It has been said that, for the patient at least, there is no such thing as minor surgery. Certainly, office-based procedures such as cutaneous surgery, performed by the GP, have the potential to result in the same major complications that might arise were the work conducted in a hospital. It is best to put out of our minds any distinction as to the location of the surgical setting, when considering the standards that must apply if general practice is to deliver a surgical service.

Another truism of office-based interventions is that the more you operate, the more likely you are to have a patient with a complication, both because of the increasing complexity of what you might be inclined to undertake and even more because of the volume of cases that you accrue. If individual GPs are to maximally prevent complications for their patients and, should one arise, be able to justify the quality of their work, there must be an active pursuit of certain standards to ensure best practice. Furthermore, if GPs are to compete collectively for appropriate surgical contracts, under Money Following the Patient (MFTP) schemes, to the benefit and convenience of the patient and at a saving to public or private purchasers, they must have robust information on quality.

In relation to skin surgery and other invasive office procedures, such as joint injections or inserting an intrauterine system, the relevant standards will relate broadly to the three areas of training, infrastructure and operative technique.

Training – formal and informal
There is little regulation of required training in Ireland as to who can do what. We tend to rely on our own ethical compass to ensure that we have assembled a sufficient expertise to offer a particular level of service. Local and international training events or programmes of study and self-assembled practical training are a key learning method for the trainee or principal. Often, the GP acquires skills over an extended period of time, starting perhaps with undergraduate exposure and often reinforced by training events such as the minor surgery programme run by the ICGP. Specific techniques, such as those associated with long-acting contraception, have come to have their own skills training.

On the other hand, in the UK, there is now a far more prescriptive approach to the regulation of training for community surgical provision. While this has ensured that formal training modules are more widely available and that competence can be certified by examination or observation of practice, the level of regulation may tend to inhibit perfectly safe surgical enterprise and to increase system costs by erring on the side of specialist referral, even for low risk diseases. In fact, in 2011 the National Institute for Clinical Excellence (NICE) relaxed its guidance on non-melanoma skin cancer as it was found to be overly restrictive.

Standard of infrastructure
As far as practice infrastructure is concerned, in Ireland there is, as yet, no policing of the environment provided by the practitioner for office procedures. However, the legislative basis for this to happen is now in place and the Health Information and Quality Authority (HIQA) has been granted the authority to license community as well as hospital sites for the provision of services.

While we may be some years away from a link between

**Niall Maguire and John Kealy describe a national skin surgery audit tool that aims to embed audit work for minor surgery in general practice**
contracts for surgical services being contingent on holding such a licence, the emerging standards are already a guide to best practice and could have medico-legal or professional registration implications where they are not met and an adverse event occurs.

HIQA’s *National Standards for Safer, Better Healthcare* abound with references that are germane to community-based surgery. While the detail is yet to be worked out, the ambitions articulated under the chapters on effective care, safe care and leadership all touch on provision of adequate premises, systems and the monitoring/audit of these aspects of practice.

Taking their cue from the HIQA document, national bodies are likely to begin to construct specific requirements around these general statements of ambition. For example, the HSE has developed a draft set of Standards and Recommended Practices for Dental Services in a Local Decontamination Unit, which runs to 160 pages. Already, the HSE national lead on decontamination has sought the input of the Primary Care Surgical Association (PCSA) in adapting this draft standard for community surgery.

**Operative technique**

Turning to the standards for operative technique, this is more familiar ground for the individual operator. While national standards for training and plant await further definition and may, in any case, be beyond the capacity of the individual surgeon to influence, the audit of results for a specific patient or set of patients is a good starting point for benchmarking our surgical work.

In the modern literature several themes recur in relation to surgical performance, including:

- The accuracy of the clinical diagnosis of a skin lesion
- The decision to excise or not and how to excise, that flows from the clinical assessment
- The adequacy of an excision of malignancy
- The frequency of operative complications such as wound infection and disease recurrence.

In general, the research describes a higher degree of clinical accuracy among dermatologists and plastic surgeons and a consequently lower rate of diagnostic excisions of benign lesions. Furthermore the skin specialist (dermatologist or plastic surgeon) tends to have a better rate of clearance of malignancies with the primary excision.

On the other hand, infection and other complications are no more frequent in the GP surgery and some papers find that the GP operator is as good as the skin specialist operator and/or better than the general surgeon. Unfortunately, many of these retrospective reviews of histology specimens, and even the only randomised controlled trial of GP versus hospital skin surgery, suffer from selection biases and often do not compare like with like.

It is probably safe to say that dermatologists will be better at diagnosis and plastic surgeons at excision. However, where the performance of GP surgeons is reported as less good than that of hospital specialists, it is not the case that their performance was poor in absolute terms. George et al’s trial in 2008, despite a negative verdict in comparing GP with hospital minor surgery services, concluded that the message must be to strengthen community surgery, not to ban it. There is evidence that audit and feedback are effective at improving practice, particularly where participants have opted in to a quality assurance process.

**Opportunity for clinical audit**

Here then, is a prime opportunity for clinical audit. What better way to improve performance than to actively review the concordance between the pre-operative clinical assessment and the reported histology? Will it not be equally useful for GPs to review their excision margins for benign and malignant lesions? GPs and other operators will naturally be interested in such questions, especially in response to an unexpected result or a critical incident. Ideally, though, we would seek to go beyond this ad hoc approach to audit.

For surgical audit to truly influence practice, it should be a continuous process. To this end, the PCSA has set about providing a national skin surgery audit tool that will embed audit in the work of the minor surgery clinic in general practice, ensuring the learning opportunity when results are less than perfect as well as enhancing the overall governance of the service.

Elsewhere, surgical audit remains at the level of the one-off or periodic review of practice conducted at intervals, for example for revalidation or maintenance of an enhanced services contract in the UK. The RCGP and the Association of Primary Care Surgeons in the UK are also developing a national audit tool for GPs, while the RACGP has an elegant online database allowing GPs to log details of skin cancers and audit their performance and compare with peers (the Skin Cancer Audit and Research Database). Invariably, however, participation in these audits requires the practice to re-enter case data in an electronic or paper-based audit template.

*Table 1* lists the audit questions that it is proposed to address in this project. It can be seen that these indicators touch on many of the aspects of a quality assured service as envisaged by HIQA.

<table>
<thead>
<tr>
<th>Table 1: Criteria for surgical audit</th>
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<tr>
<td>• What was the range and average of the times between referral to operate and procedure being carried out?</td>
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<td>• What was the proportion of cases where a sample was sent for histological examination?</td>
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<tr>
<td>• What was the proportion of cases where the likely pre-histology diagnosis matched the histologically confirmed diagnosis?</td>
</tr>
<tr>
<td>• What was the proportion of cases where the likely (pre-histology) or differential (pre-histology) diagnosis matched the histologically confirmed diagnosis?</td>
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<tr>
<td>• Of these, what was the proportion of cases where an unsuspected malignancy was submitted?</td>
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<tr>
<td>• In what proportion of cases were benign lesions excised as malignancies?</td>
</tr>
<tr>
<td>• In what proportion of malignant excisions was the excision margin not clear?</td>
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<tr>
<td>• What was the range of size of non-melanoma skin cancer excised?</td>
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<tr>
<td>• What type and frequency of complications were reported?</td>
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</table>
Developing an appropriate audit tool

In considering an appropriate audit tool for members of the PCSA, we were concerned to gather the necessary data for quality assurance without interfering with the day-to-day activities of the GP, using a method that would involve minimal learning/acclimatisation, be intuitive and, if at all possible, avoid the need for double entry of data into both the audit tool and clinical records.

The options considered included a paper-based system, a web-based data entry site, a desktop application and the integration of a data entry system with the mainstream GP practice management packages. It quickly became apparent that a one-size-fits-all solution was not going to be practicable so we initially focused on a solution that would satisfy as many of the project’s goals as possible while still reaching as many GPs as possible.

To this end, it was decided to produce an integrated data entry module or ‘mediform’ for use with the Health One GP practice management package on the basis that this was a popular option used by GPs and the facilities were available within the package to create customisable forms. The mediform acts as a front-end to prompt the user to enter the desired data in an intuitive way (see Figure 1). The data fields include all those required for making a thorough case note and include those elements which are required for the audit. No duplicate entry for recording the clinical note or providing the audit data will be required.

The data collected is stored in the patient’s file as a routine healthcare transaction record. The analysis function within Health One is harnessed to extract the data needed for audit purposes in an orderly fashion and then export it as a spreadsheet file. As with other chart analyses, only anonymous data is extracted, for collation with data from other centres.

The ultimate ambition is to produce an electronic report on a regular basis whereby contributors can see how their practice rates in accordance with contributing peers in terms of workload and each of the audit variables listed in Table 1.

Using a format whereby the necessary audit data is extracted from the relevant patient healthcare record, we have been able to achieve most of our key goals. The custom interface (mediform) guides the user logically through the pre-operative assessment, procedure and follow-up phases, and therefore generally applies some structure to the process. An additional benefit, for privately insured patients, is the facility to generate an invoice for private health insurance claims from the same healthcare record.

As expected, lessons learned up to and including the field testing of the current system has meant that the next step in the process – producing audit tools for users of other clinical records software programs – will be based on a much firmer footing. With all subsequent tools, the only limiting factor will be that the output should, for reporting consistency, contain the same core data. Once that condition is satisfied, there should be no restrictions on how it is gathered, whether by the equivalent of a mediform as in Health One or another software device.

Quality assurance

In conclusion, collective surgical audit by GPs in Ireland, as elsewhere, is coming of age. By this means we shall be able not only to reflect on our own performance but to provide the quality assurance that the public and our paymasters will increasingly need from us, especially if contracts for service are to be attracted to general practice under MFTP.

The PCSA has several strands of activity that will contribute to our achieving this aim. The surgical audit tool described briefly here is one element of it, and is supported by ongoing work on developing rational guidelines around training and operating for Irish general practice and discussion with service commissioners.

The PCSA second annual scientific meeting will take place on April 19 and 20 in Galway. Registration by email to Dr Colum Gavin, membership secretary, Email: info@acsraee.com (for further details, see page 45).