Specification for a Directed Enhanced Service
Minor Surgery

Introduction

1. There is evidence from within the UK and abroad that minor surgical procedures carried out by general practitioners in general practice premises have high levels of patient satisfaction and are highly cost effective. Since 1 April 1990, general practitioners on Health Authority minor surgery lists (and their equivalents) have been able to receive payment for undertaking a range of minor surgery procedures on their patients.

2. There has been a huge variation in the range of procedures undertaken at practice level. Many practices have provided cryotherapy, curettage and cauterisation only whilst still referring other minor surgery into the secondary sector. This directed enhanced service, which must be commissioned by every PCO, seeks to ensure that there is the opportunity to provide the maximum range of minor surgery in the primary care sector.

3. 2010 DES Directions issued by the Department of Health contain variances to the 2003 DES. The areas in Blue Italic font are those variations and therefore become the wording of this DES.

Scope of Service to be Provided

4. Cryotherapy, curettage and cauterisation will continue to be provided by general practitioners as an additional service and practices wishing to opt out of providing these treatments will be obliged to apply to do so in the prescribed manner.

Procedures in the categories below and other procedures, which the practice is deemed competent to carry out, will be covered by a directed enhanced service. These procedures have been classified into the following two groupings for payment:

(i) injections for muscles, tendons and joints – treatment guidelines provided in Appendix A (Group B)

(ii) invasive procedures, including incisions and excisions - treatment guidelines provided in Appendix A (Group A)

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Eligibility to Provide the Service

5. A practice may be accepted for the provision of this directed enhanced service if contractor can ensure that the practitioner who is involved in performing or assisting in any surgical procedure:

(i) Has the necessary experience, skills and training with regard to that procedure
(ii) Has resuscitation skills
(iii) Demonstrates a continuing sustained level of activity
(iv) Conducts regular audits
(v) Is appraised on what they do
(vi) Takes part in necessary supportive educational activities.

6. Where a PCO believes a doctor carrying out minor surgery is not complying with the terms of the contract it should invoke a remedial notice according to the procedure laid out in Regulation. In assessing suitability for the provision of this directed enhanced service, practices will pay particular attention to the following:

(i) **Satisfactory Facilities.** PCOs should be satisfied that practices carrying out minor surgery have such facilities as are necessary to enable them to provide minor surgery services properly. Adequate and appropriate equipment should be available for the doctor to undertake the procedures chosen, and should also include appropriate equipment for resuscitation. National guidance on premises standards has been issued.

(ii) **Nursing Support.** Registered nurses can provide care and support to patients undergoing minor surgery. Nurses assisting in minor surgery procedures should be appropriately trained and competent, taking into consideration their professional accountability and the Nursing and Midwifery Council guidelines on the scope of professional practice.

(iii) **Sterilisation and Infection Control** Practices providing minor surgery must operate to the highest possible standards and therefore the contractor will ensure that it has appropriate arrangements for infection control and decontamination in premises where surgical procedures are undertaken and will use:

   (i) sterile packs from the local Central Sterile Service Department, disposable sterile instruments, or approved sterilisation procedures
   (ii) the PCT’s infection control policies in relation to the handling of used instruments and excised specimens and the disposal of clinical waste

(iv) **Consent.** In each case the patient should be fully informed of the treatment options and the treatment proposed. The patient should give written consent for the procedure to be carried out and the completed NHS consent form should be filed in the patient’s lifelong medical record.

(v) **The Practitioner will take all reasonable steps to provide suitable information to patients, in respect of whom they are contracted to provide minor surgical procedures, about those procedures. The Practitioner will obtain from the patient, written consent to the surgical procedure before it is carried out (where a person

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consents on a patient’s behalf, that person’s relationship to the patient must be recorded on the consent form), and the practitioner will take all reasonable steps to ensure that the consent form is included in the lifelong medical records held by the patient’s general practitioner

(vi) **Pathology** The contractor will ensure that all tissue removed by surgical procedures is sent for histological examination, unless there are acceptable reasons for not doing so

(vii) **Audit.** The contractor will ensure that all records relating to all surgical procedures are maintained in such a way that aggregated data and details of individual patients are readily accessible for lawful purposes and as to facilitate regular audit and peer review by the contractor of the performance of surgical procedures under the plan

The contractor will supply the PCT with such information as it may reasonably request for the purposes of monitoring the contractor’s performance of its obligations under the plan.

Topics for audit will include:

1. clinical outcomes
2. rates of infection
3. unexpected or incomplete excision of basal cell tumours or pigmented lesions which following histological examination are found to be malignant.

**Pricing**

7. Treatments under this directed enhanced service will be priced depending on complexity of procedure, involvement of other staff and use of specialised equipment.

8. In 2011/12, payment for an injection will be £42.01 and for cutting surgery the fee will be £84.02.
Eligibility to Provide the Service
Minimum Expectations

5. A practice may be accepted for the provision of this directed enhanced service if contractor can ensure that the practitioner who is involved in performing or assisting in any surgical procedure:

(i) Has the necessary experience, skills and training with regard to that procedure
(ii) Has resuscitation skills
(iii) Demonstrates a continuing sustained level of activity
(iv) Conducts regular audits
(v) Is appraised on what they do
(vi) Takes part in necessary supportive educational activities

NHS Luton expects this to be:

i. New skin surgery practitioners will demonstrate competency to a suitably qualified external body using objective evidence and competency based assessment tool (Direct Observation of Procedural Skills, known as DOPS). Existing practitioners will demonstrate competency to perform the designated procedure(s) to suitably qualified external body using objective evidence and competency based assessment tools within the preceding three years. DOPS assessment, as above, is appropriate

ii. The practitioner will provide evidence of annual training in resuscitation.

iii. The practitioner will continue to perform skin surgery with a regular, sustained level of activity (an absolute minimum of 12 procedures per year) and follow a program of revalidation. 100 skin surgery procedures per year that leave a scar (excluding cryosurgery) is recommended; If less than 100 procedures per year are performed, the practitioner will demonstrate ongoing competency to perform the designated procedure(s) by completion of further DOPS assessments at three yearly intervals, unless the activity increases to the recommended amount

iv. The practitioner will demonstrate training and ongoing medical education in the recognition and management of skin lesions appropriate to their role (for example, a practice nurse performing skin surgery on pre-diagnosed skin lesions will have different skin lesion diagnostic skill requirements to a GP diagnosing and excising lesions).
6. Where a PCO believes a doctor carrying out minor surgery is not complying with the terms of the contract it should invoke a remedial notice according to the procedure laid out in Regulation. In assessing suitability for the provision of this directed enhanced service, practices will pay particular attention to the following:

**(i) Satisfactory Facilities.** PCOs should be satisfied that practices carrying out minor surgery have such facilities as are necessary to enable them to provide minor surgery services properly. Adequate and appropriate equipment should be available for the doctor to undertake the procedures chosen, and should also include appropriate equipment for resuscitation. National guidance on premises standards has been issued.

*NHS Luton’s guidance on facilities can be found in Annex A*

**(vi) Pathology** The contractor will ensure that all tissue removed by surgical procedures is sent for histological examination, unless there are acceptable reasons for not doing so.

*NHS Luton requires the practitioner to send all skin specimens removed to histology for analysis and provide information about the site of excision and provisional diagnosis on the histology request form*

*The practitioner will maintain a ‘fail-safe’ log of all procedures performed with histological outcome to ensure that patients are informed of the final diagnosis, and whether any further treatment or follow-up is required. This will be undertaken in a timely fashion.*

*NHS Luton’s Guidance in regards to Skin Tag removal can be found in Appendix C*

**(vii) Audit.** The contractor will ensure that all records relating to all surgical procedures are maintained in such a way that aggregated data and details of individual patients are readily accessible for lawful purposes and as to facilitate regular audit and peer review by the contractor of the performance of surgical procedures under the plan.

The contractor will supply the PCT with such information as it may reasonably request for the purposes of monitoring the contractor’s performance of its obligations under the plan.

Topics for audit will include:

iv. clinical outcomes

v. rates of infection

vi. unexpected or incomplete excision of basal cell tumours or pigmented lesions which following histological examination are found to be malignant.

*NHS Luton expects the practitioner to complete the Audit found in Appendix B and:*

- Provide evidence of an annual review of clinical compared with histological accuracy in diagnosis to demonstrate diagnostic competency
- Complete a wound infection and patient experience study
- Consider the above as part of the annual appraisal process
(v) The Practitioner will take all reasonable steps to provide suitable information to patients, in respect of whom they are contracted to provide minor surgical procedures, about those procedures. The Practitioner will obtain from the patient, written consent to the surgical procedure before it is carried out (where a person consents on a patient’s behalf, that person’s relationship to the patient must be recorded on the consent form), and the practitioner will take all reasonable steps to ensure that the consent form is included in the lifelong medical records held by the patient’s general practitioner.

NHS Luton expects the practitioner to be familiar with Department of Health and General Medical Council guidance on informed consent, particularly in relation to the Mental Capacity Act and obtaining consent from minors and best practice as detailed in these guidance documents will have been adopted. The DoH Guidance to Patient Consent can be obtained at the following website: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005762
Annex A

Minor Surgery Facilities

Designated rooms for minor surgery will be used for the treatment of patients from a range of age groups. Where a room is used for another purpose e.g. general patient treatment, the room should be cleared of all extraneous equipment and be thoroughly de-cluttered and cleaned before a minor operation session.

Practices must have infection control policies that are compliant with national guidelines including hand hygiene, aseptic technique, sharps management, specimens and the disposal of clinical waste. Cleaning schedules for the environment and clinical equipment will be in place and monitored.

Minor Surgery Room

Minor surgery rooms should be 18-20 m² and be supported by a waiting area. Each room should provide workspace for a practitioner and an assistant and be minimally furnished.

- **Privacy:** The room should offer speech privacy. Doors should be lockable and vision panels will be absent or obscured. Privacy curtains will be cleaned or replaced every 6 months.
- **Windows:** Washable blinds or blinds enclosed within the window itself should be used at external windows.
- **Ventilation:** In existing buildings the room should be naturally ventilated; where external noise and air pollution preclude the opening of windows the use of mechanical ventilation should be considered. New buildings will require mechanical ventilation.
- **Finishes:** Seamless vinyl floors that finish at least 20 cm up the wall (to aid cleaning), washable painted walls and splash-backs to work surfaces.
- **Lighting:** Excellent general lighting and movable task lighting will be required at the treatment chair or couch.
- **Furniture, fittings and equipment:** Furniture should be wipeable and easy to clean. The examination couch should be accessible from three sides with variable height control. Clinical hand wash basin with wall-mounted liquid soap dispenser, paper towel dispenser, antiseptic hand solution dispenser and/or alcohol hand rub. Equipment should be housed in cupboards and shelving kept to a minimum.
- **Sterile equipment:** Will be sterile disposable or sterile packs supplied by an approved sterile services department.

Activities that occur in minor surgery rooms include:

- assessment and treatment of patient while seated in a chair or on an examination couch, using specialist equipment
- minor surgical procedures including cryotherapy, curettage and cauterisation
- injections (muscles, tendons and joints) and invasive procedures including minor incisions and excisions
- preparation of treatment items by a practice nurse or other assistant
- storage of clean and disposable items
- administration work, using a computer and printer
- clinical hand washing using a clinical hand wash basin with elbow action lever taps
# Appendix A

## Treatment Guidelines

### Group A: Invasive procedures, including Incisions and Excisions

<table>
<thead>
<tr>
<th>Skin lesion</th>
<th>Comments</th>
<th>Additional Service</th>
<th>Enhanced Service</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Injections</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Ganglions</td>
<td>Equivocal evidence as to the effectiveness of aspiration</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Muscles, tendons and joints</td>
<td>Follow care pathways. Some evidence acute injuries should not be injected. May be reasonable to suggest no injection until six weeks following commencement of symptoms. (see Section B)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Cryotherapy</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Actinic Keratosis / Solar keratosis</td>
<td>Topical treatment with Solaraze (Efudix can also be used if practitioner is experienced in using this, but it can cause a significant local inflammatory reaction). Cryotherapy is useful for hyperkeratotic lesions (single 5-8 second freeze)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Molluscum Contagiosum</td>
<td>Spontaneous resolution normally occurs within 18-24 months.</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Viral Warts – Face</td>
<td>Small viral warts may be removed</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Viral Warts – Feet</td>
<td>If symptomatic and effecting gait, refer to GPwSI</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Viral Warts – Hands</td>
<td>There is no evidence to support that curettage is superior to topical therapy.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Skin lesion</td>
<td>Comments</td>
<td>Additional Service</td>
<td>Enhanced Service</td>
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<td>---------------------------------------------------</td>
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</tr>
<tr>
<td>Curettage, Cautery and Skin Biopsy</td>
<td></td>
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<tr>
<td>Benign Naevi (moles)</td>
<td>Do not treat for cosmetic reasons. Remove symptomatic lesions only.</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Excise with a 2mm margin (down to the fat layer)</td>
<td></td>
<td></td>
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<tr>
<td>Giant Comedones</td>
<td>Do not treat for cosmetic reasons.</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Incise roof of lesion and express contents.</td>
<td></td>
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<tr>
<td></td>
<td>Larger lesions (&gt;5mm) need formal excision if symptomatic.</td>
<td></td>
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<tr>
<td>Keratin Horn</td>
<td>Refer to secondary care under cancer two week wait rule if SCC a possibility.</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Keratoacanthoma</td>
<td>Refer to secondary care under cancer two week wait rule if SCC a possibility.</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Melasma/Cholasma</td>
<td>Do not treat for cosmetic reasons.</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Advise stopping hormone treatment (if appropriate) and constant sun block (bought by patient).</td>
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</tr>
<tr>
<td>Pyogenic Granuloma</td>
<td>Bleeding lesions may be treated with curettage and cautery.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Always send for histology because of amelanotic MM.</td>
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<tr>
<td></td>
<td>Warn about curettage scar.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seborrhoeic Keratosis Seborrhoeic warts</td>
<td>Do not treat for cosmetic reasons.</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Only treat symptomatic lesions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin Tags</td>
<td>Do not treat for cosmetic reasons.</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Only treat symptomatic lesions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(when excision is only option)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solar Lentigines</td>
<td>Do not treat for cosmetic reasons.</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Only treat symptomatic lesions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spider Naevi/Vascular Angiomata/Campbell de Morgan spots</td>
<td>Do not treat for cosmetic reasons. Only treat symptomatic lesions by hyfrecator or laser (for Spider naevi on face and neck only as clinical exception)</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
### Skin lesion

<table>
<thead>
<tr>
<th>Skin lesion</th>
<th>Comments</th>
<th>Minor Surgery DES</th>
</tr>
</thead>
</table>
| Dermatofibroma/ Histiocytoma                                                | **Do not treat for cosmetic reasons**  
Only treat if painful or very irritating                                                      | Yes               |
| Epidermoid/Pilar Cysts (commonly known as ‘Sebaceous cysts’)               | **Do not treat for cosmetic reasons**  
Only excise symptomatic lesions or if history of repeated infection                      | Yes               |
| In-Growing Toe Nails                                                        | Refer to Podiatry Service                                                                    | No                |
| Lipomata                                                                    | **Do not treat for cosmetic reasons**  
Excise if symptomatic or causing secondary symptoms.  
Consider referring large lipomata to secondary care | Yes               |

Please note ‘Symptomatic’ means:

- Bleeding
- Mechanical irritation or functional impairment
- Infection or risk of recurrence of infection or discharge
- Psychological distress (where the GP has been unable to persuade the patient that there are no features of malignancy)

Please note:

- Punch biopsies should not be performed on suspected skin cancer
- Immunocompromised patients should not be treated in primary care; refer to secondary care
- All skin lesions removed in primary care must be sent for histological examination and reporting
- Guidance for removal of multiple skin tags can be found in the Herts & Beds priorities guidance appendix C
## Treatment Guidelines

### Group B: Injections of Muscles, Tendon Sheaths and Joints

<table>
<thead>
<tr>
<th>Injection</th>
<th>Guidelines</th>
<th>Included within this specification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achilles Tendonitis</td>
<td><strong>Do not inject</strong> into tendon achilles tendon</td>
<td>No</td>
</tr>
<tr>
<td>Ankle Joint</td>
<td>Refer to CMS or local MSK Clinic (provide treatment history)</td>
<td>No</td>
</tr>
<tr>
<td>Back Pain</td>
<td>Epidural, facet-joint injections helpful. Refer to CMS or local MSK Clinic.</td>
<td>No</td>
</tr>
<tr>
<td>Carpal Tunnel Syndrome</td>
<td>Should only be performed by those doing so regularly as inadvertent injection into the nerve has serious consequences. <strong>Do not inject</strong> if there is wasting or loss of power or sensation – surgery is required. Refer to CMS or local MSK Clinic if in doubt (provide treatment history)</td>
<td>Yes</td>
</tr>
<tr>
<td>Dupuytrens Contracture</td>
<td>Refer to Hand Therapist/Plastic Surgeon (provide treatment history)</td>
<td>No</td>
</tr>
<tr>
<td>Elbow Joint - Lateral and Medial Epicondylitis</td>
<td>Injection if conservative measures fail. Not more than 2 injections 3 months apart. Refer to CMS or local MSK Clinic in doubt (provide treatment history)</td>
<td>Yes</td>
</tr>
<tr>
<td>Ganglion</td>
<td>Aspiration reduces size and pain in tense ganglion. Recurrence common. Ganglions over special sites e.g. over the radial artery, need referral to CMS or local MSK Clinic (provide treatment history)</td>
<td>Yes</td>
</tr>
<tr>
<td>Knee Joint</td>
<td>Avoid intra-articular injection if risk of infection is high. <strong>Do not inject</strong> around patellar and quadriceps tendons. Intra-articular injection into knee joint only in patients not fit or declining surgery and other conservative measures have failed. Must be done under strict aseptic conditions.</td>
<td>Yes</td>
</tr>
<tr>
<td>Metatarso-phalangeal joints</td>
<td>Injection into MTP joint in gout only if refractory to other forms of treatment. Refer to Hand Therapist (provide treatment history)</td>
<td>Yes</td>
</tr>
<tr>
<td>---------------------------</td>
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</tr>
<tr>
<td>Plantar Fasciitis</td>
<td>Injection helpful for pain relief if all conservative measures fail.</td>
<td>Yes</td>
</tr>
<tr>
<td>Shoulder Joint - Frozen Shoulder</td>
<td>Injection into gleno-humeral joint for pain relief. Does not improve range of movements</td>
<td>Yes</td>
</tr>
<tr>
<td>Shoulder Joint - Rotator Cuff Tendinopathy and subacromial bursitis</td>
<td>Injection into subacromial space. Repeat injection in 3 months if initial response is good. Not more than 2 injections if pain recurs. Refer to CMS or local MSK Clinic if in doubt (provide treatment history)</td>
<td>Yes</td>
</tr>
<tr>
<td>Trigger Finger and Thumb</td>
<td>Injection into tendon sheath if conservative measures fail. May be repeated in 3 months if recurs. Do not recommend repeat more than twice</td>
<td>Yes</td>
</tr>
<tr>
<td>Trochanter Bursitis</td>
<td>Injection into bursa helpful for pain relief. Do not recommend repeat treatment if previous injection not helpful</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Treatment Guidelines Cont’d

Contraindications: Intra-articular injection:
  a) Overlying Cellulitis
  b) Severe coagulopathy
  c) Anticoagulant therapy (relative contraindication)
  d) Septic effusion
  e) More than 3 injections per year in weight bearing joint
  f) Lack of response after 2 injections
  g) Bacteremia
  h) Unstable joints
  i) Inaccessible joints
  j) Joint prosthesis
  k) Osteochondral Fracture
  l) Overlying soft tissue infection or dermatitis

Precautions:
  a) Do not inject directly into tendons;
     • Injection into tendon sheath is appropriate
     • Tendon weakens with direct injection (rupture risk)
     • Do not inject high risk tendons:
       • Avoid Achilles tendon injection
       • Avoid patella tendon injection
       • Aspirate before injection to confirm no vessel
  b) Avoid needle trauma to cartilage on joint injection
  c) Limit Corticosteroid Injections to >4 week intervals:
     • Intra-articular injections are typically limited to 3 month intervals
  d) Limit Corticosteroid to one large joint per visit
  e) Exercise caution with nearby nerves:
     • E.g. Ulnar Nerve lies close to medial epicondyle
     • Withdraw needle if patient reports Paresthesias

Complications:
  a) Post injection flare (2-5%):
     • Relieved with ice to the area for 15 minutes/hour
     • Resolves within 24 to 48 hours
     • More common with longer acting Corticosteroids
  b) Steroid arthropathy (0.8%)
  c) Tendon rupture (<1%)
  d) Facial Flushing (<1%)
  e) Skin atrophy or depigmentation (<1%)
  f) Iatrogenic Infectious Arthritis (<0.07%)
  g) Transient paresis of injected extremity (Rare)
  h) Hypersensitivity Reaction (rare)
  i) Asymptomatic pericapsular calcification (43%)
  j) Acceleration of cartilage attrition (unknown)
  k) Hyperglycemia in Diabetes Mellitus patients:
     • Single intra-articular injections do not typically affect blood sugars
     • Soft tissue and peritendinous injections increase blood sugars for 5-21 days
## Appendix B

### Minor Surgery DES Clinical Audit

#### A) Individual Clinician Clinical Audit *(Add Date)*

One form must be completed for *each* clinician in the practice undertaking excisions/incisions under this DES.

The Audit must include all patients treated under this DES by that clinician.

All answers provided must relate only to procedures carried out by this individual during the audit period.

The form must be submitted to the PCT’s Clinical Governance Team by *(Add Date)*

<table>
<thead>
<tr>
<th>Name of Clinician</th>
<th>Audit Period</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Audit question</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. All clinicians carrying out excisions/incisions for this DES should carry out a minimum of 12 procedures per year</strong></td>
<td>a) Number of Group A procedures carried out between 1 April and 31 March by this clinician</td>
<td></td>
</tr>
</tbody>
</table>
| **2. Excisions/incisions of epidermoid/pilar cysts, dermatofibroma/histiocytoma, or lipomata should be sent for histology** | a) Total number of epidermoid/pilar cysts, dermatofibroma/histiocytoma, or lipomata *excised*  
   b) Total number of epidermoid/pilar cysts, dermatofibroma/histiocytoma, or lipomata samples *sent* for histology | |
| **3. All samples sent for histology should have a result recorded** | a) Total number of all samples *sent* for histology following procedures carried out under this DES  
   b) Number of samples for which histology results were *recorded* as received following procedures carried out under this DES | |
| **4. If a BCC/SCC is inadvertently excised in line with IOG guidance, practitioner should attend an MDT meeting** | a) Number of samples with significant histology *(BCC/SCC) An SEA should be completed for each BCC/SCC inadvertently excised*  
   b) Number of incomplete excision *(BCC/SCC)*  
   c) Number of MDT meetings attended | |
| **5. All wound infections requiring antibiotic treatment should be recorded** | a) Number of recorded post-operative wound infections requiring antibiotic treatment | |
| **6. Patients should give written consent for the procedure to be carried out. The completed NHS consent form should be filed in the patient’s lifelong medical record.** | Using a random sample of 30% of records for procedures carried out by named clinician during audit period e.g. if total procedures for year for this clinician *(2c)* = 40, select 12 records at random.  
   a) Number of records audited  
   b) Number of records audited with NHS Consent form filed in record | |
| **7. Fail Safe Log completed and up to date** | | ☐ YES ☐ NO |
B) Annual Summary and SEA Practice Report

Each Practice providing this service is required to collate the results of all clinicians undertaking minor surgery under this DES, discuss the audit results and any relevant significant events in a Practice meeting before completing and submitting this and the individual clinicians audit forms to the Clinical Governance Department at the PCT by the insert month – 14 months after DES Begins each year.  *One form per Practice*

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Report for Year Ending</th>
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<table>
<thead>
<tr>
<th>Report written by</th>
<th>Name</th>
<th>Job Title</th>
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</table>

**Significant events between 1st April and 31st March**

**Complications, Complaints or Significant Events in Relation to Minor Surgery DES**

Please attach a report for any events during the reporting period, including details of discussion and learning form the incident, and any changes to practice policy or protocols.

*Please note a significant event should be recorded in all cases where a BCC or SCC is inadvertently excised*
C) Training Requirement

Please list the training undertaken by each clinician performing minor surgery including recent Resuscitation Training.

Guidance for GPs performing skin surgery (outlined in ‘Revised guidance and competences for the provision of services using GPs with Special Interests GPwSI Dermatology and skin surgery) states:

- New skin surgery practitioner demonstrated competency to a suitably qualified external body using objective evidence and competency based assessment tool (DOPS)
- Existing skin surgery practitioner – have they undertaken a DOPS assessment within the preceding 3 years?
- Is there a regular level of sustained activity – 100 skin procedure a year is recommended. If less than this, GP to DOPS at 3 yearly intervals
- Training and ongoing medical education in the recognition and management of skin lesions appropriate to their role
- Annual training in resuscitation

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<tr>
<th>Clinician</th>
<th>Training undertaken (include details of course accreditation ie RCGP etc and resuscitation training)</th>
<th>Date</th>
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D) Completing the Audit Cycle

Date collated audit results discussed in Practice Meeting:     ..../ ......./......

Practice summary of Audit Findings:

<table>
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<tr>
<th>What changes do you plan to implement, if your results need improvement?</th>
<th>Who will be responsible</th>
<th>When will the action be completed</th>
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Any comment:
Appendix C

Extracts taken from Bedfordshire and Hertfordshire Priorities Forum Statement
Number: 1
Subject: The provision of cosmetic treatments and surgery
Date of decision: November 2010
Date of review: November 2013


Benign skin lesions (for example: Epidermoid (“Sebaceous”) cyst, Lipoma, Skin tags, Seborrhoeic Keratoses, benign Naevi)
Except where there is diagnostic uncertainty, a functional impairment due to the lesion (such as pain or interference with shaving or dressing), recurrent infection or discharge, suspicion of malignancy or significant psychological distress, perhaps due the location and the size of the lesion.

If a GP is uncertain of diagnosis the patient should be referred further assessment to an appropriate specialist.

Patients with precancerous Squamous Cell Carcinoma (SCC) skin lesions: Precancerous skin lesions such as actinic/solar keratoses or in situ SCC of skin (Bowen’s disease) are common, and based on NICE skin tumour IOG 2006 GP may treat these using one of the recognised treatments (eg cryotherapy, topical drug treatments, curettage and cautery). The patient may be referred to an appropriate specialist.

Based on NICE guidelines: Improving outcomes for people with skin tumours including melanoma (update) 2010, GPs (who have fulfilled the requirements of the low-risk BCC accreditation process arranged by the respective PCT) can undertake removal of low-risk BCC within the framework of the DES and LES under General or Personal Medical Services when following criteria are met:

There is no diagnostic uncertainty that the lesion is a primary nodular low-risk BCC and
• The patient is not:
Aged 24 years or younger (that is, a child or young adult) immunosuppressed or has Gorlin’s syndrome
• The lesion:
Is located below the clavicle (this is, not on the head or neck) is less than 1cm diameter with clearly defined margins, is not a recurrent BCC following incomplete excision, is not a persistent BCC that has been incompletely excised according to histology, is not morphoeic, infiltrative or basosquamous in appearance is not located:
- over important underlying anatomical structure (for example, major vessels or nerves)
- in an area where primary surgical closure may be difficult (for example, digits or front of shin
- in an area where difficult excision may lead to a poor cosmetic result
- at another highly visible anatomical site (for example, anterior chest or shoulders) where a good cosmetic result is important to the patient.

If the BCC does not meet the above criteria, or there is any diagnostic doubt, following discussion with the patient they should be referred to a member of the local specialist services for skin cancer.

If the lesion is thought to be a superficial BCC the GP should ensure that the patient is offered the full range of medical treatments (including for example, photodynamic therapy) and this may require referral to a member of the local specialist services for skin cancer.