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GPC

General Practitioners
Committee

Minor surgery in general practice

Guidance from the

General Practitioners Committee

and

The Royal College of General Practitioners

in collaboration with

The Royal College of Surgeons of England

The Royal College of Surgeons of Edinburgh

British Society for Dermatological Surgery

and the

Joint Committee on Postgraduate Training for General Practice

Introduction

This guidance has been drawn up by the Royal College of General Practitioners and the General Practitioners Committee in collaboration with the Royal College of Surgeons of England, the Royal College of Surgeons of Edinburgh, The British Society for Dermatological Surgery and the Joint Committee on Postgraduate Training for General Practice to ensure an appropriate standard of care for patients undergoing minor surgery in general practice.

Minor surgical operations have been part of general practice for many years. Prior to 1990 and the GP minor surgery scheme around 25% of GPs carried out minor surgical procedures in their practices. Since then many more GPs have provided minor surgery services to their patients, and around 75% are on minor surgery lists.

Since 1 April 1990 general practitioners on HA minor surgery lists have been able to receive payment for undertaking a range of minor surgery procedures on their patients. Individual health authorities (HAs) and health boards through their lay general managers, with professional advice, have the responsibility for determining whether a general practitioner may be admitted to their minor surgery list and thereby undertake, and be paid for, minor surgery as part of their NHS contract.

We are, however, concerned to provide advice about appropriate standards of care for all patients in general practice. This advice therefore applies not only in respect of entry to a minor surgery list, but also to all those carrying out this work, including general practitioners in private practice.

Training

(a) Workshops/courses

Many general practitioners will wish to undertake training either because they have not previously performed this work or to refresh themselves about new ideas and techniques. Doctors undergoing vocational training for general practice will wish to be equipped to undertake minor surgery in practice. We believe that regional advisers in general practice should review the provision of workshops/courses in their regions and ensure that such courses are available within a reasonable distance.

The content of these courses is recommended in this document. They should normally be approved by regional advisers in general practice (postgraduate deans in Scotland) for the postgraduate education allowance after consultation with the relevant regional specialist advisers to confirm that contributors to the courses are appropriately qualified.

It is recommended that practical techniques are demonstrated and taught by doctors with a relevant higher diploma or extensive experience in the appropriate techniques and procedures and who are currently carrying out such work in hospital or general practice. Doctors should be approved as teachers of minor surgery, or of a specified range of procedures, by regional postgraduate committees on the advice of the regional adviser in general practice.

Doctors organising courses should be approved as teachers in this field. They may be drawn from primary or hospital care, but should have relevant experience in clinical and teaching skills.

(b) Initial clinical training

As well as attending a course as outlined above, all doctors should have gained supervised clinical experience either in primary or secondary care.

Doctors wishing to be admitted to the HA/health board minor surgery list should attend a minimum of three practical sessions with approved teachers, covering the necessary range of procedures. A statement of satisfactory performance should be obtained after each session.

Some doctors may not wish to be on the minor surgery list but nevertheless may wish to carry out a limited range of procedures on the minor surgery list eg joint injections or excision of skin lesions. We recommend that in addition to going on a course such doctors should attend a practical session with an approved teacher in their particular area of interest.

Possible exemption

There will be doctors who have experience in all the relevant fields of minor surgery in general practice and the regional adviser should recommend approval for minor surgery where he/she is satisfied sufficient satisfactory experience has been acquired. Experience gained in minor surgery techniques, prior to the introduction of this guidance, should be taken into account.

(c) Extended supervised experience

Some practitioners may wish to gain further experience through attachments to more experienced general practitioners or through attachments to consultant specialist colleagues. Such education is to be encouraged and should also be considered by regional advisers in general practice for recognition for the PGEA as part of continuing medical education.

Content of courses/workshops

Courses should consist of a minimum of two full days (or part-time equivalent). A practical component is essential, incorporating the use of simulated tissue.

Courses should cover the following broad areas (see appendix 1 for full details of recommended content).

Background

Premises and equipment
Rules, regulations and the HA
Medico-legal (including consent, contingency plans and record-keeping)
Audit
Patient consent

Clinical Principles

Basic surgical technique (including instruments, sutures, needles and suturing)
Approach to skin lesions (including pigmented lesions), diagnosis and treatment
Joint and periarticular injections
Diagnosis and treatment of cysts, lipomas, ingrowing toenails
Varicose vein injections
Miscellaneous surgical techniques
Local anaesthesia

Infection control (including sterilisation of instruments etc)
Resuscitation (emphasising the need to maintain skills)
Anatomical problems and pitfalls

Practical Techniques

Basic surgical technique (including suturing)
Dermatological techniques (curettage, cryosurgery, shave excision, diathermy/cautery etc (1)
Joint and periarticular injections
Surgical treatment of lumps, ingrowing toenails, varicose vein injections and miscellaneous surgical techniques
Local anaesthesia

Details of the number of suitable courses and the numbers of general practitioners attending them should be made available, through postgraduate deans, GP tutors and the annual reports of regional advisers in general practice.

Accreditation

It is important that consistent standards apply throughout the United Kingdom. We would, therefore, expect that experience and training sufficient for accreditation by an HA or health board would be acceptable for accreditation in another locality and that consistent standards would also apply in respect of facilities, premises and equipment. We recommend that accreditation should be for periods of not more than 5 years. Reaccreditation will normally be granted, so long as the doctor has maintained appropriate standards.

1. Satisfactory experience

In future it is desirable that the necessary training should be provided during vocational training for general practice to allow the individual doctor to apply for admission to the minor surgery list.

Confirmation of what is required educationally in individual cases should be determined by the regional adviser in general practice and the appropriate regional specialist advisers.

2. Resuscitation

Doctors on the minor surgery list, as for other areas of clinical practice, should be competent in resuscitation and have a responsibility for ensuring that their skills are regularly updated.

3. Satisfactory facilities

HAs and health boards have to be satisfied that doctors on the minor surgery list have such facilities, including premises and equipment, as are necessary to enable them properly to provide minor surgery services. (2)

Appropriate medical advice to the HA or health board should take the form of a report by an appropriate professional body operating by peer review, for example, representatives of the regional general practice education committee.

Maintenance of standards

Doctors on the minor surgery list should demonstrate a continuing sustained level of activity, conduct audit data and take part in appropriate educational activities.

Where a health authority believes a doctor on the minor surgery list is not delivering an adequate level of service it should set up a review group. This group which should consist of three doctors should represent those with appropriate expertise in minor surgery both in general and specialist care.

Clinical practice

Range of procedures

Criteria for payment under the scheme include a list of procedures which HAs and health boards can accept as minor surgery for the purposes of the contract. These guidelines are solely related to the performance of procedures included in the minor surgery list. It is, however, for individual general practitioners to decide for themselves what they are clinically competent to undertake, though it is likely that the vast majority of the work done will be among the examples listed.

Equipment

Adequate and appropriate equipment should be available for the doctor to undertake the procedures chosen, including facilities for cardiopulmonary resuscitation.

Premises

A suitably furnished clean room is perfectly satisfactory for performing minor surgery in general practice. Results depend on the skill of the doctor, the efficiency of the sterilisation, and the adequacy of nursing support. General practitioners may wish to consult other general practitioners with experience in minor surgery and colleagues in dermatology, surgery or accident and emergency for advice about suitability of premises. In addition, the Department of Health has issued guidance on premises (2).

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 United Kingdom Central Council (UKCC) guidelines on the scope of professional practice (5).

Sterilisation and infection control

Satisfactory arrangements include any of the following:

1. Bench top autoclave
2. Sterile packs from the local CSSD
3. Disposable sterile instruments.

General practitioners are responsible for the effective operation and maintenance of sterilising equipment in their practices. We recommend that there is a regular service agreement with the supplier or other qualified persons.

Practices must have infection control policies including handling of used instruments, excised specimens and disposal of clinical waste. (3)

Advice on the content of infection control policies can be obtained from local consultants in communicable disease control.

In addition, general practitioners should be aware of HSC 2000/032 on decontamination of medical devices. Whilst concerns are recognised about the resource implications for general practitioners and the possible impact on minor surgery, the NHSE has confirmed that health authorities have been working with general practitioners, using tools developed for the NHS to assess current performance.

If any general practitioners are concerned about the standard of decontamination they are providing, then they should get in touch with their health authorities in the first instance and discuss the options open to them - one of which would be to cease local processing of instruments. Moreover, if general practitioners are convinced that their existing arrangements represent a danger to their patients, they should cease undertaking minor surgery until such time as suitable arrangements for decontamination/sterilisation are in place. (6)

Viral transmission

Patients' safety must be safeguarded by ensuring the health status of the general practitioner and relevant staff with particular reference to immunity to Hepatitis B. The UK advisory panel for healthcare workers with bloodborne viruses (UKAP) have recommended that some minor surgical procedures, including the excision of lipomata and sebaceous cysts, may be exposure prone procedures. Therefore, all those who may perform such procedures must comply with health service guidelines on Hepatitis B. (4)

Pathology

All tissue removed by minor surgery should be sent for histological examination. Each specimen must be separately identified. Occasionally malignant lesions will be encountered which were not diagnosed clinically.

There should be a written procedure in the practice which ensures that pathology reports are seen by the general practitioner operator (and by the patient's own general practitioner if different), and that any necessary action is taken, ideally within two weeks of the operation.

Audit

Full records of all procedures should be maintained in such a way that aggregated data and details of individual patients are readily accessible. This should apply whether records are kept manually or electronically.

General practitioners should audit minor surgery list work at regular intervals. This audit should include an element of peer review by conducting it in collaboration with a local specialist or GP colleague working in the same field and with audit groups. Reviews of this work could examine patient satisfaction and compare preoperative diagnosis with the histology reports where relevant. Any complications arising from the surgical procedure should be recorded. Other suitable topics for audit include: clinical outcomes, rates of infection and unexpected or incomplete excision of basal cell tumours or malignant pigmented lesions.

Further advice

For day-to-day matters and for all questions about the recognition of courses in minor surgery the regional advisers in general practice should be consulted.

Review

These guidelines will be reviewed from time to time in the light of experience.

References

(1) Guidelines for surgical management of common skin conditions in general practice. December 1994. British Society for Dermatological Surgery, British Association of Dermatologists, 19 Fitzroy Square, London W1P 5HQ.

(2) Health building note 46, general medical practice premises; building note 22, accident and emergency departments. Department of Health.

(3) BMA code of practice for sterilisation of instruments and control of cross infection. 1989 BMA.

(4) (a) HSG(93)40: Protecting health care workers and patients from Hepatitis B.

(b) AIDS/HIV infected health care workers: Guidance on the management of health care workers.

(5) Scope of professional practice. United Kingdom central council for nursing, midwifery and health visiting.

(6) Health service circular 2000/032, decontamination of medical devices, October 2000. Department of Health.

APPENDIX 1

Synopsis of minor surgery courses

ADMINISTRATION

HA/HEALTH BOARD

RULES & REGULATIONS

MINOR SURGERY LIST

Accreditation and reapproval

CLAIM PROCEDURE

Structure of claim system

Eligibility, numbers per month

Money

Payment for cases, claimable expenses

FACILITIES

PREMISES AND EQUIPMENT

Room, light, table, instruments, other equipment

STAFF

RECORD KEEPING

CLINICAL REQUIREMENTS

HA/HEALTH BOARD REQUIREMENTS

AUDIT

REQUIREMENT

AUDIT CYCLE

Constructive self criticism and regular review

AUDIT

Activity, outcome, postoperative complications, malignancy etc

MEDICOLEGAL MATTERS

DUTIES AND RESPONSIBILITIES

INFORMED CONSENT

Written vs verbal; adults & children

HISTOLOGY

RECORD KEEPING

Legible, contemporaneous, meticulous

COMMON PROBLEMS

AVOIDING PITFALLS

INFECTION CONTROL

GENERAL

NORMAL BODY DEFENCES

DISINFECTION/STERILIZATION

STERILIZATION

METHODS AND RELATIVE MERITS

Benchtop autoclave, CSSD, disposable instruments, hot air sterilisers

SKIN CLEANSING

HEALTH & SAFETY

REGULATIONS

INFECTION CONTROL POLICY

Patients, staff

HIV, HEPATITIS

Policy for needlestick injuries, spillages, sharps disposal

COSHH

BASIC SURGICAL TECHNIQUE

HISTOLOGY POLICY - *SEND EVERYTHING!*

PLANNING A PROCEDURE

AIM OF PROCEDURE, EXPLANATION TO PATIENT, CONTINGENCY PLANS

ANATOMICAL HAZARDS & PITFALLS

PROBLEMS

Scarring, keloid, damage to structures, blood supply

DANGER AREAS - AND WHY

Face, neck, knee, wrist, axilla, joints, others

DESIGNING & MAKING AN INCISION

LINES OF TENSION & CREASES

SKIN TENSION & BLOOD SUPPLY

PRACTICAL PROCEDURE

INSTRUMENTS

MANIPULATING INSTRUMENTS

RECOMMENDED INSTRUMENTS

Essential, desirable

SUTURES

ABSORBABLE/NONABSORBABLE; NATURAL/SYNTHETIC

NEEDLES

ROUND BODIED AND CUTTING

TYING KNOTS

REEF & GRANNY KNOTS, TYING TECHNIQUES, PITFALLS

SUTURING

INTERRUPTED AND SUBCUTICULAR

LOCAL ANAESTHESIA

AGENTS

TYPES

Lignocaine, others

DOSAGE, PREPARATIONS & CONCENTRATIONS

ADRENALINE - PROS AND CONS

INDICATIONS & CONTRAINDICATIONS

BLOCKS

LOCAL INFILTRATION & FIELD BLOCK

REGIONAL BLOCKS (INCLUDING RING BLOCKS)

PROBLEMS

GENERAL

Overdosage, anaphylaxis, allergy to local anaesthesia, other medical conditions

LOCAL

Failure to work, dangers of end arteries

RESUSCITATION

RESPONSIBILITY TO MAINTAIN SKILLS

REQUIREMENTS

Facilities, equipment, staff training

CLINICAL

Recognition, action, new guidelines

CYSTS, LIPOMAS & ABSCESSES

EPIDERMOID CYSTS

PATHOLOGY, SITES, TECHNIQUES FOR REMOVAL, PROBLEMS

LIPOMAS

PATHOLOGY, SITES, TECHNIQUES FOR REMOVAL, PROBLEMS

ABSCESSES

PATHOLOGY, SITES, PROBLEMS

MISCELLANEOUS

HYDROCOELES
HORMONE REPLACEMENT IMPLANTS
OTHERS

APPROACH TO THE PIGMENTED LESION

PIGMENTED LESIONS

BENIGN AND MALIGNANT
WHY PATIENTS PRESENT

MALIGNANT MELANOMA

INCIDENCE
TYPES
CLINICAL
- Major and minor features

DIFFERENTIAL DIAGNOSIS
MANAGEMENT
UNEXPECTED MALIGNANCY

DERMATOLOGICAL SURGERY

DIAGNOSIS BEFORE TREATMENT

DIFFERENTIAL DIAGNOSIS
COMMON SKIN LESIONS

TECHNIQUES

CURETTAGE, CRYOSURGERY, ELECTROCAUTERY, SHAVE EXCISION, SNIPPPING

WHAT TO AVOID

TREATMENT WITHOUT DIAGNOSIS, SKIN MALIGNANCIES, INAPPROPRIATE PROCEDURES, UNNECESSARY PROCEDURES, BIOPSY OF RASHES

VARICOSE VEINS & INGROWING TOENAILS

VARICOSE VEINS

REVIEW OF SURGICAL ANATOMY
VEINS SUITABLE FOR INJECTION
PATIENTS SUITABLE FOR INJECTION
- Indications, contraindications, investigations

TECHNIQUE
- Sclerosant, injection technique, bandaging, instructions after procedure

COMPLICATIONS

INGROWING TOENAILS

REVIEW OF SURGICAL ANATOMY
POSSIBLE TREATMENTS
- Indications, contraindications

LOCAL ANAESTHESIA

OPERATIVE TECHNIQUE
POST-OPERATIVE PROBLEMS

JOINT & PERIARTICULAR INJECTIONS

CLINICAL CONDITIONS

SHOULDER

Impingement syndromes, adhesive capsulitis, bicipital tendonitis, others

ELBOW

Epicondylitis

WRIST & HAND

De Quervains, carpal tunnel syndrome, trigger finger

KNEE

JOINTS

EXAMINATION TECHNIQUE

JOINTS

Shoulder, elbow, wrist & hand, knee, others

INJECTION

BACKGROUND

Indications, drugs, frequency of injection, complications

TECHNIQUE

Injection technique, asepsis, complications