NHS
Cheshire and Merseyside

Clinical Commissioning Policy

CMICB_Clin103
Scars, surgical revision
Category 2 Intervention - Only routinely commissioned when specific criteria are met

Contents

Last Reviewed: May 2025
This policy statement will be reviewed 5 years from the date of the last review unless new evidence or technology is available sooner.

1. Policy statement

1.1 Most scars will flatten and fade with time.

1.2 Surgery carries the risk of making the scar worse and the chance of re-occurrence is high.

1.3 Surgical scar revision will only be commissioned as part of a reconstruction process post trauma or cancer treatment.

1.4 All other surgical scar revisions will not routinely be commissioned unless the following conditions are satisfied:

- 2 years have elapsed since surgery to allow completion of natural flattening/fading.

AND

- The scar is causing severe functional difficulties or pain which interfere with activities of daily living.

2. Exclusions

2.1 Surgical scar revision will only be commissioned as part of a reconstruction process post trauma or cancer treatment (see above).

Other related policies –
Treatment (laser or chemical peels) for scarring
Acne Vulgaris – secondary care treatment

3. Core Eligibility Criteria

3.1 There are several circumstances where a patient may meet a 'core eligibility criterion' which means they are eligible to be referred for this procedure or treatment, regardless of whether they meet the policy statement criteria, or the procedure or treatment is not routinely commissioned.

3.2 These core clinical eligibility criteria are as follows:

- Any patient who needs 'urgent' treatment will always be treated.
- All NICE Technology Appraisals Guidance (TAG), for patients that meet all the eligible criteria listed in a NICE TAG will receive treatment.
- In cancer care (including but not limited to skin, head and neck, breast and sarcoma) any lesion that has features suspicious of malignancy, must be referred to an appropriate specialist for urgent assessment under the 2-week rule.
  NOTE: Funding for all solid and haematological cancers are now the responsibility of NHS England.
- Reconstructive surgery post cancer or trauma including burns.
- Congenital deformities: Operations on congenital anomalies of the face and skull are usually routinely commissioned by the NHS. Some conditions are considered highly specialised and are commissioned in the UK through the National Specialised Commissioning Advisory Group (NSCAG). As the incidence of some cranio-facial congenital anomalies is small and the treatment complex, specialised teams, working in designated centres and subject to national audit, should carry out such procedures.
- Tissue degenerative conditions requiring reconstruction and/or restoring function e.g. leg ulcers, dehisced surgical wounds, necrotising fasciitis.
- For patients expressing gender incongruence, further information can be also be found in the current ICB gender incongruence policy and within the NHS England gender

services programme - https://www.england.nhs.uk/commissioning/spec-services/npc-crg/gender-dysphoria-clinical-programme/

4. Rationale behind the policy statement

4.1 Hypertrophic and keloid scars are extremely common and currently there is no recognised gold standard of treatment.

4.2 However, many scars will soften and fade with time and may even disappear altogether.

4.3 Because surgery runs the risk of making the scar worse and there is a high recurrence rate, surgical revision is not routinely commissioned.

5. Summary of evidence review and references

5.1 All healing wounds can form scars which, if they become slightly thickened and raised, are known as hypertrophic scars. On the other hand, a keloid scar is one which overgrows, becoming larger than the original wound.[1] They may be more prevalent in people of African, Asian or Hispanic descent. Both keloids and hypertrophic scars are common and are caused by the proliferation of dermal tissue following skin injury.[2] Some authors have suggested that the 2 conditions may be two sides of the same coin and not distinct entities [3] and can develop in 30% – 90% of individuals.[4]

5.2 Patients most at risk are those less than 30 years old with darker skin. Sternal skin, shoulders, upper arms, earlobes and cheeks are most susceptible. Once keloids are established, these are difficult to treat with a high recurrence rate[5] regardless of therapy. [6] Hypertrophic scars in particular, however, can regress spontaneously.[7] Both types of scarring can cause functional and psychological problems for people and their management can be difficult.

5.3 A wide variety of treatment options are available and this includes excision (surgery), radiation, cryotherapy, silicone gel sheeting and intralesional injections.[8] However, a 2006 systematic review of the treatment of keloids and hypertrophic scars concluded that most treatments offered minimal likelihood of improvement.[9]

5.4 Since then, a Cochrane review (2013) determined the effectiveness of silicone gel sheeting for both prevention and treatment of hypertrophic or keloid scarring.[2] The authors concluded there is weak evidence of benefit as a prevention for abnormal scarring in high risk individuals but the poor quality of the research meant that a great deal of uncertainty prevails. Similar conclusions were drawn regarding treatment.

5.5 Another systematic review examined the impact of using laser treatment for specific scar characteristics in hypertrophic scars and keloid. The authors concluded that the specified laser systems did improve the scarring but further research is still required in the form of RCTs to confirm their findings. [8] A network meta-analysis evaluated the efficacy of different intralesional injections and topical treatments for both types of scar. It concluded that intralesional injection of triamcinolone combined with botulinum toxin type A or 5 fluorouracil was preferred. However, it also recommended triamcinolone with silicone gel in those who couldn't tolerate side effects. Again, the authors stated that more RCTs were required to confirm these results.[10] Other researchers have concluded that no one therapy has been universally accepted as the gold standard for the treatment of excessive scars.[11]

5.6 For hypertrophic scars alone, there is uncertainty whether silicone gel sheets work better than most other available treatments.[7] Overall, the evidence is still lacking for non-invasive treatments but intralesional injections may be the best option. [12, 13] Some of the problems which define the low quality of the published evidence is related to the lack of standardised assessment methods[14] and definitions of scar quality.[15]

5.7 Finally it is generally thought that surgical removal alone poses a high recurrence risk[6] and according to the British Association of dermatologists, surgical removal of keloids is rarely successful as this can cause a larger wound and regrowth is likely.[1]

5.8 In summary, many scars will soften and fade with time (particularly within 2 years) and may even regress completely. There is still no gold standard of treatment although several non-invasive options are available. Surgery runs the risk of making the scar worse and recurrence is very likely.

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6. Advice and Guidance

6.1 Aim and Objectives

6.1.1 This policy aims to ensure a common set of criteria for treatments and procedures across the region. This is intended to reduce variation of access to NHS services in different areas and allow fair and equitable treatment for all patients.

6.1.2 This policy relates to the commissioning of interventions which optimise clinical effectiveness and represent value for money.

6.1.3 This document is part of a suite of policies which the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy is a separate public document in its own right but should be considered alongside all the other policies in the suite as well as the core principles outlined.

6.1.4 At the time of publication, the evidence presented per procedure/treatment was the most current available.

6.1.5 The main objective for having healthcare commissioning policies is to ensure that:
- Patients receive appropriate health treatments
- Treatments with no or a very limited evidence base are not used; and
- Treatments with minimal health gain are restricted.

6.1.6 Owing to the nature of clinical commissioning policies, it is necessary to refer to the biological sex of patients on occasion. When the terms ‘men’ and ‘women’ are used in this document (unless otherwise specified), this refers to biological sex. It is acknowledged that this may not necessarily be the gender to which individual patients identify.

6.2 Core Principles

6.2.1 Commissioning decisions by ICB Commissioners are made in accordance with the commissioning principles set out as follows:

- Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment.
- Commissioners require clear evidence of cost effectiveness before NHS resources are invested in the treatment.
- Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment.
- Commissioners will balance the needs of an individual patient against the benefit which could be gained by alternative investment possibilities to meet the needs of the community.
- Commissioners will consider all relevant national standards and consider all proper and authoritative guidance.
- Where a treatment is approved Commissioners will respect patient choice as to where a treatment is delivered, in accordance with the ‘NHS Choice’ framework.
- Commissioning decisions will give ‘due regard’ to promote equality and uphold human rights. Decision making will follow robust procedures to ensure that decisions are fair and are made within legislative frameworks.

6.3 Individual Funding Requests (Clinical Exceptionality Funding)

6.3.1 If any patients are excluded from this policy, for whatever reason, the clinician has the option to make an application for clinical exceptionality. However, the clinician must make a robust case to the Panel to confirm their patient is distinct from all the other patients who might be excluded from the designated policy.

6.3.2 The ICB will consider clinical exceptions to this policy in accordance with the Individual Funding Request (IFR) Governance Framework consisting of: IFR Decision Making Policy; and IFR Management Policy available on the C&M ICB website: https://www.cheshireandmerseyside.nhs.uk/your-health/individual-funding-requests-ifr/

6.4 Cosmetic Surgery

6.4.1 Cosmetic surgery is often carried out to change a person's appearance to achieve what a person perceives to be a more desirable look.

6.4.2 Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore not routinely commissioned by the ICB Commissioner.

6.4.3 A summary of Cosmetic Surgery is provided by NHS Choices. Weblink: Cosmetic procedures - NHS

6.5 Diagnostic Procedures

6.5.1 Diagnostic procedures to be performed with the sole purpose of determining whether or not a restricted procedure is feasible should not be carried out unless the eligibility criteria are met, or approval has been given by the ICB or GP (as set out in the approval process of the patients responsible ICB) or as agreed by the IFR Panel as a clinically exceptional case.

6.5.2 Where a General Practitioner/Optometrist/Dentist requests only an opinion the patient should not be placed on a waiting list or treated, but the opinion given and the patient returned to the care of the General Practitioner/Optometrist/Dentist, in order for them to make a decision on future treatment.

6.6 Clinical Trials

6.6.1 The ICB will not fund continuation of treatment commenced as part of a clinical trial. This is in line with the Medicines for Human Use (Clinical Trials) Regulations 2004 and the Declaration of Helsinki which stipulates that the responsibility for ensuring a clear exit strategy from a trial, and that those benefiting from treatment will have ongoing access to it, lies with those conducting the trial. This responsibility lies with the trial initiators indefinitely.

7. Monitoring and Review

7.1 This policy remains in force until it is superseded by a revised policy or by mandatory NICE guidance or other national directive relating to this intervention, or to alternative treatments for the same condition.

7.2 This policy can only be considered valid when viewed via the ICB website or ICB staff intranet. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one published.

7.3 This policy may be subject to continued monitoring using a mix of the following approaches:

- Prior approval process

- Post activity monitoring through routine data
- Post activity monitoring through case note audits

7.4 This policy will be kept under regular review, to ensure that it reflects developments in the evidence base regarding effectiveness and value.

8. Quality and Equality Analysis

8.1 Quality and Equality Impact Analyses have been undertaken for this policy at the time of its review.

9. Clinical Coding

9.1 Office of Population Censuses and Surveys (OPCS)
In primary position
S60.4 Refashioning of scar NEC

9.2 International classification of diseases (ICD-10)
With or without
L90.5 Scar conditions and fibrosis of skin
L91.0 Hypertrophic scar

Document Control

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Version History
Version 0.1 – November 2021 - Policy reviewed – No change to policy position. Wording refreshed to aid clarity. The standard paragraph on gender dysphoria has been removed as this is covered elsewhere in the policy document.
Version 0.2 – October 2024 – Policy harmonised and reformatted to ICB policy template.
Version 0.3 – May 2025 – This policy was part of a public engagement exercise, where it was agreed to make reference to other related clinical policies within.