Audit of time management of basal cell carcinomas: Decision to treat to treatment time
OMFS Altnagelvin

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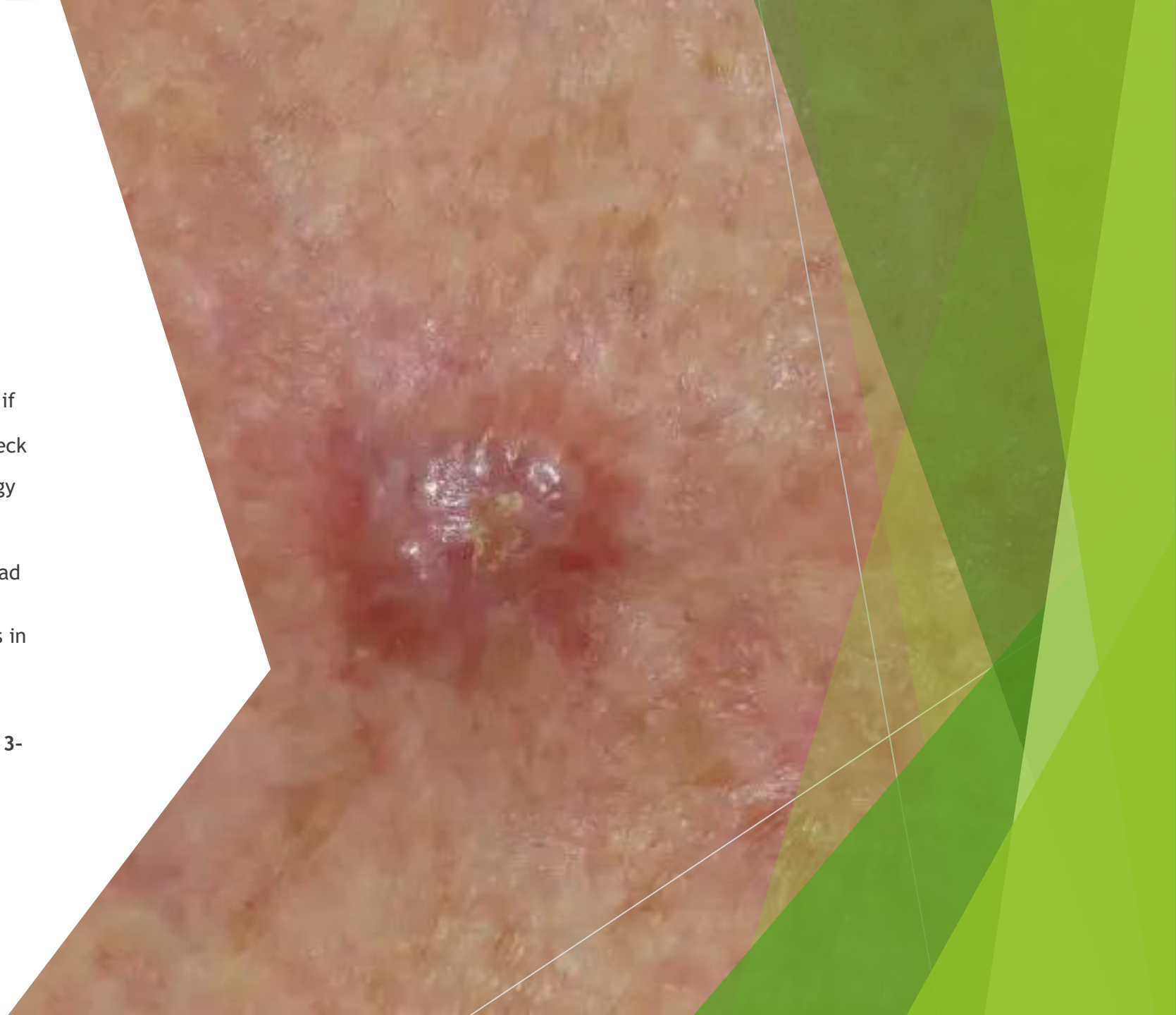
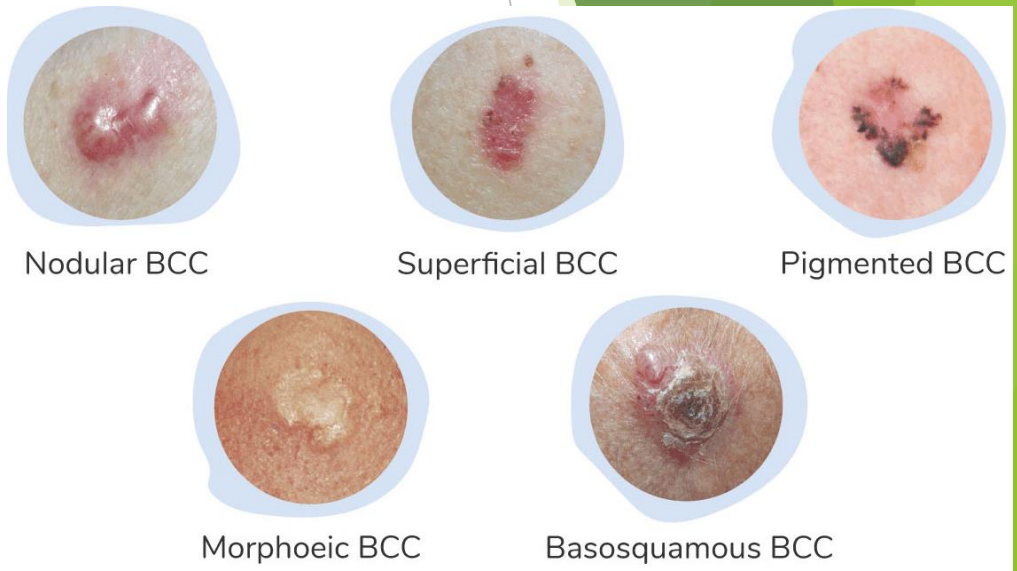
Background

- Most common type (> 80%) of all skin cancer (skin cancer incidence is < 1%) in the UK
- Basal cell carcinomas rarely metastasise however if continuous growth may erode anatomically important features particularly in the head and neck
- The epidemiology and health services epidemiology of BCC, demonstrates that the number of cases is rising significantly
- Management of BCCs imposes a significant workload on both primary- and secondary-care services
- Between cycles guidance changed to include BCCs in current red flag guidelines for removal of cancer
- **Standard surgical excision is an empirical treatment suitable for the majority of primary BCCs, with reported 5-year recurrence rates of 3-8%**



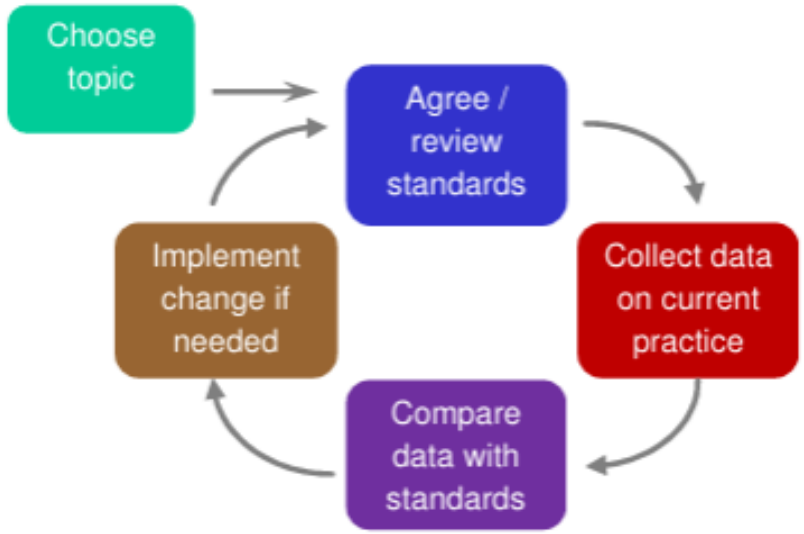
Histological Variant	Clinical Presentation
Nodular	Commonly on the face Cystic, pearly, telangiectasia May be ulcerated
Superficial	Often multiple Usually on upper trunk and shoulders Erythematous well-demarcated scaly plaques, often larger than 20 mm at presentation
Morpheoic	Skin-coloured, waxy, scar-like Prone to recurrence after treatment May infiltrate cutaneous nerves (perineural spread)
Pigmented	Brown, blue or greyish lesion May resemble malignant melanoma
Basosquamous	Mixed basal cell carcinoma (BCC) and squamous cell carcinoma (SCC) Potentially more aggressive than other forms of BCC



Methods

- Data collation of sample ~50 cases of BCC management in OMFS department
  - Waiting Time
  - Consultant UCO
  - Patient record available and accessible
- After Cycle 1 there was an update to BAD Standards to include BCC in the 31 day timeline
- New sample of cases taken in cycle 2, with additional audit criteria taken from these standards to improve patient care
  - % treatment carried out within 31 days from decision to treat
  - Photographic records of lesion taken
  - Patient should receive a Patient Information leaflet prior to commencing treatment
  - Change to surgical plan

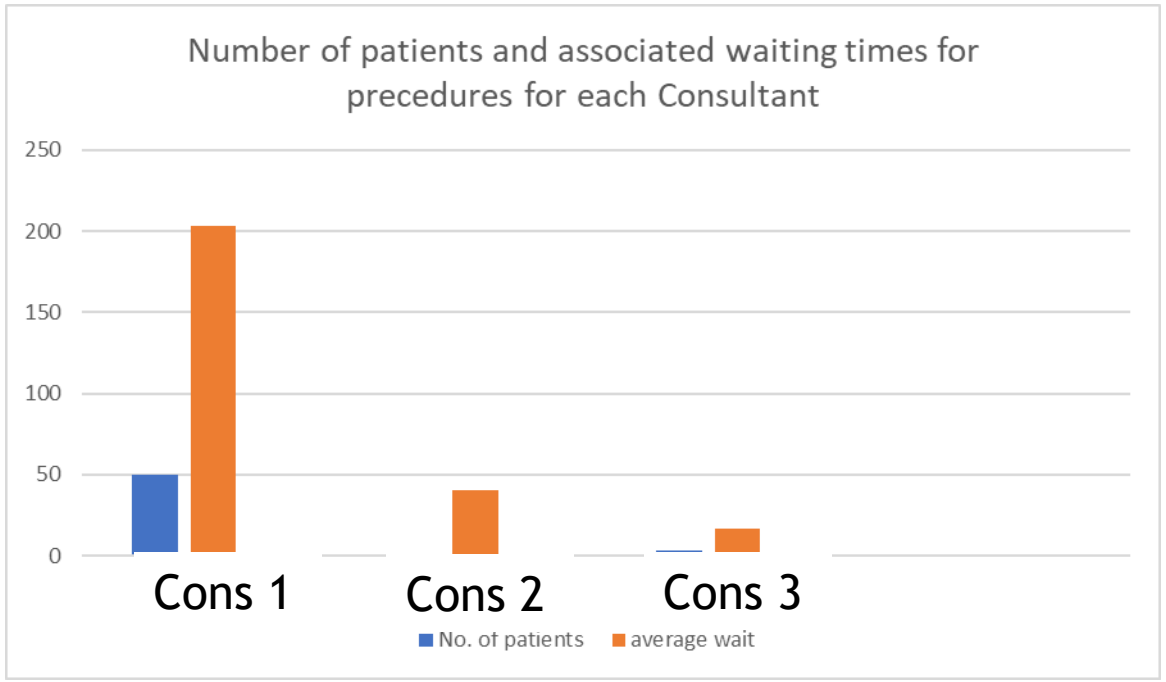
Step 1 – Plan
Aims & Objectives



Aim: Audit waiting times from decision to treat to treatment of BCC

1. To establish the current average waiting time for patients to receive surgical removal of confirmed BCCs
2. Compare data to standards
3. Highlight deficiencies within the service and identify implementable solutions
4. Improve departmental adherence to standards and overall patient experience and care

Cycle 1



	Consultant 1	Consultant 2	Consultant 3
No. of patients	50	1	3
Average waiting time (days)	203	40	17

BAD-SERVICE GUIDANCE AND STANDARDS FOR SKIN CANCER

- The NHS consolidated performance standards for cancer into 3 key standards:
  - 28-Day Faster Diagnosis Standard (FDS)
  - 62-day referral to treatment standard
  - **31-day decision to treat to treatment standard**
- Standard 3A.2 98% In Northern Ireland, at least 98% of patients diagnosed with cancer should begin their first definitive treatment within 31 days of the decision to treat. 98% Green 70-98% Yellow <70% red
- Other Standards Audited
  - Patient records are available (paper or electronic) in 100% of cases (50 cases) YES between ECR and epic
  - Skin cancer services need to ensure that they adopt the use of photography to record both lesion images and site marking for patients requiring skin surgery.

Changes Implemented

Intentional changes

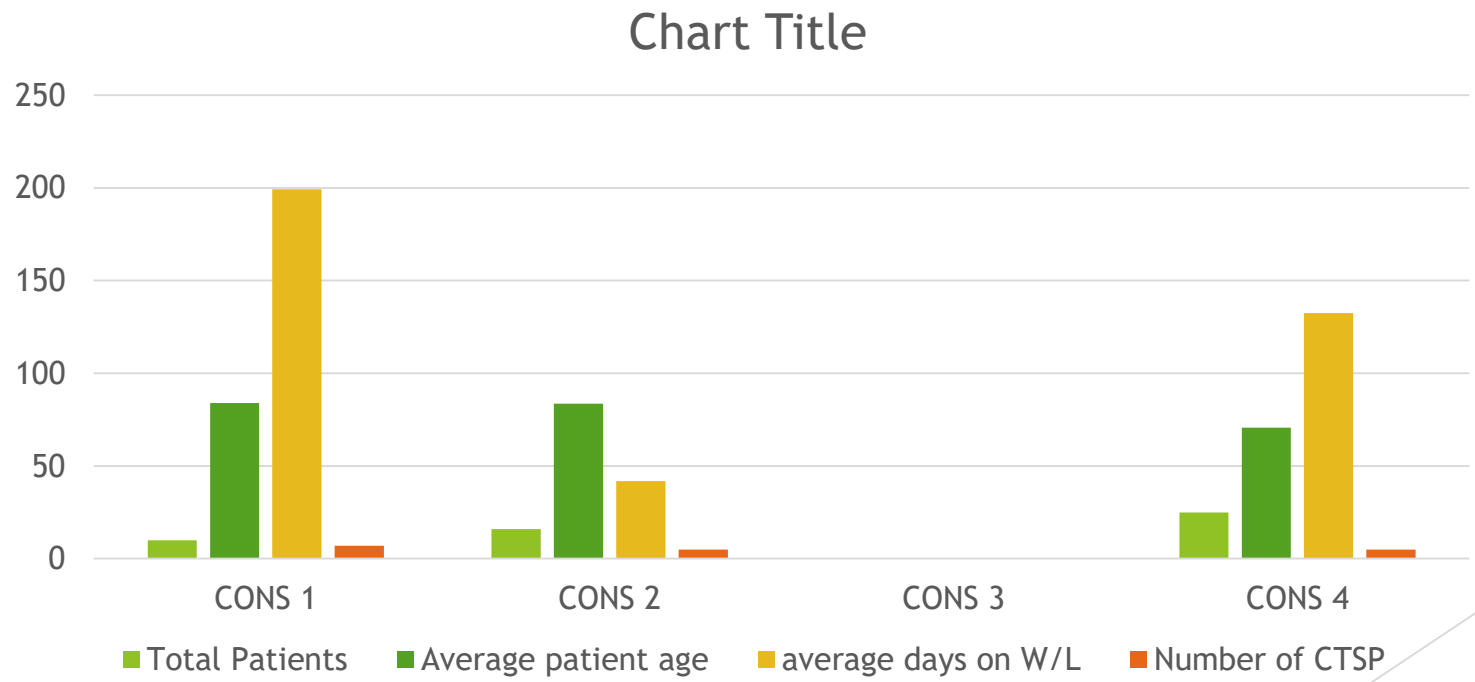
- Hiring of staff grade
- Additional LA clinics
- Additional theatre slots

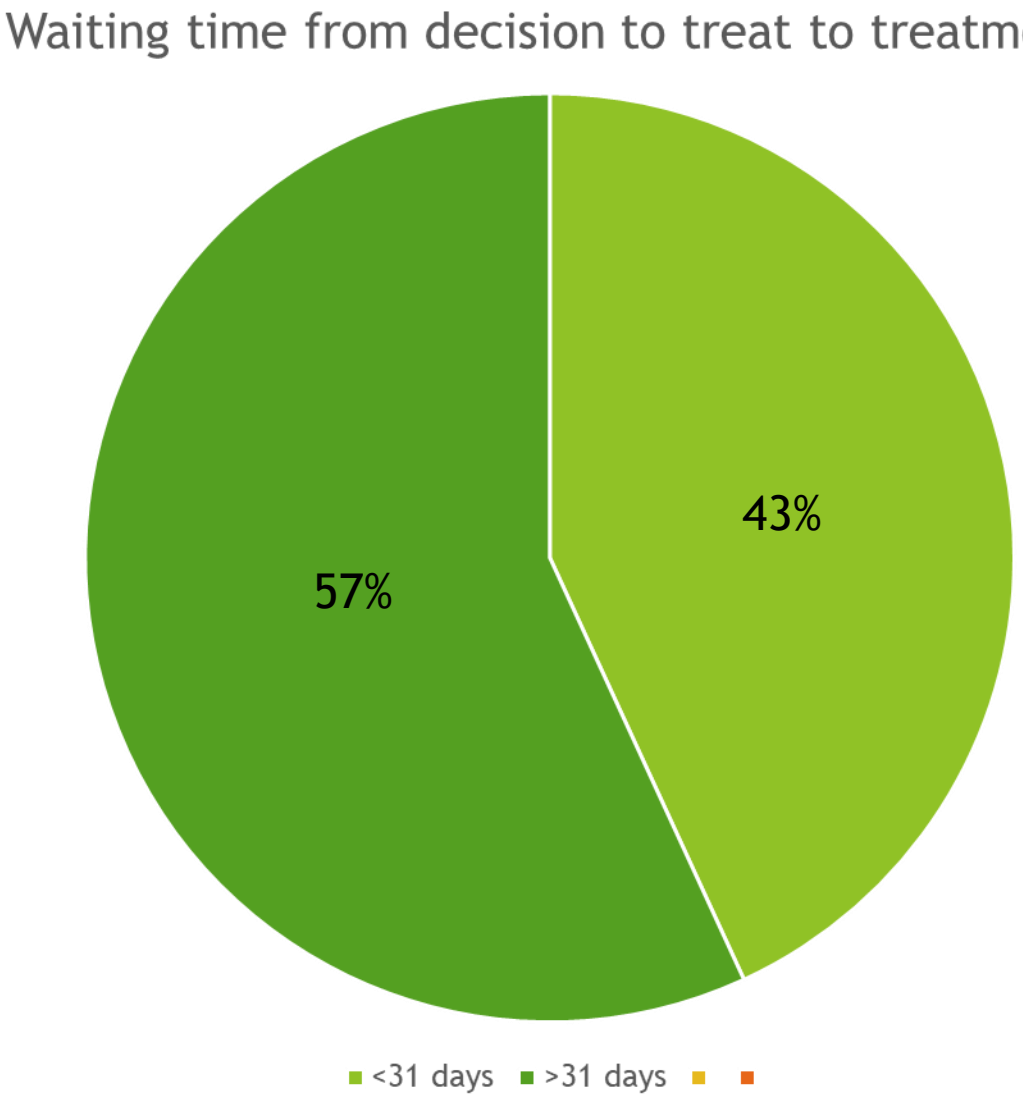
Uncontrolled changes

- Change in consultants
- Unplanned leave
- Introduction of EPIC

Results -Cycle 2 2026

Total Number of Patients In sample	Average Age W/L	Average Time on W/L in Days
51	79.4	124.5





<70% red

Red Flag [Action Required]: failure to meet these standards places undue clinical risk on patients, and/or may result in remedial action

Record Keeping

Consultant	Lesion Photographed (%)	No image of lesion (%)
1	90	10
2	50	50
4	84	16

100% of patient records in both cycle samples were available
Patients not routinely given PIL at diagnosis of BCC

Interpretation

- Consultant 1 responsible for surgical management of skin cancers in the OMFS department – fewer BCCs but longest waiting time as theatre lists occupied by SCCs, sarcomas, melanomas
- Consultant 2 and 3's primary roles are orthognathic and H&N cancer respectively, explaining why number of patients and wait list times were significantly lower.
- Consultant 4 employed by the trust initially as a locum then made permanent after Consultant 3 ceased working in the Western Trust

Comparison of Cycles

- Cycle 1

	Cons 1	Cons 2	Cons 3	Cons 4
No. of patients	50	1	3	/
Average waiting time (days)	203	40	17	/

- Cycle 2

	Cons 1	Cons 2	Cons 3	Cons 4
No. of patients	10	16	/	25
Average waiting time (days)	199	42	/	132

Better distribution of BCC cases amongst the 3 consultant surgeons
Average waiting time increased from 87 days to 124
Includes outliers from locum consultant outstanding W/L, ?artificial inflation of numbers
Periods of long-term staff leave, major staff changes
Potentially due to unavoidable changes waiting times have only increased between cycles
Highlights the importance of consistency of care

Recommendations for the future

- Repeat audit in September 2026

1. Introduction of Staff Grade clinics– possibility of parallel clinics where simple BCCs can be surgically excised under supervision of consultant, potential for doubling capacity
2. Consultant 4 introduction of additional theatre slot on Thursdays/Saturdays
3. Introduction of SOP for staff on clinic for photographic records of lesion and measuring of lesion size at time of decision to treat
4. Patient information leaflet routinely provided even for BCCs

Current waiting times mean that by the time of surgery, the BCC has been seen to increase in size resulting in change to surgical plan

Aiming for BCCs to be treated earlier, resulting in less invasive treatment, less operating time and improved patient care in line with current standards

References

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