsy, quality of clinical information provided, accuracy of diagnosis, anatomical site of biopsy, prognostic features, and completeness of excision.

Statistical analysis

Analyses were conducted using SPSS (version 17.0.0). Only primary excisions of melanoma were included. For patients with more than one primary excision, only the first was included. For differences between groups, categorical data were analysed using the χ^2 test, patient age with the independent *t*-test, and Breslow thickness with the Mann–Whitney *U* test. Multivariate analysis of the primary outcome measure (completeness of excision) was conducted using binary logistic regression to explore the independent effect of five potential confounders (patient age and sex, lesion site, specialty of operator, and abstract diagnosis).

P Murchie, BSc (Med Sci), MBChB, MSc, PhD, senior lecturer in primary care; AJ Lee, BSc, MSc, PhD, professor of medical statistics, Centre of Academic Primary Care, University of Aberdeen, Aberdeen. E Sinclair, MBChB, career start general practitioner NHS Grampian, Aberdeen.

Address for correspondence

Peter Murchie, Centre of Academic Primary Care, University of Aberdeen, Foresterhill Health Centre, Westburn Road, Aberdeen, AB25 2AY. E-mail: p.murchie@abdn.ac.uk

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- Murchie: Prof of GP, Scotland, BJGP Feb 2011
  - 1263 patients
  - 262 in Primary Care
  - 1001 Hospital Care
  - GPs 72.5% complete
  - Hosp 69.7% complete

Lies, damn lies & statistics

- GP studies:
  - GPs as good as, if not better
- Hospital Sudies:
  - Hospital care better
- Chicago, Systematic review:
  - 32 Studies
  - No difference

Don't Judge a book by its cover

MacWilliam 1991	Hosp 77 pts	Hosp>GP (90 vs 20%)
Herd 1992	Hosp 126 pts	Hosp >GP (96% vs 76%)
Khoshid 1997	Path 819 pts	Hosp>GP (75% vs 64%) too many variables
McKenna 2004	Derm 1536	Derm>GP>Plastics>Gen Surgeon 5 yr survival
Murchie 2007	GP 142 pts	No Difference (GPs 71.9% Hosp 75%)
Primrose 2008	Surgeon 36 pts	Hosp>GPs (75% vs 44%)
Neal 2008	GP 578 pts	No Difference (Derm 54.7% GP 50% Surgeon 49%)
Norfolk 2011	Derm 498 pts	Plastics>Derm>GPs (93% vs 89% vs 37%)
Murchie 2011	GP 1263 pts	No Difference (GPs 72.5% Hosp 69.7%)

Evidence

HQIP

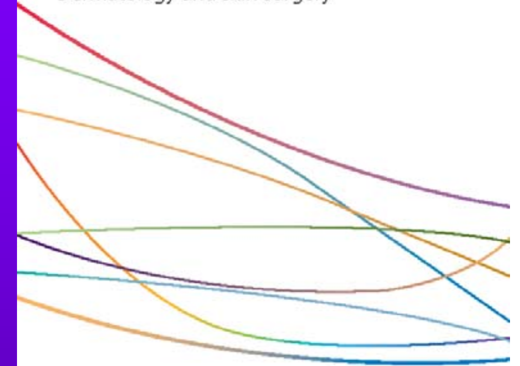
Healthcare Quality Improvement Partnership

- RCGP Multi-site audit bid - failed
- UK GP Data gathering
- Standardised data
- Patient perspective: PROMs & PREMs
- Complies with DH guidance

DH Guidance

Annual audit data inc:

- Clinical vs. histological diagnosis
- Patient experience and cosmetic outcomes
  - (for example, using before & after photos)
- Complication rates inc:
  - infection, dehiscence and incomplete excision rates
- Competency assessment tools
  - (eg DOPS) for newly acquired skills.



DIRECTIONS

THE NATIONAL HEALTH SERVICE ACT 2006

The Primary Medical Services (Directed Enhanced Services) (England) Directions 2010

The Secretary of State gives the following directions in exercise of the powers conferred by sections 8, 272(7) and (8) and 273(1) of the National Health Service Act 2006(a).

Citation, commencement and application

1.—(1) These Directions may be cited as the Primary Medical Services (Directed Enhanced Services) (England) Directions 2010 and shall come into force on 1st April 2010.

(2) These Directions are given to Primary Care Trusts in England.

Interpretation

2. In these Directions—

"the Act" means the National Health Service Act 2006;

"child" has the same meaning as in the National Health Service (General Medical Services Contracts) Regulations 2004(b);

"clinical session" means a fixed period of time made available for clinical consultations with patients and where, unless the context otherwise requires, the health care professional who is available for such clinical consultations is a general practitioner;

"core hours" has the same meaning as in the National Health Service (General Medical Services Contracts) Regulations 2004;

"CRP" means the Contractor Registered Population as defined in the Statement of Financial Entitlements;

"financial year" means the twelve months ending with 31st March;

"general practitioner" means a medical practitioner whose name is included in a medical performers list prepared by a Primary Care Trust under regulation 3 of the National Health Service (Performers Lists) Regulations 2004(c);

"GMS contractor" means a person with whom a Primary Care Trust is entering or has entered into a general medical services contract;

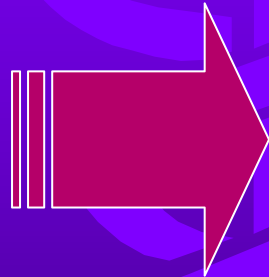
"health care professional" means a person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002(d);

"out of hours services" has the same meaning as in the National Health Service (General Medical Services Contracts) Regulations 2004;

(a) 2006 c.41.
(b) S.I. 2004/291. There are no relevant amendments in respect of the definitions in direction 2.
(c) S.I. 2004/585. The relevant amending instruments are S.I. 2004/2694, 2005/502, 893 and 3491, 2006/635, 1385 and 1914 and 2008/1187.
(d) 2002 c.17 as amended by section 127 of, and paragraph 17 of Schedule 10 to, the Health and Social Care Act 2008 (c.14).

DH Guidance

- **Annual audit data inc:**
  - Clinical vs. histological diagnosis



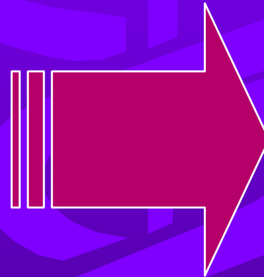
- Clinical?
  - On request form?
  - In the notes?
  - Multiple Δ?
- Histological?
  - Keratoacanthoma
  - SCC

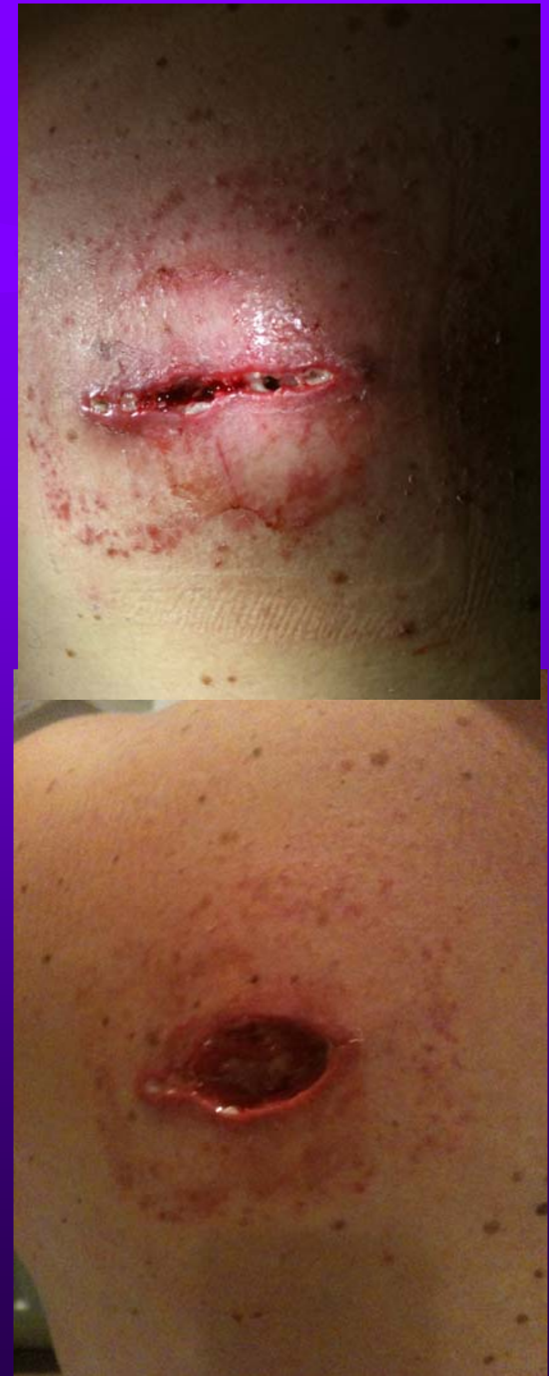
DH Guidance

- Patient experience and cosmetic outcomes
  - (e.g, before & after photos)

DH Guidance

- Complication rates inc:
  - infection
  - dehiscence
  - incomplete excision rates





DH Guidance

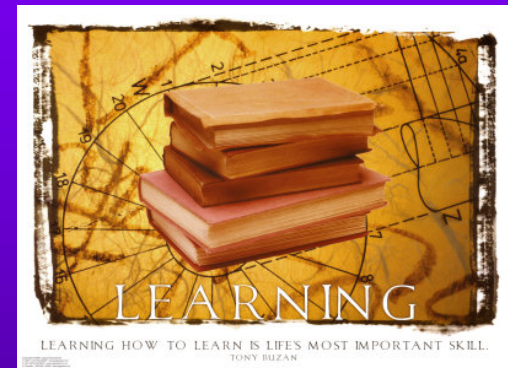
- New skin surgery practitioner competency demonstrated:
  - suitably qualified external body
  - DOPs
- Existing practitioner demonstrated competency
  - suitably qualified external body
  - within the preceding three years?
  - DOPS
- Regular, sustained level of activity (100/annum)
- Follow a program of revalidation?

DH Guidance

- Send all skin specimens to histology
- Site of excision and provisional diagnosis stated
- Maintain 'fail-safe' log of all procedures
- Ensure patients informed of the diagnosis and:
  - any further treatment or follow-up required?
  - undertaken in a timely fashion?

Complete the cycle

- Audit what we do
- Prove quality
- Embrace life-long learning
- Patient expectations
- Value for money
- Mentorship
- Get commissioned….



Any Questions?

Jonathan@Botting.net