NHS
Vale of York
Clinical Commissioning Group

Minor Skin Surgery for Skin Lesions Commissioning Policy

Interventions	**Minor Surgery for Skin Lesions**
Policy Criteria	Skin Lesions must meet at least ONE of the following criteria to be removed[3]: • The lesion is unavoidably and significantly traumatised on a regular basis (e.g. causing regular bleeding or recurrent infections). There is repeat infection requiring 2 or more antibiotics per year • The lesion bleeds in the course of normal everyday activity • The lesion is obstructing an orifice or impairing visual access. The lesion significantly impacts on function eg: restricts joint movement • If left untreated, more invasive intervention would be required for removal • Facial viral warts that have not resolved with an appropriate trial of topical treatment. • Facial spider naevi in children causing significant psychological impact
Background	NHS Scarborough and Ryedale CCG and NHS Vale of York CCG are responsible for commissioning activity in secondary care, and this policy sets out the criteria for referral to secondary care for minor surgery, as this is not always routinely commissioned. As well as the lesions specifically detailed in the policy, the policy also applies to the benign lesions listed below[3]: Please note: This list is not exclusive: • Solar comedones • Corn/callous • Dermatofibroma • Milia • Epidermoid & Pilar Cysts (sometimes incorrectly called sebaceous cysts) • Seborrheic keratosis (basal cell papillomata) • Spider naevi (telangiectasia) • Xanthelasmata • Neurofibromata

Commissioning Position	**Treatment of any condition for purely cosmetic reasons is not commissioned**. NHS Scarborough and Ryedale CCG and NHS Vale of York CCG only commission referrals to secondary care dermatology / plastic surgery in the following circumstances: • Where there is diagnostic uncertainty or a possibility of malignancy OR • A lesion has been excised in primary care and a re-excision has been subsequently recommended on clinical grounds by the histopathologist OR • After individual approval by the Individual Funding Request Panel (IFR) The following conditions should always be referred direct to secondary care (dermatology, head and neck surgery or plastic surgery as appropriate) and IFR approval is not required for: • Malignant Melanoma (2 week pathway) • Squamous Cell Carcinoma (SCC) including extensive premalignant changes to the lip (2 week pathway) • Basal Cell Carcinoma (refer as **urgent and not via 2 week pathway. Where possible those <1cm and below the clavicle should be excised *in Primary Care).*** o Removal by accredited GP Minor Surgeon (either in-house or through Practice-to-Practice referral via LES scheme o Remove with 4mm margins, send for histology • Lentigo Maligna • Naevus Sebaceous
Indications	**Criteria for secondary care referral**
Benign Skin Lesions	The removal of benign skin lesions is not routinely commissioned for cosmetic reasons**.** **Where there is diagnostic uncertainty GPs should send three photos, (field, close-up and dermatoscopic) to the Dermatologists for advice on whether the patient needs to be seen in secondary care or whether primary care excision biopsy is appropriate ("permission to biopsy")** Under the Minor Surgery Directed Enhanced Service, GP practices may undertake:

	• Incision and drainage of an abscess requiring local anaesthetic • Excision of sebaceous cysts where there is a history of more than one infection • Incision and Curettage of Meibomian Cysts (as per the Commissioning Statement Click Here) **Referral to Secondary Care services** Indications for referral to an appropriate alternative provider include: • lesions suspicious of being a basal cell carcinoma (BCC) that are > 1cm in size or above the clavicle or squamous cell carcinoma (SCC) and melanomas. • lesions of uncertain significance where a specialist opinion is that primary care treatment is appropriate or a histological diagnosis is required that should be seen and managed by an accredited clinician who has links with the local skin cancer MDT. This would include secondary care dermatologists and also (where commissioned) GPwSIs. • sebaceous cysts where there is a history of one or more episodes of infection and so which would be appropriate for removal under this enhanced service, but where the ○ patient has a history of keloid scarring or hypertrophic scarring and the lesion is in an area where the patient would not want to risk the development of such scarring **OR** ○ where the lesion lies in a position which is not appropriate for removal in primary care e.g. face or centre of spine All other requests must have prior approval through Individual Funding request Panel.
Molluscum contagiosum	Patients need to be managed in primary care. Referral to the dermatology department should only be made if patients have either of the following: • molluscum contagiosum in immunosuppressed patients

	• Diagnostic uncertainty of a solitary lesion. All other requests for referral for secondary care should have prior approval from individual funding request panel. Funding for treatment will not normally be commissioned. Where molluscum contagiosum is causing significant problems in the management of atopic eczema, or other widespread conditions, specialised opinion should be sought in Advice & Guidance attaching clinical photographs.
Viral warts	Children found to have ano-genital warts should be referred to the York 'Child Sexual Assault Assessment Centre' for confirmation of diagnosis. Treatment for Viral Warts is restricted to the minimum eligibility criteria below. This is because most plantar warts can be managed with over the counter topical treatments or by treatments prescribed in Primary Care. Treatment for Viral Warts that do not meet the criteria below are deemed to be cosmetic and will not be funded. Referral to secondary care dermatology should only be made: • for ano-genital warts in adults that have failed treatment in the Primary Care setting or Genito-Urinary (GUM) Clinic • for viral warts in immunosuppressed patients • if there is doubt about the diagnosis and concern about possible malignancy • Facial viral warts that have not resolved with an appropriate trial of topical treatment. Where there are exceptional circumstances, referral should be made to the Individual Funding Request Panel. Viral warts on face where there are physical or mental sequelae should be referred to IFR for funding.
Skin tags (including anal skin tags)	Treatment is not routinely commissioned. Where there is diagnostic uncertainty requesting a specialist opinion by sending photos via Advice and Guidance is recommended. . Where exceptional clinical indications exist (e.g. intractable pruritus ani) then referral to the Individual Funding Request Panel is advised.
Cyst of moll	Not routinely commissioned. Where there is diagnostic uncertainty requesting a specialist opinion by sending photos via Advice and Guidance is recommended.
Cyst of Zeis	Not routinely commissioned. Where there is diagnostic uncertainty requesting a specialist opinion by sending photos via Advice and Guidance is recommended.
Pingueculum	Not routinely commissioned. Where there is diagnostic

	uncertainty requesting a specialist opinion by sending photos via Advice and Guidance is recommended.
Eyelid papillomas and skin tags	Not routinely commissioned. Where there is diagnostic uncertainty requesting an ophthalmologist opinion by sending photos via Advice and Guidance is recommended. See oculoplastic eye problems commissioning statement .
Actinic solar keratosis (AK)	Referral to secondary care for Actinic Keratosis is not expected unless primary care treatments have failed, (guidance on primary care treatment is on the Referral Support Site website under Dermatology). Refer to secondary care for: • severe AK when there may be a possibility of invasive malignancy: these are thicker and harder and may have an infiltrated base refer to secondary care where there is diagnostic uncertainty. • failure of 2 different treatments • Immuno-compromised patients
Pigmented Naevi (moles)	Refer if there is clinical suspicion of malignancy or diagnostic uncertainty.
Lipoma	Surgery is NOT routinely funded for cosmetic reasons and concerns about cosmetic appearance should NOT be referred to secondary care unless there are clinically exceptional circumstances with IFR Panel approval or criteria below are met. Surgery is NOT routinely funded for excision of lipomas of any size that are confirmed as benign (clinically OR radiologically OR histologically following biopsy). Surgery is ONLY funded • for lipomas that impair function such that the impaired function resulting from the lipoma could be harmful, e.g. restricts neck movements, unable to wear a safety helmet, restricting movement of a joint, obstructing an orifice. These examples are not meant to be exhaustive. Referring clinicians and/or surgeons will need to justify the prioritisation of NHS resources for such surgery. OR • where, if left untreated, more invasive intervention would be required for removal. Such cases may require secondary care surgeons opinion. Surgery for excision out with these criteria needs IFR Panel

	approval See detailed clinical guidance, published on the RSS under General Surgery here. Diagnosis is usually clinical **– USS is not routinely required to confirm the diagnosis**. Where there is diagnostic uncertainty patients should be referred for imaging at York Teaching Hospitals Foundation Trust, not Yorkshire Health Solutions or other providers as per the pathway in the clinical guidance.
Summary of evidence / rationale	Minor surgery should only be carried out when clinically necessary and after weighing up the risks and benefits. The use of NHS resources to manage benign cosmetic lesions is not a current priority and expectations of such should be discouraged. The risks of carrying out minor surgery on skin lesions include damage to nerves, haemorrhage, failure to achieve wound closure, wound infection, wound dehiscence, over granulation, incomplete excision rate, unsatisfactory scar formation and distortion to local anatomy[1] A comparison of minor surgery in primary and secondary care carried out in the South of England suggested that the quality of minor surgery carried out in general practice is not quite as high as that carried out in hospital, but patients prefer the convenience of treatment in General Practice. However, there

	may be clear deficiencies in GPs' ability to recognise malignant lesions, and there may be differences in completeness of excision when compared with hospital doctors[2]
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Approved by	Vale of York Executive Committee
Responsible officer	Michelle Carrington, Executive Director of Quality and Nursing

References:

1. Primary Care Dermatology Society - Skin Surgery Guidelines 2007 http://www.pcds.org.uk/images/downloads/skin_surgery_guidelines.pdf
2. S George, et al. (2008) A prospective randomised comparison of minor surgery in primary and secondary care. The MiSTIC trial. Health Technology Assessment 2008; Vol. 12: No. 23. http://www.journalslibrary.nihr.ac.uk/__data/assets/pdf_file/0006/64905/FullReport-hta12230.pdf
3. NHSE/I.(2018) Evidence-Based Interventions: Consultation Document. Available at: https://www.england.nhs.uk/wp-content/uploads/2018/06/04-b-pb-04-07-2018-ebi-consultation-document.pdf. Accessed:18/12/2018