NHS
Somerset
Clinical Commissioning Group

Service Specification No.	11X-03
Service	Minor Injuries
Commissioner Lead	Sheryl Vincent, Commissioning Manager
Provider Lead	
Period	1 April 2018- 31 March 2019
Date of Review	TBC

1. Population Needs

1.1 National/local context and evidence base

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	✓
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	✓
Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

2.2 Local defined outcomes

Not applicable

3. Scope

Aims and objectives of service

3.1 This enhanced service recognises the need for a consistent approach to rewarding General Practitioners (GPs) equitably for providing minor injury services within their own provider where alternative services are not available.

3.2 This service will be commissioned in the context of reforming emergency care services and reducing pressure on Accident and Emergency departments. For the majority of areas minor injuries services are provided from Minor Injury Units (MIUs) at Community Hospitals.

3.3 Injuries and wounds over 48 hours old should usually be dealt with through normal primary care services as should any lesion of a non-traumatic origin. By definition such cases are usually the self-presenting "walking wounded" and ambulance cases are not usually accepted except by individual prior agreement between the doctor and the attending ambulance personnel. Patients treated under this service would generally be those that would be referred to another provider in the absence of this service.

Service description/care pathway

SERVICE OUTLINE

3.4 This enhanced service will fund:

- initial triage including immediately necessary clinical action to staunch haemorrhage and prevent further exacerbation of the injury
- history taking, relevant clinical examination, documentation
- wound assessment to ascertain suitability for locally based treatment and immediate wound dressing and toilet where indicated
- appropriate and timely referral and/or follow up arrangements. This should include advice on prevention including referral to falls service where appropriate
- adequate facilities including premises and equipment, as are necessary to enable the proper provision of minor injury services including facilities for cardiopulmonary resuscitation
- registered nurses to provide care and support to patients undergoing minor injury services
- maintenance of infection control standards, to include use of single use instruments where the skin has been broken
- transmission of all tissue removed by minor surgery for histological examination where appropriate
- maintenance of records of all procedures
- **audit** at regular intervals
- any complications arising from any procedure should be recorded
- other topics for audit include clinical outcomes, rates of infection, patient satisfaction and unexpected or incomplete excision of basal cell tumours or malignant pigmented lesions. This should be completed in addition to the Minor Surgery enhanced service audit where that service is provided
- **child protection** - in any suspected case of non-accidental injury in a child the Somerset Safeguarding Children's Board guidance should be followed.

CONSENT

3.5 In each case the patient should be fully informed of the treatment options, risks and the treatment proposed.

3.6 Where the patient treated is under 18 years of age, The Fraser guidelines or competencies should be considered in addition to the need to seek parental consent. These relate to the child's competency to understand and be able to give informed consent and should be used to determine whether the child's consent is sufficient or whether parental consent is needed. The other aspect of the Fraser guidelines is whether the health professional considers it to be in the child's best interests to have the treatment.

3.7 If Providers have a specific query with regard to consent further guidance can be sought from the Somerset CCG Caldicott Guardian (Director of Quality, Safety and Governance).

3.8 National guidelines suggest that written consent should be obtained from patients. The Somerset CCG wishes the Providers to note that their interpretation of 'written consent' in this context is the recording of consent by Read Code. Where the provider Read Codes consent given, the Somerset CCG will take this to mean that the patient has been fully informed of the treatment options and risks, has been offered written information and has given consent.

3.9 Somerset CCG would expect that there would be exceptions to this interpretation in certain circumstances (for example if a patient was not competent or appeared uncertain) and or for certain procedures, where actual written consent would be required. It would be for the individual clinician to make the judgement as to what could be deemed necessary, this should be influenced by when risks of dissatisfaction are higher, for example where incisions where scarring is visible.

3.10 Providers must ensure valid consent is obtained from the patient in accordance with the provider's local consent policy. For guidance on developing a consent policy providers should refer to the current Department of Health Guidance.

3.11 The indication for surgery should be recorded, alongside advice given with regard to possible adverse outcomes, this may obviate the need to provide written information mentioned above. However, where risk of dissatisfaction is higher, clinicians should consider this carefully.

PROCEDURES INCLUDED

3.12 The following list gives guidance on the types of injuries and circumstances that lead to the use of Minor Injury Services and is not comprehensive:

- lacerations capable of closure by simple techniques (stripping, gluing, suturing)
- minor dislocations of phalanges
- removal of foreign bodies from ears, noses etc. (see exclusions below)
- non-penetrating superficial ocular foreign bodies
- following blows to the head where there has been no loss of consciousness
- recent (under 48 hours) minor eye injury
- partial thickness thermal burns or scalds involving broken skin
- not over 1 inch diameter
- not involving the hands, feet, face, neck, genital areas
- foreign bodies superficially embedded in tissues
- minor trauma to hands, limbs or feet where it is suspected that there is a strain or sprain

3.13 Any patient presenting with a wound or injury over 48 hours old should be treated as part of routine primary medical services.

PROCEDURES/INJURIES NOT INCLUDED

3.14 Patients in The following categories are not appropriate for treatment by the Minor Injury Service these should be referred on to the appropriate destination:

- 999 call (unless attending crew speak directly to the doctor)
- any patient who cannot be discharged home after treatment
- any patient with airway, breathing, circulatory or neurological compromise (unless known to the practice and management plan in place)
- actual or suspected overdose
- accidental ingestion, poisoning, fume or smoke inhalation

- blows to the head with loss of consciousness or extremes of age
- sudden collapse or fall in a public place
- penetrating eye injury
- chemical, biological, or radioactive contamination injured patients
- full thickness burns
- burns caused by electric shock
- partial thickness burns over 3cm diameter or involving:
    - injuries to organs of special sense
    - injuries to the face, neck, hands, feet or genitalia
- new or unexpected bleeding from any body orifice if profuse
- foreign bodies impacted in bodily orifices, especially in children
- foreign bodies deeply embedded in tissues
- trauma to hands, limbs or feet substantially affecting function
- penetrating injuries to the head, torso, abdomen
- lacerating/penetrating injuries involving nerve, artery or tendon damage

3.15 Patients in the following categories are not appropriate for treatment by the Minor Injury Service these should be treated under routine primary medical services:

- injuries not amenable to simple domestic first aid
- injuries that have occurred over 48 hours prior to the consultation
- referrals to other services where appropriate
- patients requiring immediate and necessary treatment

TRAINING/ACCREDITATION

3.16 Doctors providing minor injury services would be expected to:

- have current minor surgery experience, or
- have recent accident and emergency experience, or
- have equivalent training which satisfies relevant appraisal and revalidation procedures

3.17 Doctors carrying out minor injury services should have annual basic life support training and be competent in resuscitation and, as for other areas of clinical practice, have a responsibility for ensuring that their skills are regularly updated. Evidence of this training and updating will be required as part of the annual review process.

3.18 Doctors carrying out minor injury activity should demonstrate a continuing sustained level of activity, conduct audit data and take part in appropriate educational activities.

3.19 Nurses assisting in providing this service should be appropriately trained and competent taking into consideration their professional accountability and the Nursing and Midwifery

Council (NMC) guideline on the scope of professional practice. This will include training associated with anaphylaxis and basic life support as a minimum.

INFECTION CONTROL

3.20 Providers must have infection control policies that are compliant with national guidelines, which include:

- disposal of clinical waste
- needle stick incidents
- environmental cleanliness, and
- standard precautions, including hand washing.

MONITORING AND AUDIT

3.21 Each consultation should be recorded in the patient's lifelong medical record using the agreed codes (see codes below).

3.22 Where the patient is known to have attended Accident and Emergency following the minor injury consultation, a record of this should be made – the Provider should determine whether this episode should have been counted as an immediate and necessary treatment rather than a minor injury.

3.23 The Provider should provide an annual audit which should provide information on case mix, outcome and potentially identifying when there were the highest levels of demand.

3.24 Information regarding the number of consultations should be recorded on the enhanced services quarterly monitoring return.

3.25 Codes (need to ensure that the searches can run independently of minor surgery enhanced service):

8923	Consent for procedure
9879	Incision
987A	Excision
7G20	Suturing (head or neck)
7G21	Suturing (other site)
81H	Dressing
SG0..	Foreign body removal (external eye)
72743	Foreign body removal (eye)
7G23	Foreign body removal (general)
SH..	Burns
S5..	Sprains/strains (location to be noted in text or subset of codes such as S51.. - S57..)
SD82	Minor eye injury
S6460	Minor head injury
58z-3	Laceration
8H..	Recommended to attend other service (location to be noted in text or subset of codes such as 8HC.. or 8H2.. to be used)

SIGNIFICANT/ADVERSE EVENTS

3.26 The Department of Health emphasizes the importance of collected incidents nationally to ensure that lessons are learned across the NHS. A proactive approach to the prevention of

recurrence is fundamental to making improvements in patient safety.

3.27 The Provider should be aware of the various reporting systems such as:

- the National Patient Safety Agency National Reporting and Learning System
- the Medicines and Healthcare products Regulatory Agency reporting systems for adverse reactions to medication (yellow card system), and accidents involving medical devices, and
- the legal obligation to report certain incidents to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

3.28 In addition to any regulatory requirements the Somerset CCG wishes the Provider to use a Significant Event Audit system (agreed with the Somerset CCG) to facilitate the dissemination of learning, minimising risk and improving patient care and safety.

3.29 In addition to their statutory obligations, the Provider will give notification, within 72 hours of the information becoming known to him/her, of all emergency admissions or deaths of any patient treated by the Provider under this enhanced service, where such admission or death is or may be due to the Providers treatment of the relevant underlying medical condition covered by this specification. Notifications are to be sent to the Director of Quality, Safety and Governance with a copy to the Primary Care Commissioning Manager for the specific locality.

3.30 Incidence of post-operative Methicillin-Resistant Staphylococcus Aureus (MRSA) and/or Clostridium difficile infection should be regarded as an adverse incident and as such be reported to the Somerset CCG Infection Control Team and the individual clinician with peri-operative responsibility.

PRICING

3.31 The Somerset CCG will agree with the provider the basis on which the enhanced service will be funded in light of the procedures to be carried out and the volume to be carried out, including setting an upper cap. This should be reviewed by the Somerset CCG and the provider when the provider is approaching the number of procedures set by the upper cap. The Somerset CCG may wish to consider the impact that the provider's service provision is having on the reduction of demand on other services.

3.32 In most instances the cost of drugs, dressings and appliances used in providing this service will be claimable by the FP10.

PAYMENT

3.33 The payment for the retainer will be made pro rata on a monthly basis with the activity paid after the end of the financial year as part of the reconciliation process for the enhanced services.

PATIENT AND PUBLIC INVOLVEMENT

3.34 The service will conform to professional and legal requirements especially clinical guidelines and standards of good practice issued by the National Institute for Clinical Excellence (NICE) and professional regulatory bodies, and legislation prohibiting discrimination. It is anticipated that for the majority of enhanced services translated information will be available via the Department of Health. If a patient wishes to communicate via a language that is not covered via these leaflets please let the Somerset CCG Equality and Diversity Lead know and use the commissioned interpretation and translation service (Applied Language Solutions3) to facilitate the consultation and provision of information to the patient. Use of the interpretation/translation service should be recorded in the patient's lifelong medical record including confirmation of the first language of the patient.

3.35 Practices should encourage, consider and report any patient feedback (positive and negative) on the service that they provide and use it to improve the care provided to patients, particularly if there are plans to alter the way a service is delivered or accessed.

3.36 Population covered

3.37 Any acceptance and exclusion criteria and thresholds

Not applicable

3.38 Interdependence with other services/providers

Not applicable

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The Health Act 2006: Code of Practice for the Prevention and Control of Healthcare Associated Infections. The Stationary Office, 2006.

Department of Health (England) Guidance on Consent for Examination or Treatment

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

Not applicable

4.3 Applicable local standards

Not applicable

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

5.2 **Applicable CQUIN goals (See Schedule 4 Part E)**

6. Location of Provider Premises

6.1 The Provider's Premises are located at:

As defined in Schedule 5 Part A of the Contract Particulars

7. Individual Service User Placement

Not applicable