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 [see references 1, 2, 3]. 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 [see reference 1] 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 scheme, which must be commissioned by every primary care organisation (PCO), seeks to ensure that there is the opportunity to provide the maximum range of minor surgery in the primary care sector.

**Scope of service to be provided**

3. 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 (DES). These procedures have been classified into the following three groupings for payment:

(i) injections (muscles, tendons and joints)
(ii) invasive procedures, including incisions and excisions
(iii) injections of varicose veins and piles.

**Eligibility to provide the service**

4. A practice may be accepted for the provision of this DES if it has a partner, employee or sub-contractor, who has the necessary skills and experience to carry out the contracted procedures in line with the principles of the generic GPs with special interests (GpwSI) guidance or the specific examples as they are developed. Clinicians taking part in minor surgery should be competent in resuscitation and, as for other areas of clinical practice, have a responsibility for ensuring that their skills are regularly updated. Doctors carrying out minor surgery should demonstrate a continuing sustained level of activity, conduct regular audits, be appraised on what they do and take part in necessary supportive educational activities.

5. 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. There is considerable guidance available on techniques and facilities for conducting minor surgery in general practice. In assessing suitability for the provision of this DES, practices should 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 properly to provide minor surgery services. 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 [see reference 4].

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. Although general practitioner minor
surgery has a low incidence of complications, it is important that practices
providing minor surgery operate to the highest possible standards.
Practices should take advantage of any of the following arrangements:

(a) sterile packs from the local CSSD
(b) disposable sterile instruments
(c) approved sterilisation procedures that comply with national guidelines.

General practitioners are responsible for the effective operation and
maintenance of sterilising equipment in their practices. Practices must have
infection control policies that are compliant with national guidelines
including inter alia the handling of used instruments, 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) Pathology. All tissue removed by minor surgery should be sent routinely
for histological examination unless there are exceptional or acceptable
reasons for not doing so.

vi) Audit. Full records of all procedures should be maintained in such a way that aggregated data and details of individual patients are readily accessible. Practices should regularly audit and peer-review minor surgery work. Possible topics for audit include:

(a) clinical outcomes
(b) rates of infection
(c) unexpected or incomplete excision of basal cell tumours or pigmented lesions which following histological examination are found to be malignant.

(vii) Patient information. Practices must ensure that details of the patient's minor surgery procedure as part of the NES is included in his or her lifelong record. If the patient is not registered with the practice providing the NES, then the practice must send this information to the patient's registered practice for inclusion in the patient notes.

**Pricing**

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

7. In 2010/2011 payment for an injection, for example joint injection, will be £43.36 and for cutting surgery the fee will be £86.72. The PCO will agree with the provider the basis on which the DES will be funded in light of the procedures to be carried out and the volume to be carried out, including setting an upper cap.

**References**


**Activity monitoring**

Practices are to submit activity on the following procedures carried out on a quarterly basis:
   (i) Injections (muscles, tendons and joints)
   (ii) Invasive procedures, including incisions and excisions
   (iii) Insertion and removal of Implanon

You can find guidelines on Implanon and inclusion and exclusion criteria below.

Please see Minor surgery DES Activity form for a copy of the activity data collection sheet, which needs to be completed and submitted for payment. It should be noted that practices are to itemise each procedure by specifying exactly what it was and giving details of treatment.

This activity data is to be submitted on the following dates:

<table>
<thead>
<tr>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submission deadline</td>
<td>23/07/10</td>
<td>22/10/10</td>
<td>21/01/11</td>
</tr>
</tbody>
</table>

Activity must be submitted by the dates above to guarantee payment and activity must be claimed within the quarter it is done. It is preferred that the activity is sent by email to enhancedservices.camden@nhs.net

**Quality monitoring**
Practices must be able to satisfy the Directed Enhanced Service specification for minor surgery as well as provide the quality monitoring information required below to continue to be commissioned for this service. Practices are required to submit the following information by 21st January 2011 (Quarter 3) to enrichedservices.camden@nhs.net. The template for completion is in Minor surgery DES Quality form.

- Practice details
- A statement of achievement regarding the CPR facilities available in the minor surgery treatment room and equipment and drugs
- A statement of achievement describing the practice system for obtaining written patient consent for a minor surgery procedure to be carried out
- A blank copy of the practice’s consent form.
- A statement of achievement regarding all tissues removed by minor surgery being sent routinely for histology examination. Best practice is for all removed skin lesions, including sebaceous cysts to be sent for histological analysis
- A copy of the practice results protocol.
- A clinical audit of the proportion of histology reports that require onward referral or show malignant results from 1st January 10 – 31st December 10. Please specify in the audit;
  - The total samples sent for histology
  - The total number of histology reports requiring onward referral
  - The total number of histology reports that show malignant results
- A completed copy of the PCT’s Infection Control audit. Practices will be advised separately by the PCT’s Infection Control team about completing the infection control audit and the date of submission.
Inclusion of Contraceptive Implants in the Minor Surgery DES

The insertion and removal of Implanon contraceptive implants will now be funded in line with the current minor surgery DES and practices are invited to claim for procedures performed.

* Lower rate for each Implanon implant insertion -£43.36
* Higher rate for each Implanon removal -£86.72

Criteria for inclusion:

Fitting, monitoring, checking and removal of contraceptive implants should be carried out in accordance with current best practice guidance (NICE guidance on Long Acting Reversible Contraceptives, Faculty of Family Planning and Reproductive Health)

Practitioners undertaking these procedures must have undertaken appropriate training; this should be based on modern, authoritative medical opinion, for example, the current requirements set down by the Faculty of Family Planning and Reproductive Health Care (FFPRHC).

Removal of Contraceptive implants is carried out by the use of aseptic techniques and has therefore been classified as an invasive minor surgery procedure. Practices should have appropriate facilities, meeting the requirements of the minor surgery Directed Enhanced Service (see link below to specification).

Practices not currently commissioned to provide the Minor Surgery DES may apply for funding subject to meeting the DES. Please email the Enhanced Services Team if you would like to be commissioned for the DES and are not already.

CG30 Long-acting reversible contraception: Full guideline (NICE)
http://www.nice.org.uk/Guidance/CG30/Guidance/pdf/English

Contracts & Performance Directorate 1/14/2009
Minor Surgery DES Inclusion and Exclusion Criteria

Notes:
This DES specifically excludes patients under 16, patients currently prescribed Warfarin and procedures to the face.

Below is a matrix laying out which procedures will fall under Additional and Enhanced Service and when to refer to Dermatology, this list is not exhaustive, if you feel others should be included this may be considered on a case by case basis.

All excised tissue MUST be sent to histology. Where results confirm malignancy, good practice is to alert the MDT coordinator at the relevant trust.

Contact details for MDT:

Whittington: Rudolfo Jackson, MDT co-ordinator -Skin, Level 6, Highgate Wing, Whittington Hospital, Magdala Avenue Tel 020 7288 5227 or Rudolfo.Jackson@whittington.nhs.uk

UCLH: Nicola Castagnetti, MDT Coordinator Haematology, Paediatrics and Dermatology, 3rd Floor West, 250 Euston Rd Tel 0845 155 5000 Ext 3424

RFH: Royal Free: Katie Walton, Skin MDT Coordinator, Royal Free Hampstead NHS Trust, 1st Floor MDT Office, Pond Street London NW3 2QG. Tel: 0207 794 0500 ext 35812 FAX: 0207 317 7559

Treatment of skin cancers
In line with NICE Guidance “Improving outcomes for people with skin tumours including melanoma” issued in February 2006 the PCT wishes to make clear that no GPs should remove skin cancers under the auspices of the Minor Surgery DES. This is contrary to NICE guidance and beyond the scope of what the Enhanced Service is meant to deliver. The NICE guidance clearly states that:

“All patients where there is the possibility of a melanoma or an SCC of the skin, should be referred urgently to a specialist who is a member of the LSMDT/SSMDT, (Local Skin Cancer Multiple Disciplinary Team/ Specialist Skin Cancer MDT) usually to the local dermatology department rapid access skin cancer clinic or pigmented lesion clinic”.

And:
“Where a patient has a lesion that may be a low risk BCC, he or she may be referred either to the local hospital specialist who is a member LSMDT/SSMDT, normally a dermatologist, or to a doctor working in the community who is a member of an LSMDT/SSMDT.”

And:
“If the GP is uncertain of the diagnosis the patient should be referred for further assessment to a dermatologist who is a member of an LSMDT/SSMDT.” These statements can be found on page 78 of the guidance and a useful flow chart is also on page 79. Advice on patients with precancerous lesions such as solar keratoses can also be found on page 78 of the guidance. The guidance can be found at: http://www.nice.org.uk/guidance/index.jsp?action=download&o=28906
<table>
<thead>
<tr>
<th>Skin Lesion</th>
<th>Comments</th>
<th>Additional Service Level</th>
<th>Minor Surgery DES</th>
<th>Dermatology Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Viral Warts (Hands/Feet)</td>
<td>There is no evidence to support that cryotherapy is superior to topical therapy.</td>
<td>Yes</td>
<td>No</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>
<td>No</td>
</tr>
<tr>
<td>Seborrhoeic Warts / Keratosis</td>
<td>Do not treat for cosmetic reasons. Treat symptomatic lesions only. NHS treatment available only if large bleeding lesion or if diagnostic opinion required. Cryotherapy thin lesions and curettage thicker lesions (&gt;3mm).</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Actinic Keratosis / Solar keratosis</td>
<td>Topical treatment with Solaraze/Efudix. Cryotherapy useful for hyperkeratotic lesions (Single 5-8 second freeze)</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Bowen’s Disease/Intra Epidermal Carcinoma</td>
<td>Topical treatment with Efudix or Cryotherapy (Single 5-8 second freeze). Care on lower limbs as poor healing.</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Skin Tags SMALL</td>
<td>Do not treat for cosmetic reasons. Treatment of problematic lesions only.</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Skin Tags LARGE</td>
<td>Do not treat for cosmetic reasons. Treatment of problematic lesions only.</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Benign Naevi</td>
<td>Do not treat - cosmetic. Treatment of symptomatic lesions only by shave and cautery.</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Pyogenic Granuloma</td>
<td>Bleeding lesions may be treated with curettage and cautery. Always send histology because of amelanotic MM. Warn about curettage scar.</td>
<td>Yes</td>
<td>No</td>
<td>Adults: No Children: Yes</td>
</tr>
<tr>
<td>Spider Naevi/Vascular Angiomata/Campbell de Morgan spots</td>
<td>Do not treat for cosmetic reasons.</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Solar Comedones/Giant Comedones</td>
<td>Do not treat for cosmetic reasons. Incise roof of lesion and express contents if small. Larger lesions (&gt;5mm) need formal excision if symptomatic.</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Solar Lentigines</td>
<td>Do not treat - cosmetic.</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Melasma/Cholasma</td>
<td>Do not treat - cosmetic. Advise stopping hormone treatment (if</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Condition</td>
<td>Treatment Options</td>
<td>Yes</td>
<td>No</td>
<td>Referal Needed</td>
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<tr>
<td>Keratin Horn</td>
<td>Curettage. Always send histology. Referral to dermatology if SCC* a possibility.</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Keratoacanthoma</td>
<td>Curretage and cautery (may need excision) histology essential. Referral to dermatology if SCC a possibility.</td>
<td>No</td>
<td>Yes (if confident in diagnosis)</td>
<td>Yes (under 2 week rule if concern re SCC)</td>
</tr>
<tr>
<td>Epidermoid/Pilar Cysts</td>
<td>Do not remove for cosmetic reasons. Excise symptomatic lesions or if history of repeated infection.</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Dermatofibroma Histiocytoma</td>
<td>Do not treat - cosmetic. Only if painful or very irritating.</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Lipomata</td>
<td>Do not treat - cosmetic. Excise if symptomatic or causing secondary symptoms. Large lipomata may need surgical secondary care referral (&gt;5cm).</td>
<td>No</td>
<td>Yes</td>
<td>Yes (if &gt;5cm)</td>
</tr>
<tr>
<td>Naevus Sebaceous</td>
<td>Excise because of long-term risk malignancy children &gt; 12 years. Refer to dermatology.</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Congenital Naevi</td>
<td>Do not treat for cosmetic reasons. Refer to dermatology.</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Basal Cell Carcinoma</td>
<td>Refer to dermatology *should not be removed under DES unless gp is linked to a local specialist skin cancer group</td>
<td>No</td>
<td>* No</td>
<td>Yes</td>
</tr>
<tr>
<td>Benign Apocrine Eccrine Tumours</td>
<td>Refer dermatology – high local recurrence rate after surgery</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Lentigo Maligna</td>
<td>Refer dermatology</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Squamous Cell Carcinoma</td>
<td>Refer Dermatology 2-Week Rule</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Malignant Melanoma</td>
<td>Refer Dermatology 2-Week Rule</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>