CBSA Newsletter. December 2013

Dear fellow community surgeons. Welcome to the second CBSA newsletter. I will repeat my first newsletter comment: For those who have been actively using the system thank you. To those who have not yet started data entry do please start. This system is for you, not me, or the RCGP, or the Dept of Health! With this in mind I have copied an email we received from Dr Craig Wakeham who has been using the system from the beginning, please do read his comments:

“The first thing I have to say is that I feel that it is vital that we have a way of recording the activity we undertake on a regular basis for the benefit of our patients. Unfortunately it is all too easy to remain isolated an in blissful ignorance of how our work really stands up to the dimensions by which modern health care needs to be measured. These are Effectiveness and Efficiency; Quality and Safety, and Value and Outcomes.

I have personally tried to audit my work over the last few years but with few frames of reference or any substantive body of comparative figures from my peer group, this has been a struggle, made harder by recent assault on community based minor surgery undertaken by GPs occasioned by the NICE improving outcomes guidance. I read this guidance thoroughly (more than once) and was astounded by how little substantive evidence the recommendations were based on. As a result I became even more determined to find ways of recording the activity undertaken in primary care and how it could be assessed on the criteria above. I had been trying to promote a local audit tool with little success and when the opportunity to be involved in the development of the RCGPs I jumped at it.

The initial phase of the development if the audit was quite challenging due to a combination of the early developmental nature of the audit tool and working in an unfamiliar environment. However this initial work must have been effective as the audit tool that was developed has certainly delivered on the aspirations laid down in the ‘clinician information’ document, specifically:

To facilitate ease of use, data entry via a drop down list system has been employed as much as possible. Familiarity with the system and its structure will also increase the speed of data entry. A user guide and FAQs have been provided to support your use of the system.

I would say that this is certainly the case. The more I use the tool, I find it quicker and easier to use. Ideally I would love to see the audit integrated into clinical systems, but unfortunately I concede that the coding available does not support the depth and complexity required. The way the audit has been constructed certainly softens the ‘blow’ of having to record the information on a separate system.

There is one area where I find the form and process of the audit really effective, this is the recording of provisional diagnosis. The way the audit takes you through the process really aids this and makes it easy to order your thoughts.

I continue to explore the functionality of the audit tool as I accumulate activity within the database and look forward to the tool delivering the other aspirations laid out in the project documentation. I have only had to use the supporting documents in a fairly cursory way as the tool is so intuitive. However when I have had to consult them I have found them clear and instructive.”
News

Today I was at the National Cancer Intelligence Centre meeting for the Skin site specific group where I am the RCGP representative. The data that has been coming out shows how the incidence of skin cancer, in particular melanoma is increasing exponentially in the elderly, and particularly in males. Those aged 70yrs and above have seen an increase in incidence of 150% in the last 10 years. Data also shows that the most accurate diagnoses in primary care tend to come from regions with the highest incidence of skin cancer. The confirmation of 2 week wait referrals as melanomas or SCCs is as low as 14% in London but still only reaches about 25% in the south west. That means that between 75% and 86% of all skin cancer 2 week wait referrals are not actually high risk cancers.

This is then tied in with the costs of surgery in secondary care. In 2011 there were 81,822 surgical excisions for skin cancer in UK hospitals (in addition there were curettage, biopsies, grafts and MOHs). The average cost of a UK hospital day-case excision is £727, that’s £59.5m purely for simple excisions in 2011. If that shifted to the community, at the present DES tariff it would save the UK around £52m in purely surgical costs, let alone outpatient costs. We need to prove our surgical skills and that is best done through audit!

Developments:

We have almost agreed the priorities for developing the dashboard for the audit tool. It has been a challenge balancing what we would like versus what we can afford. We also need to be mindful of any change to the actual audit tool that could destabilise the reporting functionality. By the time of the third newsletter it should be in development. We already have over 1000 surgical procedures recorded, a fantastic effort, thank you!

We tried very hard to raise funds from a pharmaceutical company to help develop the system and on this occasion failed, so if any of you have suggestions about possible funding streams please let us know.

Please keep the feedback coming in.

Jonathan