Community Based Surgery Audit – A one-year national pilot of the diagnostic and surgical skills of GPs

Final report

RCGP Clinical Innovation and Research Centre (CIRC) – September 2015
The Royal College of General Practitioners was founded in 1952 with this object:

‘To encourage, foster and maintain the highest possible standards in general practice and for that purpose to take or join with others in taking steps consistent with the charitable nature of that object which may assist towards the same.’

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FOREWORD

How do we encourage the development of safe and effective surgical services within the community? By encouraging GPs to audit their surgical outcomes and by comparison with their peers.

It is almost a misnomer to refer to practice-based surgery as ‘minor’ because the implications of this kind of work are often so significant.

When College members and the Clinical Innovation and Research Centre (CIRC) identified minor surgery as a clinical priority in 2009, they did so in response to NICE guidance that effectively removed the management of all skin cancers from primary care. That guidance would have benefited from more GP representation and was based on secondary care studies that were highly critical of GP surgical skills. Although subsequently revised in 2010 to allow some skin cancer work to be undertaken by GPs, the damage had been done. Many GPs ceased providing minor surgery.

After the appointment of Dr Jonathan Botting as the RCGP Clinical Champion to lead on minor surgery, funding was secured to allow the development of a unique UK-wide audit database by the Health and Social Care Information Centre. A clinicians’ working group was set up to oversee the work and on behalf of CIRC, we thank the members of the group for their helpful input and advice and Jonathan’s leadership in driving the work forward.

The aim of setting up the database was to encourage GPs to audit their surgical outcomes particularly in comparison with their peers, with a view to the development of safe and effective surgical services within the community.

One year after opening the CBSA tool to all GP surgeons, the audit has shown that the system is fit for purpose. Furthermore it has demonstrated impressive levels of diagnostic and surgical accuracy by those GPs using the CBSA combined with very low levels of complications. Additionally and uniquely, it has demonstrated significant improvements in outcomes for specialist trained GPs undertaking skin cancer surgery compared to other GPs.

The results of this audit provide evidence that GPs do have an important role in the diagnosis and removal of skin lesions.

Collaboration between primary and secondary care is important and evidence that highlights safe care can be used to help reduce pressure on secondary care and specialist units.

Patients trust their GP and many feel comfortable having this type of treatment at their local practice, rather than going to hospital. Establishing the results of procedures that are taking place in the community which confirm safe and effective care can only help to strengthen the ethos of care closer to home.

Dr Imran Rafi
Chair of CIRC, RCGP

Dr Maureen Baker
Chair of Council, RCGP
INTRODUCTION

Published evidence regarding community-based minor surgery is conflicting.\(^{12345}\) Commissioners have very disparate investment in both cancer and non-cancer community-based surgery resulting in patients being directed to secondary care. This in turn results in patients being denied care close to home and in increased hospital costs to the NHS.

In 2011 there were 81,822 surgical excisions for skin cancer in UK hospitals (in addition, there were curettage, skin biopsies, grafts and other advanced surgeries). The average cost of a UK hospital day-case excision is £727\(^{6}\); that’s £59.5m purely for simple excisions in 2011. If that activity shifted to the community, at the present DES tariff, it would save the UK around £52m purely in surgical costs, let alone outpatient costs, but only if we can demonstrate we have the knowledge and skills required.

GPs have been portrayed as poor diagnosticians, poor surgeons and reckless with pathology specimens\(^{7}\). These conclusions are at variance with many GPs’ own audit results and models of successful primary care skin cancer work existing in other countries with comparable socio-economic structures.

The only way to counter this bias is through published, national evidence. The Community-Based Surgery Audit’s (CBSA) web-based on-line audit platform was designed to produce this evidence. The ground-breaking audit aimed to establish for the first time the quality and quantity of community-based surgery, including the removal of skin cancers, pre-cancerous skin lesions, benign skin cysts, lipomas, and excision of ‘small lumps and bumps’. Additionally, the tool provides feedback on submitted data to be used for re-accreditation, appraisal, revalidation and local contracting for the individual contributor.

The tool was developed in collaboration with the Health and Social Care Information Centre (HSCIC) in Leeds. Its objective is to provide GPs operating in the community with a system that allows them to collect and report their surgical data – not only their surgical activity but also their diagnostic accuracy (compared to histology), their surgical skill (looking at completeness of excision) and their complication rates. Most uniquely, the CBSA tool allows clinicians to compare these statistics to their peers’ data once they’ve logged three months of data. This unique reporting system is similar in principle to that found throughout secondary care to allow units to benchmark their quality and its existence is well overdue in primary care.

Nationally it provides the evidence about exactly what standard of surgery GPs can provide to their patients. That information in turn will provide commissioners with the confidence to invest in quality community surgical services. It will allow community surgeons to demonstrate the necessary credentials for revalidation and finally it may allow them as a specialty to develop, with evidence, a greater part in the management of skin cancer services. This unique reporting tool has provided the first ever ‘snapshot’ of community surgery responses in general practice across the UK.

The design of the audit included GPs both with and without specialist interests, dermatologists, dermatological surgeons, statisticians and systems designers. Within the steering group we had representation from the British Association of Dermatologists, the

British Society of Dermatological Surgery, the British Medical Association, the Primary Care Dermatology Society and the Association of Surgeons in Primary Care.

The pilot began in 2013 with a limited release phase during which a number of practitioners who had expressed an interest in early involvement, the Clinicians Working Group, used and tested the system. The only extra work involved for contributors was the data entry and this process was made as easy, quick and as user-friendly as possible with data security maintained to the highest level. The system was updated based on their experience and feedback and the audit then progressed to a national pilot. The data collection for the report ran from 18/4/13 until 31/3/15. The numbers of GP users of the CBSA, the number of patient records and the number of surgical records over time is shown in Table 1.

Table 1: number of registered users and activity within the CBSA system

<table>
<thead>
<tr>
<th>Activity</th>
<th>Current users</th>
<th>Number of Patient records</th>
<th>Number of surgery records</th>
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The audit refers to the following objectives in the RCGP strategic plan:

Priority Goal 1: Delivered excellent patient care by supporting GPs and members of the primary health care team through the provision of high quality services and valued member benefits. It has achieved this by establishing an audit process that will help to drive national standards of care in general practice minor surgery.

Priority Goal 2: Continue to develop our role as a leading global organisation for general practice / family medicine through international partnerships and by influencing health policy towards our goals. The development of the audit has illustrated the leading role the RCGP is taking in supporting best practice in minor surgery.

Priority Goal 3: Provide leadership at all levels in healthcare by supporting the professional development of General Practitioners to maintain standards of excellence and promote patient safety and quality in general practice. The audit has achieved this by creating a process that supports best practice in general practice minor surgery, encourages engagement with patients regarding this issue and provides information for commissioning in regards to primary care based minor surgery.
RESULTS

This audit was based on self-reported data of minor surgery cases and outcomes from volunteer GPs. We classified GPs as working in one of three settings:

1. **Enhanced Services General Practitioners (ESGPs):** GPs carrying out minor surgery in their own practices under a contracting system called “Enhanced Services”. These GPs will operate on benign lesions and if suitably trained, on low risk BCC situated below the neck. There is a national contract for “Directly Enhanced Services” (DES) and sometimes, additionally “Locally Enhanced Services” (LES).

2. **GPs with a special interest (GPwSIs):** GPs who have undertaken specialist training in the diagnosis and management of skin cancer. They will be accredited to undertake treatment of low risk BCCs above and below the neck. They will work regularly with a core member of their local Site Specific Multi-Disciplinary Team (SSMDT), attend MDT meetings and undertake regular audit and professional development.

3. **GPs working under acute trust governance (Model 2):** GPs with specialist training who can operate on all skin cancers (within their skill range) on cases pre-discussed with a core member of the local Skin MDT. Their contracting arrangements mean they operate under acute trust governance.

The individual practitioner data was processed by the HSCIC, and aggregated tables were provided to the University of Surrey, where this analysis took place. Data from the HSCIC was reported for each of the three types of practitioners listed above, or unclassified where the type of practitioner was not listed.

Where relevant, percentages were calculated and graphed. Confidence intervals of 95% were calculated for each estimated percentage, this was done using the CRITBINOM function on Microsoft Excel; they are represented graphically using error bars. A chi-square test, using the R statistical software, was used to determine the statistical significance of any differences across the counts; the p-values of this test are reported.

**Data analysis**

The total number of procedures conducted was 6,138, out of which 2,289 (37%, CI 36.1-38.5) were by ESGPs, 2,331 (38%, CI 36.8-39.2) were by GPwSIs, and 1,045 (17%, CI 16.1-18.0) were by Model 2 practitioners. 473 (8%, CI 7.0-8.4) were unclassified.

Almost half of procedures were excision biopsies (3,009, 49% CI 47.8-50.3). Out of the procedures conducted by ESGPs, 46% (CI 44.2-48.3) were excision biopsies, compared with 57% (CI 54.8-58.8) for GPwSIs, and 59% (CI 56.1-62.0) for Model 2 practitioners.

The next most common procedures were shave excisions (19%, CI 18.4-20.3), and curettage or scoop biopsies (13%, CI 12.6-14.3). Procedures like partial nail avulsions were not undertaken by Model 2 practitioners at all, and skin grafts following excision were only performed by this group.

There were 471 procedures (8%, CI 7.0-8.3) with missing data regarding type.

The location of lesions operated on has been divided by head/face and rest of body (Figure 1) and 41% (CI 39.5-41.9) of all procedures were on head/face. Model 2 practitioners were more likely than GPwSIs and ESGPs to operate on head/face. This is a statistically significant difference (p <0.001).
The method of closure is divided in our analyses into suture and non-suture. 57% (CI 56.2-58.4) of all closures were sutures (Figure 2). Model 2 practitioners and GPwSIs were more likely than ESGPs to use sutures, and this is statistically significant (p <0.001).

ESPGs performed 63% (CI 58.9-67.5) of all adhesive strips closures. Almost half of all procedures with no closure or healing by secondary intention (including destructive procedures such as cautery) were performed by ESGPs (977, 47% CI 44.9-49.2).

![Figure 1: Location of lesions operated on (head/face and rest of body), by type of practitioner](image1)

![Figure 2: Closure method (suture and non-suture), by type of practitioner](image2)

Nearly all the samples from a procedure expected to be sent to histology were sent, though the percentage is slightly lower for Model 2 practitioners (92% CI 90.2-93.5), compared to ESGPs (97% CI 96.8-98.1) and GPwSIs (96% CI 95.7-97.2), and this is a statistically significant difference (p <0.001) – Figure 3.

Out of all procedures with a histological diagnosis, 17% (CI 15.9-17.8) were malignant, 6% (CI 5.0-6.3) were pre-malignant and 78% (CI 76.4-78.6) were benign. Of the malignant lesions, 10% (CI 8.1-12.0) were operated on by ESGPs, 43% (CI 40.1-46.4) by GPwSIs, and 39% (CI 35.9-42.1) by Model 2 practitioners.

By far the most common of the malignant lesions was basal cell carcinoma (BCC), with GPwSIs having the highest proportion (86%, CI 82.8-89.5) and ESGPs having the lowest proportion (81%, CI 72.0-88.2) of malignant lesions being BCCs. BCCs were a small proportion (4%, CI 2.8-4.3) of the total number of lesions ESGPs operated on; the percentage for GPwSIs was 17% (CI 15.6-18.8), and 32% (CI 29.3-35.3) for Model 2 practitioners.
The diagnostic accuracy of each group of practitioners for malignant (Figure 4) and benign lesions varied. Both GPwSIs and Model 2 practitioners are more accurate in diagnosing malignant lesions than ESGPs. All practitioners had diagnostic accuracy rates of more than 95% for benign lesions, but Model 2 practitioners are less accurate in diagnosing benign lesions. Both of the differences in diagnostic accuracy (for malign and benign lesions) are statistically significant (p-value <0.001). Additionally, the specific diagnostic accuracy rates with respect to BCCs (Figure 5) show that Model 2 practitioners and GPwSIs have statistically significantly higher diagnostic accuracy rates relating to BCCs, compared to ESGPs (p <0.001).
Figure 5: Diagnostic accuracy for basal cell carcinoma, by practitioner type

Model 2 practitioners and GPwSIs have statistically significant higher rates of completeness of excision, compared to ESGPs (p <0.001; Figure 6). There were very low rates of both major and minor complications developed within 2 months of the operation. Neither group conducted procedures resulting in a high number of major or minor complications, and there were not statistically significant differences between them (p=0.27 for major complications; p=0.10 for minor complications). The two most common major complications were wound infections and wound dehiscence. Half of these complications were from procedures conducted by ESGPs. There was one instance of nerve damage by a GPwSI, and two instances of significant bleed, both by ESGPs. Wound infections were the most common complications for ESGPs and GPwSIs, while wound dehiscence was the most common for Model 2 practitioners. Out of the 6,138 operations, there were only 45 major complications.

Figure 6: Completeness of excision for malignant lesions, by practitioner type

The majority of the operations were conducted in less than 8 weeks (Figure 7); however, a slightly higher proportion of Model 2 practitioners offered surgery with a wait of 8 weeks or more. This difference is statistically significant at the 5% level, but not at the 1% level.

The average wait for histology results was around 2 weeks, with the maximum wait being over 3 months; these figures did not vary much across the three practitioner groups.
ESGPs and GPwSIs nearly always took written consent for surgery, but this proportion was 37% (CI 34.3-40.1) for Model 2 practitioners, as they took oral consent instead.

GPwSIs nearly always provided a post-operative sheet to patients (94.8%, CI 93.9-95.7), while this proportion is 75.5% (CI 73.7-77.2) for ESGPs and 66.6% (63.7-69.5) for Model 2 practitioners.

Of all patients receiving a malignant histology diagnosis, 21.5% were referred to secondary care afterwards. This proportion was 48.4% for ESGPs, 25.1% for GPwSIs and 11.6% for Model 2 practitioners. Within this, the majority of the referrals were routine.
DISCUSSION

Summary
It is feasible to capture and publish detailed audit data from GP surgeons, as part of the Community-Based Surgery Audit. Extensive data was recorded from a large number of minor surgery procedures. This could form the basis of a register of GP surgery with the capability to provide feedback to practitioners, commissioners and regulators.

Current data demonstrates:

- GPs in this audit are shown to offer safe surgery.
- Diagnostic accuracy is shown to be good, excisions adequate and histology frequently requested.
- Complication rates are low.
- Surgery is prompt.

Nearly all samples were sent for histological diagnosis across all three groups, especially ESGPs (97.5%) and GPwSIs (96.5%) but it is difficult to understand the lower percentage amongst Model 2 GPs (91.9%). This may represent incorrect coding and warrants further investigation.

Across a range of indicators, GPwSI and Model 2 practitioners appear to have higher quality standards than practitioners working under enhanced services arrangements in their own practices. The differences between types of GP surgeons might be because of the selection processes to become a GPwSI or Model 2 practitioner, the supervision available, the quality of the system, or other reasons.

Strengths and limitations
The strengths of the study are its size and the careful way the questionnaire was put together to test whether previous issues with GP minor surgery are still apparent. Also, the completeness of the data across its sections was impressive. The audit shows differences in case selection between different GP minor surgeons and may represent them working within their expertise. Once pre-operative clinical diagnoses were entered into the CBSA tool, they became date-stamped and un-editable thereby ensuring an accurate measurement of diagnostic skill when compared to histological results.

The principal limitations of the audit are that we are analysing self-selected data from a self-selected group of GP minor surgeons, compared with previous trials. The audit may therefore reflect what the best can achieve. Given that the GPs volunteered to participate in the study, there could be a bias towards GPs with a better performance, across all types of practitioners. Additionally, as seen in the procedure type, more challenging locations to operate on are not distributed uniformly across all GPs, which might affect the levels of performance of the GP; a randomised trial, where patients would be randomly allocated to any GP would reduce this bias.

This audit was based on an analysis of aggregated data. As such, it is not possible to ascertain the factors behind differences in surgery performance. Having data regarding the individual practitioner characteristics, such as years of experience, qualifications, etc., would greatly expand the scope of recommendations to be made from this audit. Patient preference has not been included, which is a crucial factor in the delivery of minor surgery by GPs.

Comparison with literature
The study refutes many of the notions of poor quality reflected in the MiSTIC trial. The surgeons appear to achieve higher standards of diagnosis, excision completeness, and use of histology than reported in that study. However, the range of conditions being operated on seems to be more extensive. The similarity in results between ESGPs and GPwSI reported in the other studies was not seen in these data.
CONCLUSION

- GP surgeons operate on all parts of the body, including the face.
- Their diagnostic acumen is adequate and they use histology appropriately.
- The wait for GP minor surgery is short.
- Across a range of indicators, GPs working as GPwSI and as Model 2 perform better.

GPwSIs and Model 2 Practitioners have very high levels of diagnostic accuracy and completeness of excisions. Because numbers are smaller due to activity being restricted by existing guidelines, it is not possible to be as certain about skin cancers other than BCCs. What evidence we have demonstrates completeness of excisions for all skin cancers amongst GPwSI and Model 2 practitioners to be very high.

Model 2 practitioners seem to be less accurate at diagnosing benign lesions compared to their colleagues however this may reflect the greater proportion of skin cancer work they experience and their increasing tendency to record a malignant clinical diagnosis.

Reassuringly, across all types of GP there is a greater tendency to diagnose skin lesions as potentially malignant which turn out to be benign (ESGP 13%, GPwSI 6.4% and Model 2 8%) than vice versa (0.8%, 3.8% and 1% respectively). This suggests the GPs in this study very rarely misdiagnose a lesion as benign when it is in fact malignant.

ESGPs were more likely to undertake more minor procedures (shave excisions and curettage) than GPwSIs and Model 2 GPs (45% vs 19% and 27%) which is to be expected and this helps explain their higher rates of wounds left to heal by secondary intention (36%, 25% and 30% respectively).

**Minor surgery by GPs is safe, and a register of all GP minor surgical procedures through the use of the CBSA tool could ensure and assure that it was practiced to a high standard.**

*Implications of the study for research and practice*

Further research is needed. A new trial with non-aggregated data and, ideally, a randomisation of patients, would be preferable. Moreover, alongside the data collection on the performance of GPs, it would be useful to collect patient preference data.

The CBSA tool allows practitioners to compare their diagnostic and surgical skills to their peers. All GPs who offer a minor surgery provision to their NHS patients should be encouraged to enter their surgical data into the CBSA tool. By this means, individual GPs can demonstrate their competence to operate. The audit should be retained but also developed to become a more explicit surgical checklist and register. Clinical systems should be developed to enable consistent and compatible coding to enable data extraction to the CBSA tool.

GP surgeons using the CBSA appear to operate safely on all parts of the body, including the face. Their diagnostic acumen appears adequate and they use histology appropriately. The wait for GP minor surgery is short. For UK GPs therefore, it would seem reasonable that within their competence, cancer and facial surgery restrictions should be relaxed but carefully audited.
RECOMMENDATIONS

The CBSA tool provides support for clinicians using it, reassurance for patients they operate on, accountability to the commissioners of their services and strategic planning for the NHS.

If it is to continue to provide these benefits, the CBSA will need financial support both to exist year-on-year and in order to develop and improve. Investment in the CBSA will enable GPs with the necessary diagnostic and surgical skills to develop the business case to develop skin cancer management in the community. This will provide the opportunity for significant savings to the NHS budget as well as providing patients with high quality care close to home.

The CBSA tool is already cited by the Care Quality Commission (CQC) as an example of outstanding practice by those using it\(^8\). All practices undertaking community-based surgery should be encouraged to use the tool and to submit their reports to CQC.

The CBSA tool allows users to generate an annual audit that meets the requirements for appraisal and revalidation. All GP appraisers should be encouraged to promote its use to their appraisees who operate in the community.

Support for the CBSA should be encouraged. The relevant Primary Care Associations should be approached for their official endorsement. These should include the Primary Care Dermatology Association and the Association of Surgeons in Primary Care. It is hoped that they will encourage all their members who operate to use the CBSA tool.

In addition the relevant specialist associations and Royal Colleges should be approached for endorsement including The British Association of Dermatologists, the Royal College of Surgeons, the British Association of Plastic and Reconstructive Surgeons and the Royal College of Histopathologists.

Finally, all commissioners of community-based surgery should be encouraged to expect quarterly and annual reports from their GP surgeons using the CBSA reporting system. Only in this way will they ensure a quality service for the populations they serve and value for money in the surgical services they commission.

\(^8\) http://www.cqc.org.uk/content/nigels-surgery-14-how-show-outstanding-practice-minor-surgery
ADDITIONAL REFERENCES


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