General Commissioning Policy

Treatment	**Minor Surgery**
For the treatment of	**Skin Lesions**
Background	From April 2013, NHS England took over responsibility for commissioning primary care activity and to: • Review current levels of competency (Training needs analysis) • Review and promote RCGP training sessions • Support GPs with ongoing professional development Procedures which practices are deemed competent to undertake include skin biopsy (punch and shave), endometrial sampling, removal of toenails and removal of contraceptive implants. NHS Scarborough and Ryedale CCG is 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.
Commissioning position	Treatment of any condition for purely cosmetic reasons is not commissioned. NHS Scarborough and Ryedale CCG only commissions 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 NHS Scarborough and Ryedale CCG Individual Funding Request Panel (IFR) The following conditions should always be referred direct to secondary care dermatology / plastic surgery (IFR approval not required): • Malignant Melanoma (2 week pathway) • Squamous Cell Carcinoma (SCC) including extensive premalignant changes to the lip (2 week pathway) • Basal Cell Carcinoma (BCC) Benign Apocrine / Eccrine Tumours (not 2 week pathway) • Lentigo Maligna • Naevus Sebaceous

Notes

1. This Policy will be reviewed in the light of new evidence, or guidance from NICE.

Indication	Criteria for secondary care referral
Benign skin lesions	All cysts can be removed where there is diagnostic uncertainty. The removal of benign skin lesions is not routinely commissioned for cosmetic reasons. Under the Minor Surgery Directed Enhanced Service, GP practices may undertake: • incisions of abscesses • for patients experiencing pain, bleeding when shaving, lesions which are infected, lesion catches on clothes Excision of sebaceous cysts where there is a history of recurrent infections (two or more episodes). **Referral to Secondary Care services** Procedures for referral to an appropriate alternative provider include: • lesions suspicious of being a basal cell carcinoma (BCC) or squamous cell carcinoma (SCC) and melanomas. • lesions of uncertain significance where a histological diagnosis is required 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 which would be appropriate for removal under this enhanced service, but where the patient has a history of keloid scarring or hypertrophic scarring • sebaceous cysts which would be appropriate for removal under this enhanced service, but 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 dept should only be made if patients have either of the following: • molluscum contagiosum in immunosuppressed patients OR • molluscum contagiosum causing significant problems in the management of atopic eczema All other requests for referral for secondary care should have prior approval from individual funding request Panel. Funding should not be routinely commissioned for cosmetic reasons.

Viral warts	Patients should be managed in Primary Care. Referral to dermatology dept should only be made for: • viral warts on face – any age • viral warts in immunosuppressed patients • if there is doubt about the diagnosis and concern about possible malignancy (e.g. a solitary lesion in a sun-exposed site in a patient over the age of 40) **Prior to referral** Referral of patients with hand warts and plantar warts should only be made if patients have had initial treatment in primary care or the community (e.g. podiatrist) and have failed to respond to treatment (unless the referral criteria above apply). Where there are exceptional circumstances, referral should be made to the Individual Funding Request Panel.
Skin tags (including anal skin tags)	Will not be routinely commissioned. Where exceptional clinical indications exist (e.g. intractable pruritus ani) then referral to the Individual Funding Request Panel is advised. This does not restrict referral to secondary care for a surgical opinion where there is diagnostic uncertainty.
Cyst of moll	Not routinely commissioned. Referral for diagnostic uncertainty.
Cyst of Zeis	Not routinely commissioned. Referral for diagnostic uncertainty.
Pingueculum	Not routinely commissioned. Referral for diagnostic uncertainty.
Eyelid papillomas and skin tags	Not routinely commissioned. Referral for diagnostic uncertainty only.
Actinic solar keratosis (AK)	No referral to secondary care for mild AK – guidelines for treatment are available on map of medicine. Referral for severe AK when there may be a possibility of invasive malignancy: these are thicker and harder and may have an infiltrated base.
Pigmented Naevi (moles)	Refer if there is clinical suspicion of malignancy or uncertainty.
Lipoma	Not routinely commissioned. Referral for diagnostic uncertainty.
Summary of evidence / rationale	Minor surgery should only be carried out when clinically necessary and after weighing up the risks and benefits. 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 (ref 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 (ref 2).

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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. A Guide to Dermatology (v15) (HEYHT) http://www.hey.nhs.uk/herpc/guidelines/dermatologyAGuideTo.pdf