Phase 1 - Development

Service Guidance and Standards for Mohs Micrographic Surgery (MMS)

Issue Date:

Review Date:
Preface

Assessment of performance against accredited standards provides the incentive and warrant to help to drive continuous improvement in the quality of services. *Standards for Better Health (2006)* demand a rigorous approach to assessment and accreditation of providers of National Health Service (NHS) services. Lord Darzi’s *High Quality Care for All: NHS Next Stage Review (2008)* confirms Government support for provider accreditation schemes in the NHS.

This guidance was developed in accordance with the methods outlined in the NICE Service Guidelines for producing accredited standards. The methodology for core service standards have taken into consideration existing NICE clinical guideline. Key factors identified in our evidence review which underpin the service provision of a Mohs surgery service are as follows:

- The National Cancer Peer Review Programme[^1] either explicitly or by implication, effectively specifies six levels of care, differing in the degree of specialisation and service consolidation needed. These requirements are incorporated into the Network referral guidelines and Network infrastructure for Skin Cancer, set out in the Skin Cancer measures[^1];

- Mohs Micrographic Surgery (MMS) is designated under Level 5 Care and must be carried out by core members of the hospitals specialist skin cancer multidisciplinary team (SSMDT);

- The Strategic Clinical Network (SCN) Director is responsible for naming and authorising those designated MMS hospital practitioners for the network;

- MMS is a specialised service commissioned and funded by NHS England as set out by Regulation in the Manual. The specialised service specifications for skin cancer clearly define what NHS England expects to be in place for providers to offer evidence-based, safe and effective services[^2];

- Trusts are advised to log details about those patients on a local registry when specialist diagnosis (ICD10) and treatments (OPCS) such as MMS are provided. Patients can be removed once specialist management is no longer required so this can be used as a reference point for commissioning data flows[^3] and payment.

In May 2014 the British Association of Dermatologists (BAD) invited a range of professionals and patient representatives to form a multidisciplinary Working Party Group (WPG). The British Society of Dermatological Surgery (BSDS) President-Elect was nominated as Chair of the WPG.

The remit of this WPG is to provide a multi-professional consensus for measurable standards for MMS service provision in the UK. The members were selected from around the UK and from a variety of units for their expertise in Mohs surgery and skin cancer as well as from a range of specialties that are important for supporting a MMS service.

Statement of Our Service Standards:

1. Written service standards covering patient referral, information, consent, treatment and discharge.

2. All staff involved with MMS will have undergone appropriate training and will maintain an up-to-date portfolio of continuing professional development.

3. Treatment options and outcomes will be safe and effective for patients. We will monitor, update and validate our service standards to ensure these conform to best outcomes of practice.

4. MMS equipment will be well maintained and routinely checked for reliability, safety and compliance with regulatory standards.

5. The MMS unit will provide a safe and patient-centred environment, with responsive clinical monitoring and feedback.

In order to achieve these core outcomes each Service Standard has set criteria which will need to be demonstrated through self-assessment and audit. This is expected to be a dynamic process which allows service improvement areas to be identified by departments and prioritised within their health organisation.
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Aims

The core aims of our national MMS service standards are:

- To agree and set acceptable standards for MMS which ensure safe, appropriate and consistent services are provided to skin cancer patients;
- To quality assure MMS practice;
- To quality assure MMS service provision.

Purpose

These multidisciplinary service guidelines for MMS are designed to provide a set of required service standards which harmonise with existing NICE guidelines for skin cancer and the Quality Surveillance Team (QST) (formerly National Peer Review Programme and Skin Measures 2014). This document forms the basis of a quality assurance programme for MMS services and identifies the standards which support the delivery of care to patients receiving MMS.

All service standards areas are supported by clinical governance frameworks within secondary and tertiary care health organisations.

Scope

It is important for MMS service standards to reflect the issues which determine the experience of the person undergoing skin cancer treatment. For this reason, the standards follow the patient pathway and attempt to capture the multidisciplinary aspects of the way the MMS services should be delivered. As far as possible, standards are written from the perspective of the individual experiencing MMS treatment and the need for patient safety.

We recognise that services are under increased pressure to demonstrate that they comply with national policies and guidelines. For this reason, our standards incorporate requirements and recommendations already set out nationally for UK services and are aligned with:

- NICE guidance – IOG 2006 and update 2010 – Wales, England, Northern Ireland and SIGN adapted by Scotland;
- The Quality Surveillance Team (QST) (formerly National Cancer Peer Review Programme and Skin Measures 2014);
- Cancer Alliance and formerly Clinical Strategic Networks (Cancer) Pathology and Clinical
Management Guidelines;

• NHS Improvement Specialised Services PbR tariffs for Mohs

It is important that the standards aim to explain the service infrastructure required for delivering an effective, safe and high-quality MMS service. Where a service standard is affected by an existing Quality Surveillance peer review measure, this will be reflected in the audit outcomes. This should support the Quality Surveillance peer review process for MMS.
Introduction

The following standards include the rationale and demonstrable essential criteria which are applied within a NICE accredited service standards framework.

These standards clearly define the minimum expectations for achieving a safe, effective and high-quality MMS service. Self-assessment and audit outcomes are used by MMS services to assess their performance against the standards. Clinicians who carry out MMS are also bound by the standards set by their respective professional bodies in relation to practice and revalidation.

Definitions

Standard

A standard is something considered by an authority or by general consensus as a basis of comparison in measuring or judging adequacy or quality. These standards have been developed by a multi-professional group set up by the BAD to carry out this work.

The criteria defined under each standard are something which services must adhere to as an overriding duty of principle in order to meet the accredited standard. They provide the basis for evaluating the overarching quality of service and will evolve over time.

Evidence/Minimum requirements

The evidence requirements are intended to be well-defined and easy to understand. They must be met to satisfy each accredited standard. Many of the evidence requirements relate to national policy and guidelines.

Examples of suitable evidence

Examples of suitable evidence are provided for each standard and should be collected to demonstrate these requirements have been met. The defined evidence in the next section illustrates the types of information required to demonstrate compliance with a standard. This is not intended to be either prescriptive or exhaustive. Service providers may provide what they consider the most convincing evidence available for their achievement of each standard, whether or not it appears among the examples.

Self-Assessment

Self-Assessment against these accredited standards will be a voluntary and cyclical process. This process provides independent self-validation that a service has demonstrated competence measured against the standards and is considered to be fit for purpose. It drives continuous improvement by allowing services to identify areas for improvement and take the necessary remedial action(s).
Who is this guidance for?

These service standards are integral to providing safe and effective care for patients, measuring quality outcomes and effectively managing service performance and governance.

They help to:

- Ensure that new and existing services are set up in a way that will ensure patient safety and optimal treatment;
- Clarify expectations for patients, clinicians, management, commissioners and NHS employees;
- Drive service improvement and development;
- Contribute to better clinical monitoring and quality outcomes.

Service standards are developed primarily for all commissioners of NHS services and service providers (NHS and private practice). They only address those clinical interventions that are likely to have implications for the configuration of services such as skin cancer.

They also reinforce governance and accountability by making service provision transparent and increase patient confidence by demonstrating commitment to service excellence. This will also ensure commissioners of NHS services procure services from appropriately qualified providers.

These standards and required suitable evidence are intended to apply to all MMS services provided in the UK.

The standards are to be reviewed on a 3-yearly basis to reflect any changes to NICE Guidelines, Quality Surveillance Peer Review and NHS England Cancer Outcome and performance requirements.

What approach have we taken to develop this guidance?

This guidance was developed in accordance with the methods outlined in the NICE Accredited Service Guidelines for achieving their kite mark. The methodology for developing service standards is underpinned and informed by an evidence review which includes The National Cancer Peer Review Programme1 and Skin Measures 2014. In achieving our objective for UK wide service standards for MMS this is an important and critical factor to consider, in order to avoid destabilisation of established service frameworks for patients.

Each service standard is supported by the available evidence and expert clinical judgment of the WPG. The MMS service standards have been piloted on a number of nominated SSMDT hospital sites using a self-assessment and audit process. Evidence and feedback gathered as
part of this exercise was submitted for review by the WPG. The finalised service standards have been scrutinised and approved by the British Association of Dermatologists and representatives from the British Association of Plastic, Reconstructive and Aesthetic Surgeons, British Association of Oral and Maxillofacial Surgeons, the British Oculoplastic Surgery Society and the Royal College of Pathologists.

A formal consultation period then occurred where all SSMDT Mohs service providers and reciprocal LSMDT services were invited to comment on the Mohs service standards. Comments were collected using a standard proforma. These were reviewed at the end of the consultation period by the WPG and necessary changes made to the service standard before dual publication on the BAD website and NICE evidence database.
The Standards Framework

MMS is ideally suited to the management of complex skin cancers and where the confirmation of complete clearance is paramount prior to reconstruction: where complex is defined as high risk pathology within a high risk anatomical site.

High risk non-melanoma skin cancers (NMSCs) include:

- Recurrent and incompletely excised tumours following previous treatment including prior radiotherapy;
- When the cancer is large (often more than 2cm);
- If the edges of the cancer are poorly defined (the clinician should aim to visualise with good illumination and magnification);
- Specific histological features associated with local recurrence e.g. micronodular, morphoeic/infiltrative, perineural, perivascular invasion;
- Cancers in immunosuppressed patients.

High risk sites include those where preservation of healthy tissue is important for maintenance of function and physical appearance:

- Cancers in facial anatomical sites (H-Zone) e.g. eyelids, medial canthus, nasal tip and ala, preauricular area, ears, lips where preserving healthy tissue is critical to maintaining a person’s skin function and physical appearance;
- Thumb and fingers;
- Genitalia.

Alternative management strategies may be suitable dependent on individual patient factors. As with any treatment, patient selection for Mohs surgery is important. MDTs should take account of the patient’s views, preferences and circumstances when considering their advice on the care that is most appropriate for an individual.
The Self-Assessment Process

There are examples of good practice already in Mohs services across the UK. However, delivering a service which meets all 'essential criteria' defined under each standard requires a long-term programme of change. Service providers will require additional support and tools for evaluating their performance and areas for improvement.

Therefore, each service standard’s ‘essential criteria’ is supported by a range of documentary evidence and auditable outcomes. The main source of evidence for auditing essential criteria is obtained from patient case notes (paper based or electronically). As a minimum, 20 cases should be selected for this purpose along with the collation of core evidence for each standard. Some of the activities to be undertaken by SSMDTs will include:

- Activity data review on referral to treatment start times;
- Staff and patient/carer and unit/manager questionnaires;
- A service user feedback;
- A review of case notes;
- An audit of treatment, with relevant documentation of equipment and facilities.

Self-Audit and Reporting

The data and evidence collected during self-assessment against the Mohs service standards should be used to complete the MMS Service Self Audit Form. The audit outcomes are contained within each standard and outline the level required to meet essential criteria. The following flag status system is used to identify each essential criteria and areas of most risk and should be applied to the self-audit outcomes report.

For Example:

<table>
<thead>
<tr>
<th>Essential Criteria</th>
<th>Comments</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Red Flag</td>
</tr>
</tbody>
</table>

Red Flag [Action Required]: failure to meet these standards places undue clinical risk on patients, breaches their rights or dignity and/or may result in litigation;

Yellow Flag [Monitoring Required]: service standards that a service would be expected to meet;

Green Flag [No Action Required]: meets service standard essential criteria

Given the variation to current service provision, providers implementing MMS service standards have a grace period (12 months) to identify shortfalls in their service provision. This enables the SSMDT to review their local practices against the accredited Mohs service standards and, if necessary, implement the changes required. A summary of the results from the self-assessment and audit would form the basis of a business case for any identified areas of service improvement.
The NICE accredited Mohs standards should be referenced in all service specifications for specialised Skin Cancer Services and inform performance measures in the NHS Standard Service contract. The self-assessment process and audit outcomes will provide evidence of performance against these required standards for Peer Review teams, Trust Boards, Healthwatch, local council service users and commissioners.
STANDARD 1: Referral and Patient Assessment

Standard Statement 1A– Referrals

**Rationale**

Any GP practitioner who identifies a skin cancer patient with specific needs such as treatment using Mohs surgery can refer the case directly to the SSMDT. A core member of a local skin cancer multidisciplinary team (LSMDT) may also choose to refer a patient case straight to the SSMDT without prior discussion by the LSMDT, the case being reviewed locally in retrospect after being passed on.

It should be understood and expected that any case referred by an LSMDT to an SSMDT for discussion, may be taken on for treatment by the SSMDT without further permission from the referrers.

These are areas for agreement in the local Network clinical guidelines.

**Essential Criteria**

1A.1 The Network Group should name those hospital practitioners which the network authorises as the only practitioners to carry out the procedure known as Mohs surgery, for the network. This includes the procedure known as 'Slow or paraffin section Mohs surgery (11-1C-111j). Paraffin section Mohs surgery employs the same tissue mapping principles and horizontal sections as standard frozen Mohs surgery but is used when rapid paraffin sections are deemed essential for higher tissue quality.

1A.2 Agree the referral arrangements between the LSMDTs and SSMDTs across the Network Group.

1A.3 Agree with specialist commissioners the location of the MMS service for the SSMDT population.

**Examples of Suitable Evidence**

- SSMDT Network clinical guidelines for basal cell carcinomas (BCCs) and Squamous Cell Carcinomas (SCCs).
- Referral management guidelines for MMS services.

**Audit Outcomes**

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4 Skin cancer measure 2014 - last paragraph: page 21
5 Skin cancer measure 2014 - first two points: page 25
6 Strategic Clinical Networks should have a clinical network group who agree and produce network wide pathways and guidelines for the treatment of skin cancer to improve the quality of care and outcomes.
Audit of referrals using an agreed minimum dataset (for example - [http://www.bsds.org.uk/resources/bsds-policy-documents](http://www.bsds.org.uk/resources/bsds-policy-documents)).

### Standard Statement 1B – Patient Assessment

#### Rationale

Patients considered for MMS are referred with histology to the SSMDT, by their GP or LSMDT. They are given a consultation appointment with the MMS surgeon for their pre-operative assessment and biopsy if not previously undertaken. All patients being considered for Mohs surgery should be added the SSMDT list for discussion.

#### Essential Criteria

| 1B.1 | A locally agreed minimum dataset of information about complex skin tumour patients to be considered for MMS (should be collated and summarised prior to MDT meetings wherever possible) – which should include diagnostic and relevant clinical information (for example histology and co-morbidities). |

#### Examples of Suitable Evidence

- MMS activity data for 6 months and MDT case lists with outcomes.
- Agreed minimum dataset of information for Mohs patient.

#### Audit Outcomes

- 100% of Mohs patients are listed on SSMDT Case lists - with complex cases flagged up for discussion.
- Percentage of patients with complex skin cancers referred for Mohs surgery and percentage subsequently treated by Mohs surgery are stated annually.
## STANDARD 2: Patient Information and Consent

### Standards Statement 2A- Provision of Written Patient Information

#### Rationale

The MDT should provide written /electronic material for patients and carers which includes:

- Information specific to the Mohs surgical services provided by the SSMDT for its locality;
- Information specific to the group of cancers which can be treated by Mohs surgery and other treatment options (including names and functions/roles of the team treating them);
- Information about patient involvement groups and patient self-help groups;
- Information about the services offering psychological, social and spiritual/cultural support, if available; It is recommended that patients are given the opportunity to talk to other patients who have had Mohs surgery;
- Information about services available to support the effects of living with cancer and dealing with its emotional effects.

It is recommended that the information and its delivery to patients and carers follow the principles of the NHS Information Prescription project ([www.informationprescription.info](http://www.informationprescription.info)) (11-2J-124).

#### Essential Criteria

<table>
<thead>
<tr>
<th>2A.1</th>
<th>All patients should have access to a Cancer Nurse Specialist (CNS).</th>
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<tbody>
<tr>
<td>2A.2</td>
<td>All patients should be provided with written patient information leaflets to discuss potential risks and benefits of Mohs surgery.</td>
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<tr>
<td>2A.3</td>
<td>Patients should be seen in a multidisciplinary clinic for a preoperative consultation by the Mohs surgeon and reconstructive surgeon when joint surgical care is required. Information on both stages of surgery should be provided to the patient.</td>
</tr>
</tbody>
</table>

#### Examples of Suitable Evidence

- Pre and post-operative information provided to patients in letters and or leaflets.
- Evidence of local skin cancer support group.
- Macmillan or other information resources on skin cancer care.

#### Audit Outcomes

- >95% written evidence of consent in case note reviews.
- >95% of patients have had the opportunity to see written patient information material (as part of consent process).
### Standard Statement 2B - Patient Experience Exercise

#### Rationale

Each skin cancer MDT should have undertaken or be undertaking an exercise during the previous two years prior to review or completed self-assessment to obtain feedback on patients’ experience of the MMS services offered.

The exercise should at least ascertain whether patients were offered:

- Opportunity to see a key worker, who may be the MDT CNS;
- The MDTs information for patients and carers (written or otherwise);
- The opportunity of a permanent record or summary of a consultation at which their treatment options were discussed;
- Functional and cosmetic outcome assessment at least 3 months post-surgery (part of MMS minimum dataset).

#### Essential Criteria

| 2B.1 | The exercise may consist of a survey, questionnaire, focus group or other method, and use prospectively captured data when possible e.g. 3-month outcomes. |

#### Examples of Suitable Evidence

- The exercise should have been presented and discussed at an MDT meeting and the team should have implemented relevant action points from previous exercise.

#### Audit Outcomes

- The results (complete or in progress) of the exercise.
- A report for the action taken.

### Standard Statement 2C - Two- (or more) -Stage Patient Consent

#### Rationale

Patients receiving elective treatment for which written consent is appropriate should be familiar with the contents of their consent form **before** they arrive for the actual procedure and should have received a copy of the page documenting the decision-making process. They may be invited to sign the form, confirming that they wish treatment to go ahead, at any appropriate point before the procedure: in out-patients, at a pre-admission clinic, or when they arrive for treatment. If a form is signed before patients arrive for treatment, a member of the healthcare team **must** check again with the patient at this point whether they have any further concerns and whether their condition has changed.

#### Essential Criteria

| 2C.1 | The patient’s medical records or a consent form must be used to record the key elements of any clinical discussion with the patient. This should include the information discussed, any specific requests by the patient, any written, visual or audio information given to the patient, and details of any decisions that were made. |

<p>| 2C.2 | The GMC guidance states that the task of seeking consent may be delegated to another person, as long as they are suitably trained and qualified. In particular, they must have sufficient knowledge of the proposed investigation or treatment, and understand the risks involved, in order to be able to provide any information the patient may require. |</p>
<table>
<thead>
<tr>
<th>2C.3</th>
<th>Organisations must create standardised documentation for patients undergoing invasive procedures that promotes the sharing of patient information between individuals and teams at points of handover and forms a record for future reference.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Examples of Suitable Evidence</strong></td>
<td>Patient information leaflets (PILs), advocacy services, expert patient programmes, or patient support groups (PSGs) for people with specific conditions (see the British Association of Dermatologist’s (BAD) PILs and list of PSGs or advise the patient to contact their local health watch team).</td>
</tr>
<tr>
<td><strong>Audit Outcomes</strong></td>
<td></td>
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</table>
STANDARD 3: Staff Training, Education and Competency

Standard Statement 3A
All health care professionals providing MMS must be specialty specific trained to be competent in undertaking the duties for which they have been employed. Professional development must be ongoing and include internal and external multidisciplinary education.

Rationale
MMS services require staff to have specialist training, knowledge and clinical skills appropriate to the role they are undertaking to support the Mohs surgeon. Staff must be assessed as being competent and safe in order to provide treatments that maximise benefit and minimise the potentially serious adverse effects of therapies.

Nursing staff should be qualified and registered with the Nursing and Midwifery Council (NMC), and Health Care Assistants (HCAs) should be trained, supported and recognised by appropriate bodies.

Essential Criteria
3A.1 Mohs surgeon should regularly undertake a caseload that is sufficient to maintain and develop their Mohs resectional surgery skills, Mohs pathology interpretation and reconstructive options, whilst running a high-quality Mohs laboratory to support this.

3A.2 An individual Mohs surgeon will undertake a minimum of 2 PAs (programmed activities) of Mohs surgery or pro-rata if part time. Irrespective of PA number, each named practitioner should have performed a total of at least 50 complete Mohs surgical procedures per year averaged over the last two complete calendar years prior to the networks peer review visit or completed self-assessment.

3A.3 Laboratory staff should be compliant with national standards. Mohs laboratory biomedical scientists will be either dedicated or be one of a small team of biomedical scientists who regularly cut Mohs sections and complete a sufficient number in order to maintain a high technical expertise in preparing Mohs sections.

Examples of Suitable Evidence
- The Mohs surgeon’s job plan.
- Record of attendance at relevant conferences and courses.
- Evidence of training/ continuing professional development such as certification by the Institute of Biomedical Scientists.
- Record of cases treated.

Audit Outcomes
- Audit of job plans within a Unit.
- For each individual Mohs surgeon an audit from the minimum dataset including number of cases per year, case mix of patients, number of stages of MMS surgery, and outcomes post-surgery.
### STANDARD 4: Clinical Management & Monitoring

#### Standard Statement 4A – Pathology

#### Rationale

Mohs surgeons should understand the process involved in producing high quality frozen section Mohs specimens and be able to supervise, train and direct the technicians within the Mohs laboratory.

The Mohs surgeon will read their own slides and mark the Mohs map. They should have access to second opinions on interpretations of slides with a Mohs surgery trained colleague and / or dermatopathologists when necessary.

The SSMDT should agree network-wide pathology guidelines for the diagnosis of skin cancer.

The guidelines should address:
- Laboratory and histopathology/histochemical investigations;
- Their specific indications.

#### Essential Criteria

<table>
<thead>
<tr>
<th>4A.1</th>
<th>Mohs surgery notes should be available to be submitted with microscope slides for third party audit / evaluation. A Mohs map signed by the Mohs surgeon should be part of the patient record.</th>
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<tr>
<td>4A.2</td>
<td>A diagnostic specimen of the tumour should be analysed pre-operatively or the debulk sent during surgery. If there are any discrepancies, residual tissue from the Mohs surgery blocks should be fixed for further evaluation as deemed necessary.</td>
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<tr>
<td>4A.3</td>
<td>The Mohs surgery laboratory should be accredited by the UK accreditation body.</td>
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</table>

#### Examples of Suitable Evidence

- SSMDT Agreed Pathology Guidelines for Diagnosis and Assessment.

#### Audit Outcomes

Audit of second cold reading of Mohs slides. Assessment of a random sample of Mohs cases with a minimum of 10% per annum or 25 (whichever is greater) to be agreed with local dermatopathologist or Mohs surgeon not involved with the cases. At least 95% concordance is expected.

100% of cases should have diagnostic pathology available either pre-operatively or as the debulk specimen sent during surgery.
## Standard Statement 4B – Clinical Results

### Rationale

An agreed minimum dataset for Mohs (example in Appendix 2) will record patient demographics, date of Mohs procedure, tumour diagnosis, diagnostic biopsy pre-Mohs where available, indications for Mohs procedure, anatomical site, number of stages and number of blocks to clearance, stain used for sections, tumour and defect sizes, method of reconstruction.

<table>
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<tr>
<th>Essential Criteria</th>
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<tr>
<td><strong>4B.1</strong></td>
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<tr>
<td><strong>4B.2</strong></td>
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<tr>
<td><strong>4B.3</strong></td>
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### Examples of Suitable Evidence

- Standardised methods for recording incidents such as DATIX.

### Audit Outcomes

- Record of audit of the Mohs surgeon interpreted slides.
- Departmental annual audit unit of minimum dataset parameters.

## Standard Statement 4C – National Safety Standards for Invasive Procedures (NatSSIPs)

### Rationale

Standardised documentation for invasive procedures performed in all areas within an organisation must ensure the recording of essential information throughout the patient pathway, to include pre-procedural assessment and planning, the conduct of anaesthesia or sedation, the invasive procedure itself and post-procedural care.

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<tr>
<th>Essential Criteria</th>
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<tr>
<td><strong>4B.1</strong></td>
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<tr>
<td><strong>4B.2</strong></td>
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</table>

### Examples of Suitable Evidence

- Local Safety Standards for Invasive Procedures (LocSSIPs) created by multiprofessional clinical teams and their patients.
<table>
<thead>
<tr>
<th>Record of WHO Surgical Safety Checklist in patient cases.</th>
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<tr>
<td>Register of never events such as wrong site surgery.</td>
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</table>

**Audit Outcomes**

- Evidence of action plans incorporating timescales for addressing non-compliance
- Evidence of regular review of LocSSIPs and their adjustment, as required.

### Standard Statement 4C – Recording Mohs Surgical Activity

#### Rationale

As Mohs surgery usually requires multiple procedures the recording of activity undertaken on a patient at the time of their treatment is essential to provide an accurate record of their care. Failure to record a diagnosis, co-morbidities and the number of procedures by the Mohs surgeon in NHS England affects the payment the department receives for this specialised service from NHS England. All procedures in NHS England should be recorded using the procedure codes below, as set by monitor. An example of a Mohs coding form is provided in Appendix 2 to assist departments.

#### Essential Criteria

4C.1 The following clinical activities must be recorded for all patient undergoing Mohs surgery (regardless of where the surgery takes place) for payment by NHS England.

**New Consultation (pre-assessment with histology provided by referrer) – Mohs Surgeon**

- WF01B First Attendance - Single Professional

**Or**

**New Consultation (pre-assessment with no histology) – Mohs Surgeon**

Prior to the initiation of Mohs surgery, a biopsy specimen is obtained to establish diagnosis.

- Biopsy of lesion of skin of head or neck – S151
- Biopsy of lesion of skin NEC - S152

Where the diagnosis is clinically obvious and Mohs surgery has been scheduled without a prior biopsy, debulking of surgical site during the first Mohs surgery layer is carried out. This would be assessed as part of the frozen section analysis, however should also be sent for paraffin (formalin-fixed) section pathologic evaluation in lieu of a prior biopsy.

- Mohs excision of skin of head or neck - S051
- Mohs excision of lesion of skin -S052

**Or**

**New Consultation (pre-assessment with histology) – Multidisciplinary (Mohs surgeon and reconstructive surgeon)**

- WF02B First Attendance - Multi Professional
Patients case with histology is listed on SSMDT case list for review/discussion at next available meeting. Patient is booked for day case surgery and their treatment recorded as follows:

- Primary Diagnosis (ICD10) code along with any existing co-morbidities which affect the patient’s treatment
- Mohs Primary Procedure (OPCS) codes along with the site code of the lesion, surgical closure, suture, and dressing.

Please refer to Appendix 2 Mohs coding form which contains the required primary diagnosis and primary procedure codes for recording Mohs surgery in a dermatology service.

- WF01A Follow Up Attendance(s) - Single Professional

<table>
<thead>
<tr>
<th>4C.2</th>
<th>Agree protocols for recording the Mohs procedure with the Hospitals coding team.</th>
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<tbody>
<tr>
<td>4C.3</td>
<td>Regularly review Mohs activity data for the department to ensure accuracy of clinical information before charges are made to NHS England.</td>
</tr>
</tbody>
</table>

**Examples of Suitable Evidence**
- Mohs clinical coding form with site location, co-morbidities and procedures.
- Patient case notes with procedures recorded.

**Audit Outcomes**
- >95% accuracy of recorded procedures and co-morbidities of patients undergoing Mohs surgery.
STANDARD 5: Equipment and Facilities

<table>
<thead>
<tr>
<th>Standard Statement 5A - Safety and Compliance</th>
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<tr>
<td><strong>Rationale</strong></td>
</tr>
<tr>
<td>The facility for Mohs surgery will usually consist of two or more procedure rooms with all the necessary equipment for Mohs cases of all complexities and including access to appropriate surgical beds and recovery areas, electrosurgical equipment and surgical instruments for peri-ocular, aural and fingertip tumours.</td>
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<tr>
<td>A Mohs laboratory is a dedicated and co-located room in the same unit, equipped with several critical pieces of equipment including a high quality microscope, a low-temperature cryostat microtome, cell stainers using volatile solvents, and heat plates. Liquid nitrogen is often used to freeze tissue blocks. There should be monitoring of cryostat temperature with relevant documentation.</td>
</tr>
<tr>
<td><strong>Essential Criteria</strong></td>
</tr>
<tr>
<td>5A.1 The Mohs laboratory will have access to at least one backup cryostat on site, along with staining facilities (manual and / or automated) for Haematoxylin &amp; Eosin and / or Toluidine Blue staining of Mohs sections.</td>
</tr>
<tr>
<td>5A.2 All drugs and other chemicals used in the MMS unit must have a COSHH assessment and be stored in a secure place.</td>
</tr>
<tr>
<td>5A.3 The protection of the MMS Unit staff is necessary to comply with safety standards. Protective clothing including scrubs, gloves, eye protection and cryo-protective clothing must be used where required. All entrances to treatment areas must have appropriate warning signs and hazard labels.</td>
</tr>
<tr>
<td>5A.4 Designated waiting areas for Mohs surgery patients should be provided. Patients should have access to a bed or reclinable chair between stages if required.</td>
</tr>
<tr>
<td>5A.5 Resuscitation equipment must be available.</td>
</tr>
<tr>
<td><strong>Examples of Suitable Evidence</strong></td>
</tr>
<tr>
<td>Formal written risk assessments of the Mohs unit must be carried out at least annually.</td>
</tr>
<tr>
<td>Current COSHH assessment of risks from exposure to liquid nitrogen and cell staining solvents, where used.</td>
</tr>
<tr>
<td><strong>Audit Outcomes</strong></td>
</tr>
<tr>
<td>Audit of key pieces of equipment. To comply with UK accreditation scheme (UKAS) standards and local governance.</td>
</tr>
</tbody>
</table>
MMS services should operate within the departmental clinical governance process. It is recommended as a minimum a clinical governance framework for a MMS service should include a named MMS lead clinician. The role of the lead clinician is to take clinical responsibility for ensuring that the service is safe, effective and complies with:

- National service delivery standards;
- Treatment-specific guidelines;
- Disease specific guidelines.

The MMS service is delivered by a multi-professional team. Members of the team and their roles in contributing to the service should be recorded. Team members would typically include the following: Mohs surgeons in the unit; lead laboratory technician; Mohs surgical nurse; +/- trainee grade for any of the above.

### Essential Criteria

<table>
<thead>
<tr>
<th>6A.1</th>
<th>The MMS team should have regular team meetings. The broad aim of these meetings is to ensure that the service is focused on the need to provide timely, safe and effective MMS services to local patients.</th>
</tr>
</thead>
</table>
| 6A.2 | The agenda for these regular MMS clinical governance meetings should include the following elements:  
Review of MMS activity since the previous meeting (in other words, summary of treatment numbers for each clinician).  
Review of MMS waiting list data (if a waiting list exists) to assess demands on the service and issues for service delivery.  
Review of adverse events. All adverse events should be discussed by the team. Where patient safety is an issue, the team need to consider the cause of the adverse event, and measures to be taken if necessary to avoid a repeat in the future.  
Discussion of difficult or instructive cases. As with any clinical therapy service, there may be some cases that are atypical or unusual. Discussion of these cases is often instructive for team members and may improve patient outcomes. |

### Examples of Suitable Evidence

As above.

### Audit Outcomes

- Record of at least 3 team meetings per year.
- Record of DATIX data.
- Summary of MMS governance meetings reported to the SSMDT.
Appendix 1

Types of high-risk pathology tumours which may be treatable by MMS

NMSCs constitute a substantial burden to the national health services across the UK because of the large number of cases diagnosed each year; however, NMSC incidence figures are under-estimates because the recording of NMSC is known to be incomplete.\(^8\)

Many cancer registries record only the first NMSC of each histological type (e.g. BCC or squamous cell carcinoma (SCC)) per person, and information on small NMSCs treated in primary care or the private sector may never reach the registries.\(^9\) An estimated 30-50%\(^{10,11}\) of BCC and around 30%\(^12\) of SCC goes unrecorded, though this may vary by registry.\(^13\)

Non-melanoma skin cancers (NMSCs) are extremely common, but relatively few deaths are caused by them. In 2011, there were 102,628 cases of NMSC registered in the UK: 57,800 (56%) in men and 44,828 (44%) in women, and 585 deaths.\(^14\)

There are two main subtypes of non-melanoma skin cancer: BCC and SCC. There are also a number of rarer skin cancers which are often treated with Mohs Surgery, including dermatofibrosarcoma protuberans (DFSP), lentigo maligna, sebaceous carcinoma, atypical fibroxanthoma (AFX) and microcystic adnexal carcinoma (MAC).

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\(^8\) National Cancer Intelligence Network (NCIN) Data Briefing, The Importance of Skin Cancer Registration. London: NCIN; 2010.


\(^14\) ONS. Mortality Statistics: Deaths Registered in England and Wales (Series DR), 2011
BCC

The majority of NMSCs are BCCs, making up 74% \(^{15}\). BCCs are the commonest type of cancer in the UK, placing a significant burden on NHS resources.\(^{16}\)

BCCs rarely metastasise and are unlikely to be fatal, although if untreated the tumours can become destructive and cause disfigurement.\(^{17}\) The recorded incidence of BCCs increased by around a third (36% in males and 32% in females) between 2000-2002 and 2008-2010 in England, Scotland, Northern Ireland and Ireland combined.\(^{15}\)

Whilst improved registration may partly explain these increases, some of the increase is probably genuine, reflecting increased UV exposure from the sun or sunbeds.\(^{15}\) MMS has been shown to achieve excellent long-term cure rates for basal cell carcinoma. MMS should be considered for BCCs with ill-defined margins and / or aggressive histology (e.g. micronodular, morphoeic, infiltrative or perineural involvement) and should be the preferred treatment if associated with a high risk site.\(^{18,19}\)

As per the NICE IOG, Mohs surgery should also be considered for recurrent and large, high risk BCCs located at surgically complex regions of the face.

SCC

Cutaneous SCC accounts for around 23% of NMSC\(^{15}\) and can spread beyond the skin and therefore lead to death.\(^{20}\) SCC incidence increased by a similar amount to BCC (34% in males and 39% in females) over the same time period.\(^{15}\) As with BCC, sun exposure is a major risk factor. Systematic reviews of large numbers of studies show that MMS has high cure rates compared to other treatment modalities, and whilst surgery with a predefined excision margin is the treatment of choice for most cutaneous SCCs, MMS is recommended for higher risk tumours in cosmetically sensitive sites.\(^{20}\)

\(^{15}\) National Cancer Intelligence Network (NCIN). Non-melanoma skin cancer in England, Scotland, Northern Ireland, and Ireland. London: NCIN; 2013


\(^{19}\) Madan V, Lear JT, Zeimies RM. Non-melanoma skin cancer. Lancet. 2010;375(9715):673-85

**Lentigo Maligna**

Lentigo maligna is an in-situ form of melanoma and about 1 in 10 melanomas (10%) are of this type. Lentigo maligna is most common in elderly people and related to sun exposure. It tends to appear as a pigmented flat patch, however if it progresses and invades beyond the epidermis (upper layer of the skin) as a lentigo maligna melanoma, it may form lumps (nodules).

The exact percentage of cases that progress to an invasive tumour is unknown, and the lifetime risk has been estimated to be around 5%. Once lentigo maligna melanoma develops, its prognostic features are similar to other forms of invasive melanoma. The standard treatment of lentigo maligna is complete surgical excision of the lesions, but this can be challenging in selected cases due to disease extending beyond what is visible to the naked eye (subclinical spread). The option of adjuvant therapies e.g. radiotherapy, imiquimod mean the management of such cases should be considered by the SSMDT.

**Dermatofibrosarcoma Protuberans**

Dermatofibrosarcoma protuberans is a very rare type of skin cancer with a prevalence of 5-8 per million people. It most commonly affects people in their 20s to 40s with men and women being equally affected. It tends to develop in the deeper layers of the skin (the dermis) and not infrequently invades fat and muscle. Around 8% occur within the head and neck region.

While this type of skin cancer tends to grow slowly, it may be aggressive. However, DFSP rarely spreads to other parts of the body, which gives DFSP a very high survival rate.

Surgical treatment tends to be wide surgical excision with pre-determined margins or alternatively with MMS.

The general prognosis for DFSP is excellent. MMS has been reported to show benefit as the growth pattern of DFSP may not be concentric and therefore microscopically tracing out tumor roots tends to achieve a higher cure. Randomised controlled trial evidence is not available; however, a systematic review in 2012 concluded ‘A weak recommendation is given in favour of MMS or similar surgical techniques with meticulous histologic evaluation of all margins as the first-line therapy for DFSP’. It would seem appropriate to suggest MMS for primary lesions occurring in high risk sites or recurrent lesions.

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21 Cancer Research http://www.cancerresearchuk.org/cancer-help/type/melanoma/about/types-of-melanoma#lentigo


Sebaceous Carcinoma

Sebaceous carcinoma is a very rare type of skin cancer. Of the 3,392 new cases of rare skin cancers registered from 1999-2008 in England, 713 of these were sebaceous carcinoma. The sebaceous glands are the glands that produce our natural skin oils. The most common site is the upper eyelid and 3 out of 4 of these cancers are diagnosed around the eye with the remainder elsewhere on the body. It is more common in elderly people, but sebaceous carcinoma is sometimes found in younger people who have previously had radiotherapy to the face or with a background of Muir-Torre syndrome.

They are often slow growing but in 1 out of every 5 cases spread to another part of the body. Despite the rarity of these tumours there is evidence of MMS being an effective treatment option.

Atypical Fibroxanthoma

Atypical Fibroxanthoma are tumours that usually occur in older people on the skin of the head and neck that has been damaged significantly by sun exposure and/or radiotherapy. It may also occur elsewhere on body and where other skin cancers have been found and treated. AFX occurs equally in men and women. AFXs typically appear as raised, red dome shaped lesions which may be ulcerated. Lesions often grow rapidly, over just a few weeks or months. The term pleomorphic dermal sarcoma is used to describe tumours with similar pathological features but deep subcutaneous invasion.

Diagnosis is made by clinical examination and biopsy. Literature reviews have suggested that MMS may have a higher cure than wide local excision.

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26 Rare Skin Cancer in England: NCIN Data Briefing. NCIN. Nov 2011
Microcystic Adnexal Carcinoma

Microcystic adnexal carcinoma is a rare skin neoplasm. The Surveillance, Epidemiology, and End Results (SEER) database collected between 1973 and 2004 found an incidence rate of 6.5 per 10 million white individuals.\textsuperscript{30} Similar cases might have been previously reported as malignant syringoma. MAC can be clinically and histologically confused with other malignant and benign cutaneous neoplasms, leading to inadequate initial treatment. This neoplasm is locally aggressive and deeply infiltrating, characterised by high morbidity and frequent recurrence. Hence MMS can be beneficial.\textsuperscript{31}

\textsuperscript{30} Surveillance, Epidemiology, and End Results (SEER) Database Analysis of Microcystic Adnexal Carcinoma (Sclerosing Sweat Duct Carcinoma) of the Skin. JB, Blitzblau RC, Patel SC, Decker RH, Wilson LD. Am J Clin Oncol 2010;33:125-7

Appendix 2 Mohs Coding Form

Patient Details: Episode of Care: Inpatient/Day Case

Consultant: Trust Name:

1. **Histology Date:** ……………………… **MDT Date:** ……………………… **Procedure Date:** ………………………

2. **Diagnosis**

<table>
<thead>
<tr>
<th>BCC</th>
<th>DFSP</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCC</td>
<td>Sebaceous Carcinoma</td>
</tr>
<tr>
<td>Lentigo Maligna</td>
<td>Microcystic adnexal carcinoma</td>
</tr>
<tr>
<td>Other: (please specify)</td>
<td></td>
</tr>
</tbody>
</table>

3. **Site/ Side**

<table>
<thead>
<tr>
<th>Eyelid</th>
<th>Canthus</th>
<th>Eyebrow</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cutaneous Lip</td>
<td>Mucosal Lip</td>
<td>External ear</td>
</tr>
<tr>
<td>Nose</td>
<td>Scalp</td>
<td>Male genitalia</td>
</tr>
<tr>
<td>Female genitalia</td>
<td>Trunk and limbs</td>
<td>Digits</td>
</tr>
<tr>
<td>Other Site: (please specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. **Co-Morbidities/Complications:** (Circle presenting conditions at time of treatment)

<table>
<thead>
<tr>
<th>Previous chemo/radiotherapy</th>
<th>Drug Dependency</th>
<th>Alcohol Dependency</th>
<th>Cerebrovascular disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>COPD/COAD</td>
<td>Smoking</td>
<td>Asthma</td>
</tr>
<tr>
<td>Acute/Chronic Renal failure</td>
<td>Chronic liver disease</td>
<td>Immuno-suppressants</td>
<td>Epilepsy</td>
</tr>
<tr>
<td>Parkinson’s Disease</td>
<td>Dementia</td>
<td>Multiple Sclerosis</td>
<td>History of Falls</td>
</tr>
<tr>
<td>Diabetes Type I/II</td>
<td>Bleeding disorders</td>
<td>Long Term Anticoagulation</td>
<td>History of Malignant disease</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>Psychosis</td>
<td>History of self-harm</td>
<td>Other Mental Health problems</td>
</tr>
<tr>
<td>Rheumatoid Arthritis</td>
<td>Dysphasia</td>
<td>Dysphagia</td>
<td>Ischaemic Heart Disease</td>
</tr>
<tr>
<td>----------------------</td>
<td>------------</td>
<td>-----------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Cardiac failure</td>
<td>Sickle Cell disease</td>
<td>Anaemia</td>
<td>Blood disorders</td>
</tr>
<tr>
<td>Immobility</td>
<td>Deaf/Hearing loss</td>
<td>Lives alone</td>
<td>Spinal/Skeletal injury</td>
</tr>
<tr>
<td>Decubitus ulcer</td>
<td>Vasculitis</td>
<td>Chronic ulcer</td>
<td></td>
</tr>
<tr>
<td>Other: (Please specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. **Mohs Procedures:**

- **S051** Microscopically controlled excision of lesion of skin of head or neck using fresh tissue technique (Mohs Surgery head and neck only)
- **S055** Microscopically controlled excision of lesion of skin of head or neck NEC (Slow Mohs head and neck only)
- **S052** Microscopically controlled excision of lesion of skin using fresh tissue technique NEC (Mohs Surgery excludes head and neck)
- **S058** Other specified microscopically controlled excision of lesion of skin (Slow Mohs excludes head and neck)
- **S059** Unspecified microscopically controlled excision of lesion of skin

6. **Reconstruction:** (excludes reconstruction procedure undertaken by a separate reconstructive surgeon)

<table>
<thead>
<tr>
<th>Flap Type</th>
<th>Graft type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local</td>
<td>Pedicle / Axial / Random/sensory</td>
</tr>
<tr>
<td>Distant Flap</td>
<td>Axial / Random</td>
</tr>
<tr>
<td>Flap</td>
<td>Z plasty/ W plasty</td>
</tr>
</tbody>
</table>

**Extent of reconstruction:**

- Skin with sub-cutaneous tissue
- Involving muscle
- Involving fascia
- Involving periosteum/ bone
- Hair bearing flap of skin
- Involving mucosa

7. **Dressing:**

- **S561** Debridement of skin of Head or Neck
- **S573** Toilet of skin NEC
- **S571** Debridement of skin NEC
- **S564** Dressing of skin of head and neck
- **S563** Toilet of skin of head or neck
- **S574** Dressing of skin NEC

8. **Follow-up:**

- Outpatient Appointment
- Advice Sheet
- Onward referral
- Discharge
<table>
<thead>
<tr>
<th>References</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Protection Act 1998</td>
<td></td>
</tr>
<tr>
<td>How to write in Plain English. The Plain English Campaign.</td>
<td></td>
</tr>
<tr>
<td>BAD and BSDS working party report on setting standards for Mohs micrographic surgery services – November 2011</td>
<td></td>
</tr>
<tr>
<td>Improving Outcomes for People with Skin Tumours including Melanoma. NICE Guidance on Cancer Services. IOG. 2006 and update in 2012.</td>
<td></td>
</tr>
<tr>
<td>BAD Guide to Validating Consent: Dermatology Examinations or Treatments (2017)</td>
<td></td>
</tr>
<tr>
<td>National Standards for Invasive Surgical Procedures</td>
<td></td>
</tr>
<tr>
<td>WHO Safer Surgery Checklist</td>
<td></td>
</tr>
<tr>
<td>Statutory Duty of Candour</td>
<td></td>
</tr>
</tbody>
</table>
## Glossary of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFX</td>
<td>Atypical Fibroxanthoma</td>
</tr>
<tr>
<td>BAD</td>
<td>British Association of Dermatologists</td>
</tr>
<tr>
<td>BCC</td>
<td>Basal Cell Carcinoma</td>
</tr>
<tr>
<td>BSDS</td>
<td>British Society for Dermatological Surgery</td>
</tr>
<tr>
<td>CNS</td>
<td>Cancer Nurse Specialist</td>
</tr>
<tr>
<td>DFSP</td>
<td>Dermatofibrosarcoma Protuberans</td>
</tr>
<tr>
<td>IBMS</td>
<td>Institution of Biomedical Science</td>
</tr>
<tr>
<td>LSMDT</td>
<td>Local Skin Cancer Multidisciplinary Team</td>
</tr>
<tr>
<td>MAC</td>
<td>Microcystic Adnexal Carcinoma</td>
</tr>
<tr>
<td>MDT</td>
<td>Multi-Disciplinary Team: all health professionals involved in patient care</td>
</tr>
<tr>
<td>MMS</td>
<td>Mohs Micrographic Surgery</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
</tr>
<tr>
<td>NMC</td>
<td>Nursing and Midwifery Council</td>
</tr>
<tr>
<td>NMSC</td>
<td>Non-Melanoma Skin Cancer</td>
</tr>
<tr>
<td>PA</td>
<td>Programmed Activities</td>
</tr>
<tr>
<td>SCC</td>
<td>Squamous Cell Carcinoma</td>
</tr>
<tr>
<td>SCN</td>
<td>Strategic Clinical Network</td>
</tr>
<tr>
<td>SEER</td>
<td>Surveillance, Epidemiology and End Results</td>
</tr>
<tr>
<td>SSMDT</td>
<td>Specialist Skin Cancer Multidisciplinary Team</td>
</tr>
<tr>
<td>UKAS</td>
<td>United Kingdom Accreditation Scheme</td>
</tr>
<tr>
<td>WPG</td>
<td>Working Party Group</td>
</tr>
</tbody>
</table>
Glossary of Terms

**Accredited specialist**
A UK accredited specialist practising in Mohs Surgery has undertaken a period of structured Mohs training in addition to their CCT, regardless of their specialty.

The training competences for a dermatological Mohs surgeon are outlined in the BAD / BSDS “Setting standards for Mohs micrographic surgery” document. Others Mohs surgical practitioners are eligible to practice following a period of specialist training providing equivalent standards / competencies can be demonstrated.

All individuals practising in the UK are required to revalidate this part of their practice through their Annual Appraisal and with their Regional Officer.

**Audit**
Systematic review of the procedures used for diagnosis, care, treatment and rehabilitation, examining how associated resources are used and investigating the effect care has on the outcome and quality of life for the patient.

**Clinical audit**
Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery (National Institute for Health and Clinical Excellence).

**Clinical governance**
Clinical governance provides a quality framework through which healthcare organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence will flourish.

**Clinical practice guidelines**
Clinical practice guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances. They aim to provide evidence-based interventions to improve patient outcomes.

**Clinical supervision**
Clinical supervision is a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence. Clinical Supervision is central to the process of learning and to the scope of the expansion of practice and should be seen as a means of encouraging self-assessment analytical and reflective skills.
Clinician
A clinician is a professionally qualified person providing clinical care to patients.

Competent
Competent means that the individual can perform the task with ability.

Contract reviews
Contract reviews are periodic evaluations performed by the service provider and the customer to ensure that the agreement specifies all of the customer’s requirements and that all of those requirements are being satisfied.

Data
Data refers to all records and correspondence.

Equality
This means recognising that while people are different and need to be treated as individuals, everyone is the same in terms of having equal value, equal rights as human beings and a need to be treated with dignity and respect.

Fit to practise
The health professional possesses the appropriate knowledge, skills and experience to practise safely and effectively.

Health care
Health care refers to services provided for or in connection with the prevention, diagnosis or treatment of illness, and the promotion and protection of public health.

Multidisciplinary
A multidisciplinary team is a group of people from different disciplines (both healthcare and non-healthcare) who work together to provide care for patients with a particular condition. The composition of multidisciplinary teams will vary according to many factors. These include: the specific condition, the scale of the service being provided, and geographical/socio-economic factors in the local area.

Peer review
Peer review is a structured, consistent and objective evaluation of an organisation or its services or processes reflecting accepted standards. It should be performed by true peers: i.e. similar professionals.

Quality
Quality is used in this document to denote a degree of excellence.

Quality assurance
Quality assurance refers to the planned and systematic activities that gives confidence or make certain that quality requirements for a product or service will be fulfilled.
Research
Research is the gathering of data, information and facts and aims to derive generalisable new knowledge.

Slow Mohs
Slow or paraffin section Mohs represents a staged excision where the margins are processed as rush permanent sections rather than the frozen sections integral to conventional Mohs. Slow Mohs surgery employs the same tissue mapping principles and horizontal sections as standard frozen Mohs surgery but is used when rapid paraffin sections are deemed essential for higher Mohs section quality.

Scope of practice
Scope of practice refers to the areas of a health professional’s occupation where they have the knowledge, skills and experience to practise safely and effectively.

Service level agreement
A service level agreement is a document which specifies the services that will be delivered and the way in which they will be delivered to ensure uniform understanding.

Staff
The entire group of people who work at an organisation including those who are:
• Employed / agency / bank / voluntary;
• Clinical e.g. nurses, doctors and occupational health technicians;
• Non-clinical e.g. administrative staff.
Acknowledgements

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Multidisciplinary Working Party

Dr Raj Mallipedi  WPG Chair
Consultant Dermatologist – Guy’s & St Thomas’ Hospital, London
Immediate Past President – British Society for Dermatological Surgery

Dr Colin Fleming  Consultant Dermatologist – Ninewells Hospital, Dundee

Mr Howard Peach  Consultant Plastic, Reconstructive and Aesthetic Surgeon, Leeds Teaching Hospitals NHS Trust, Chair BAPRAS Skin Cancer Special Interest Group

Pelham Allen  Patient Representative

Mr Rajiv Anand  Consultant Oral and Maxillofacial Surgeon, Portsmouth British Association of Oral and Maxillofacial Surgeons (BAOMFS) representative

Dr Rupert Barry  Consultant Dermatologist – St James’s Hospital, Co Wicklow, Ireland

Dr Andrew Birnie  Consultant Dermatologist – Kent & Canterbury Hospital, South East

Dr Eduardo Calonje  Consultant Dermatopathologist - British Society for Dermatopathology

Dr Olivia Dolan  Consultant Dermatologist – Royal Victoria Hospital, Belfast

Dr Vindy Ghura  Consultant Dermatologist – Salford Royal Hospital, Manchester

Dr Thomas Ha  Consultant Dermatologist – Addenbrooke’s Hospital, Cambridge

Dr Steve Keohane  Consultant Dermatologist – Queen Alexandra Hospital, Portsmouth
Dr James Langtry  Consultant Dermatologist, Royal Victoria Infirmary, Newcastle Upon Tyne

Allison Mendelsohn  Patient representative

Erin Mewton  Clinical Nurse Specialist, Guy’s and St Thomas NHS Foundation Trust

Mr Marc Moncrieff  Consultant Plastic, Reconstructive and Aesthetic Surgeon, Norfolk and Norwich University Hospital, British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS) representative

Dr Guy Orchard  British Society of Mohs Histologists (BSMH) Representative

Dr Catherine Roberts  Consultant Dermatologist – University Hospital of Wales

Miss Julia Sen  Consultant Oculoplastic Surgeon – Worcestershire Acute NHS Trust, British Oculoplastic Surgery Society (BOPSS)

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Dr Graeme Stables  Consultant Dermatologist – Leeds Teaching Hospitals NHS Trust

Mr Hamid Tehrani  Consultant Plastic, Reconstructive and Aesthetic Surgeon – St Helens and Knowsley NHS Trust, British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS) representative

Dr Richard Turner  Consultant Dermatologist – Churchill Hospital, Oxford

Dr Irshad Zaki  Consultant Dermatologist – University Hospitals Birmingham, Solihull Hospital, West Midlands

Tania von Hospenthal  WPG Project Manager, British Association of Dermatologists

Paul Callaghan  Medical Writer, British Association of Dermatologists
**Mohs Micrographic Surgery Standards Consultation Form**

We hope that you have found the MMS standards useful and would very much appreciate your feedback.

Your comments will be incorporated, with the approval of the MMS standards, into future editions of this publication.

1. Have you found these standards useful? Yes/No
   Comments: *Type here*

2. Do you have suggestions for new sections or topic areas you would like to see included in future versions?
   *Type here*

3. Do you have suggestions for new standards you would like to see included in future versions?
   *Type here*

4. Do you have any general suggestions about this document that would improve its usefulness?
   *Type here*

5. What is your profession?
   *Type here*

Thank you for taking the time to complete this form. Your comments will be considered carefully.

Please photocopy and return this form to:

Clinical Services Unit  
British Association of Dermatologists  
Willan House  
4 Fitzroy Square  
London  
W17 5HQ