NHS
Fylde and Wyre
Clinical Commissioning Group

POLICIES AND PROCEDURES FOR THE COMMISSIONING OF APPROPRIATE, EFFECTIVE AND PRIORITY HEALTHCARE

POLICY NUMBER 5

Policy for the Commissioning of Cosmetic Procedures.

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CHANGE CONTROL SHEET

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Revision No.	Date of Issue	Author(s)	Page/Section Changed	Description of Change
4	25.5.11		Amendment to sections on:- Correction of Hair Loss (Alopecia) Correction of Male Pattern Baldness Hair Transplantation Skin and Subcutaneous Lesions Fatty Lumps (Lipomata) Viral Warts Other Benign Skin Lesions Zanthelesma Vascular Skin Lesions Acne Vulgaris Skin Resurfacing Techniques Hair Depilation Tattoo Removal Skin Hypo-Pigmentation) Rhinophyma) Miscellaneous) Botulinum Toxin) Gender Reassignment Surgery)	

Chief Executive	**Director**
Signature:	**Signature:**
Date:	**Date:**

Fylde and Wyre Clinical Commissioning Group

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Policies for the Commissioning of Appropriate, Effective and Priority Health Care - Policy for the Commissioning of Cosmetic Procedures.

1 Introduction

1.1 This is the policy of the Clinical Commissioning Group (CCG) to enable it to commission cosmetic healthcare. It forms part of a suite of Policies for the Commissioning of Appropriate, Effective and Priority Health Care. It is based on the considerations outlined in the *General Policy* within that suite. It will be applied in accordance with the CCG's *Procedure for the Application, Amendment and Waiver of Policies for the Commissioning of Appropriate, Effective and Priority Health Care,* and in accordance with the other policies and procedures within the suite.

1.2 This policy is written in recognition of service agreements that exist for the provision of this service (explicitly or implicitly). The policy describes eligibility criteria for treatment within those service agreements. Patients may satisfy those criteria, or may be confirmed as exceptions in writing by the CCG on an individual patient basis. Funding for the treatment of these patients should be taken from that contained within the service agreement, and their cases can be counted towards the healthcare activity required by those service agreements. The criteria will also apply to requests for treatment outside of the service agreements, when the provisions of the CCG's Policy for the Choice of Service Provider for Health Care will also apply.

1.3 This policy does not constrain decisions by general practitioners about treatments that can be carried out entirely within general practice, or about prescribing. However general practitioners may decide to follow the provisions of this policy in reaching such decisions.

2 Definition.

2.1 For the purpose of this policy, cosmetic procedures are ones carried out on the human body for no purpose other than to achieve a desire for a different appearance.

2.2 The CCG is aware of the competing demands for its limited financial resources and the need to expend those resources on the most appropriate and effective treatments to improve the health of its

population. The CCG's view is that (subject to careful consideration of the circumstances of the individual case to see whether there is an exceptional reason for adopting a more favourable view) the treatments addressed by this policy should not receive as high a priority in the allocation of resources as services of proven effectiveness for illnesses which are life threatening or cause more severe pain, discomfort or disability.

2.3 This policy applies to health care (including out of area treatments) for which this CCG is the ultimate source of funds. It also applies to health care commissioned by this CCG for people who reside elsewhere, but who are referred to NHS Trusts for whom this CCG is the lead commissioner, for out of area treatments.

3 The Policy

3.1 The CCG may commission procedures designed to restore a reasonable appearance following trauma, disease, or surgical interventions for trauma or disease.

3.2 The CCG may commission procedures designed to restore or achieve a reasonable appearance to the eyeball.

3.3 The CCG may commission the removal of stable scar tissue following recovery from trauma or surgery when one or more of the following apply:

i when the patient is a child under the age of 18, and there is a probability of a substantial improvement in the appearance of the scar(s),

ii when the scars are affecting the normal functioning of the body,

iii as part of a package of restorative treatment of which removal of the scar tissue is a minor component.

3.4 The CCG may commission procedures undertaken on patients aged below 18 years, which are designed to achieve a reasonable appearance in children who were born with, or who developed disfiguring anomalies. The CCG may also commission removal of such a lesion from a young adult, when removal had been requested before the age of 18, but had been deferred for clinical reasons,

3.5 The CCG may, subject to prior authorisation of the Commissioning Panel, who will consider the circumstances of the individual patient, commission treatment of a cosmetic problem that is reasonably preventing the person from obtaining any form of suitable employment.

3.6 The CCG may commission reversals, corrections or improvements to cosmetic procedures carried out at the expense of other commissioners (including private sector healthcare) only when complications of the procedure are threatening other aspects of the health of the patient (e.g. as a result of infection).

3.7 The CCG may commission Plastic Surgery for the following conditions or procedures:-

3.8 Breast Procedures

3.8.1 **Female Breast Reduction (Reduction Mammoplasty**)

Breast Reduction Surgery is an effective intervention that should be available on the NHS if the following circumstances are met::

1. The patient has a body mass index of less than 30kg/m^2

AND

2. Either

(i) The patient is suffering from persisting, disabling neck/upper back pain attributable to oversized breasts despite:

a. treatment with analgesia/anti-inflammatory medication, and
b. having received a recognised course of physiotherapy/manipulative therapy, and
c. the wearing of a professionally fitted brassiere

Or

(ii) The patient has intractable intertrigo.

Patients should have an initial assessment prior to an appointment with a consultant plastic surgeon to ensure that these criteria are met. At, or, following this assessment, there should be access to a trained bra fitter and where it is available, laser scanning of the thorax should be considered.

Rationale

Breast reduction places considerable demand on NHS resources (volume of cases and length of surgery) and yet has been shown to be a highly effective health intervention. There is published evidence showing that most women seeking breast reduction and not wearing a bra of the correct size and that a well fitted bra can sometimes alleviate the symptoms that are troubling the

patient. Recent evidence has shown that not all commercial bra fitters meet the required standards and so commissioners will need to satisfy themselves that a suitable service is available.

The upper limit of normal BMI is 25 kg/m². Patients seeking breast reduction have physical restrictions on their ability to exercise and additional weight in their excess breast tissue (sometimes 3-4 kg). Major complications for surgery in general and specifically related to breast reduction surgery have been shown to be greater if the BMI exceeds 30. Despite a higher complication rate, obese patients generally benefit from breast reduction. Local policies will need to consider both these factors in setting a NMI threshold for inclusion.

3.8.2 Male Breast Reduction for Gynaecomastia

Surgery to correct significant gynaecomastia is allowable if the patient is:

Post pubertal and of normal BMI (< = 25 Kg/m²)

There should be a pathway established to ensure that appropriate screening for endocrinological and drug related causes and/or psychological distress occurs prior to consultation with a plastic surgeon.

Liposuction may form part of the treatment plan for this condition.

Rationale

Commonly gynaecomastia is seen during puberty and may correct once the post-pubertal fat distribution is complete if the patient has a normal BMI. It may be unilateral or bilateral. Rarely may it be caused by an underlying endocrine abnormality or a drug related cause including the abuse of anabolic steroids. It is important that male breast cancer is not mistaken for gynaecomastia and, if there is any doubt, an urgent consultation with an appropriate specialist should be obtained,

3.8.3 Breast enlargement (Augmentation mammoplasty)

Will only be performed by the NHS on an exceptional basis and should not be carried out for “small” but normal breasts or for breast tissue involution (including post partum changes).

Exception should be made for women with an absence of breast tissue unilaterally or bilaterally, or in women with a significant degree of asymmetry of breast shape and/or volume. Such situations may arise as a result of:

- Previous mastectomy or other excisional breast surgery
- Trauma to the breast during or after development
- Congenital amastia (total failure of breast development)
- Endocrine abnormalities
- Developmental asymmetry

Patients who are offered breast augmentation in the NHS should be encouraged to participate in the UK national breast implant registration system and be fully counselled regarding the risks and natural history of breast implants. It would be usual to provide patients undergoing breast augmentation with a coy of the DH guidance booklet *"Breast Implants Information for Women considering Breast Implants".*

It is important that patients understand that they may not automatically be entitled to replacement of the implants in the future if they do not meet the criteria for augmentation at that time.

Rationale

Demand for breast enlargement is rising in the UK. Breast implants may be associated with significant morbidity and the need for secondary or revisional surgery (such as implant replacement) at some point in the future is common. Implants have a variable life span and the need for replacement or removal in the future is likely in young patients. Not all patients demonstrate improvement in psychosocial outcome measures following breast augmentation.

3.8.4 Revision of Breast Augmentation

Revision surgery will **only** be considered if the NHS commissioned the original surgery. If revisional surgery is being carried out for implant failure, the decision to replace the implant(s) rather than simply remove them should be based upon the clinical need for replacement and whether the patient meets the policy for augmentation at the time of revision.

Rationale

Prior to the development of inclusion policies such as this, a small n number of patients underwent breast augmentation in the NHS for purely cosmetic reasons. There may however be clinical reasons why replacement of the

implants remains an appropriate surgical intervention. For these reasons it is important that:

Prior to implant insertion all patients explicitly should be made aware of the possibilities of complications, implant life span, the need for possible removal of the implant at a future date and that future policy may differ from current policy.

Patients should also be made aware that implant removal in the future might not be automatically followed by replacement of the implant.

3.8.5 Breast Lift (Mastopexy)

This is included as part of the treatment of breast asymmetry and reduction (see above) but not for purely cosmetic/aesthetic purposes such as post lactational ptosis.

Rationale

Breast ptosis (droopiness) is normal with the passage of age and after pregnancy. Patients with breast asymmetry often have asymmetry of shape as well as volume and correction may require mastopexy as part of the treatment.

3.8.6 Nipple Inversion

Nipple inversion may occur as a result of underlying breast malignancy and it is essential that this be excluded.

Surgical correction of nipple inversion should only be available for functional reasons in a post-pubertal woman and if the inversion has not been corrected by correct use of a non-invasive suction device.

Rationale

Idiopathic nipple inversion can often (but not always) be corrected by the application of sustained suction. Commercially available devices may be obtained from major chemists or online without prescription for use at home by the patient. Greatest success is seen if it is used correctly for up to three months.

An underlying breast cancer may cause a previously normal everted nipple to become indrawn: this must be investigated urgently.

3.9 Facial Procedures

3.9.1 Face Lifts and Brow Lifts (Rhytidectomy)

These procedures will be considered for treatment of:

- Congenital facial abnormalities
- Facial palsy (congenital or acquired paralysis)
- As part of the treatment of specific conditions affecting the facial skin e.g. cutis laxa, pseudoxanthoma elasticum, neurofibromatosis
- To correct the consequences of trauma
- To correct deformity following surgery
- They will not be available to treat the natural processes of ageing

Rationale

There are many changes to the face and brow as a result of ageing that may be considered normal, however there are a number of specific conditions for which these procedures may form part of the treatment to restore appearance and function.

3.9.2 Surgery on the upper eyelid (Upper lid blepharoplasty)

This procedure will be commissioned by the NHS to correct functional impairment (not purely for cosmetic reasons).

As demonstrated by

- Impairment of visual fields in the relaxed, non-compensated state
- Clinical observation of poor eyelid function, discomfort, e.g. headache, worsening towards end of day and/or evidence of chronic compensation through elevation of the brow.

Rationale

Many people acquire excess skin in the upper eyelids as part of the process of ageing and this may be considered normal. However, if this starts to interfere with vision or function of the eyelid apparatus then this can warrant treatment.

3.9.3 Surgery on the lower eyelid (Lower lid blepharoplasty)

This is available on the NHS for correction of ectropion or entropion or for the removal of lesions of the eyelid skin or lid margin.

Rationale

Excessive skin in the lower lid may cause “eyebags” but does not affect function of the eyelid or vision and therefore does not need correction. Blepharoplasty type procedures however may form part of the treatment of disorders of the lid or overlying skin.

3.9.4 Surgery to reshape the nose (Rhinoplasty)

Rhinoplasty should be available on the NHS for

- Problems caused by obstruction of the nasal airway
- Objective nasal deformity caused by trauma
- Correction of complex congenital conditions e.g. cleft lit and palate

Patients with isolated airway problems (in the absence of visible nasal deformity) may be referred initially to an ENT consultant for assessment and treatment.

3.9.5 Correction of prominent ears (Pinnaplasty/Otoplasty)

To be available on the NHS the following criteria must be met:

- The patient must be under the age of 19 years at the time of referral
- Patients seeking pinnaplasty should be seen by a plastic surgeon and following assessment, if there is any concern, assessed by a psychologist
- Patients under 5 years of age at the time of referral may benefit from referral with their family for a multi-disciplinary assessment that includes a child psychologist

Rationale

Prominent ears may lead to significant psychological dysfunction for children and adolescents and impact on the education of young children as a result of teasing and truancy. The national service framework for children defines childhood as ending at 19 years. Some patients are only able to seek correction once they are in control of their own healthcare decisions. Children

under the age of 5 years rarely experience teasing and referrals may reflect concerns expressed by the parents rather than the child.

3.9.6 Repair of external ear lobes (lobules)

This procedure is only available on the NHS for the repair of totally split ear lobes as a result of direct trauma.

Prior to surgical correction, patients should receive pre-operative advice to inform them of:

- Likely success rates
- The risk of keloid and hypertrophic scarring in this site
- The risks of further trauma with re-piercing of the ear lobule

Rationale

Many split earlobes follow the wearing of excessively heavy earrings with insufficient tissue to support them, such that the earring slowly "cheese-wires" through the lobule. Correction of split earlobes is not always successful and the earlobe is a site where poor scar formation is a recognised risk.

3.9.7 Operations on congenital anomalies of the face and skull

These are usually available on the NHS. Some such conditions are considered highly specialised and are commissioned in the UK through NSCAG.

Rationale

The incidence of some congenital conditions affecting the cranio-facial skeleton is small and the treatment complex. It is considered that specialised teams, working in designated centres and subject to national audit, should carry out such procedures.

3.9.8 Correction of post traumatic bony and soft tissue deformity of the face

This is available on the NHS.

3.9.9 Correction of hair loss (Alopecia)

See Policy No. 22 – Policy for Commissioning Interventions for Correcting Hair Loss.

3.9.10 Correction of male pattern baldness

See Policy No. 22 – Policy for Commissioning Interventions for Correcting Hair Loss.

3.9.11 Hair transplantation

See Policy No. 22 – Policy for Commissioning Interventions for Correcting Hair Loss.

3.10 Body Contouring Procedures

It is recognised that the consequences of morbid obesity will become an increasing problem for the NHS and that robust inclusion criteria need to be developed to ensure that appropriate patients benefit from interventions that change the body contour.

3.10.1 "Tummy tuck" (Apronectomy or Abdominoplasy)

Abdominoplasty and apronectomy may be offered to the following groups of patients who should have achieved a stable BMI between 18 and 27 kg/m² and be suffering from severe functional problems:

- Those with scarring following trauma or previous abdominal surgery
- Those who are undergoing treatment for morbid obesity and have excessive abdominal skin folds and have maintained their weight loss for at least two years.
- Previously obese patients who have achieved significant weight loss and have maintained their weight loss for at least two years
- Where it is required as part of abdominal hernia correction or other abdominal wall surgery
- For the removal of redundant skin, when the problem is seriously disfiguring, and has resulted from previous childbirth. Such cases are unlikely to be authorised until at least three years since the birth of the last child.

Severe functional problems include:

- Recurrent intertrigo beneath the skin fold
- Experiencing severe difficulties with daily living i.e. ambulatory restrictions
- Where previous post trauma or surgical scarring (usually midline vertical, or multiple) leads to very poor appearance and results in disabling psychological distress or risk of infection
- Problems associated with poorly fitting stoma bags.

Rationale

Excessive abdominal skin folds may occur following weight loss in the previously obese patient and can cause significant functional difficulty. There are many obese patients who do not meet the definition of morbid obesity (see glossary) but whose weight loss is significant enough to create these difficulties. These types of procedures, which may be combined with limited liposuction, can be used to correct scarring and other abnormalities of the anterior abdominal wall and skin. It is important that patients undergoing such procedures have achieved and maintained a stable weight so that the risks of recurrent obesity are reduced. The availability of teams specialising in the surgical treatment of the morbidly obsess ("bariatric" surgery) is limited, although this may rise with the implementation of NICE guidance in this area. Many patients therefore achieve their weight loss outside such teams and should not be disadvantaged in accessing body contouring surgery if required.

3.10.2 Other skin excision for contour
e.g. Buttock lift, thigh lift arm lift (brachioplasty)

These procedures will only be commissioned in exceptional circumstances.

Rationale

Whilst the patient groups seeking such procedures are similar to those seeking abdominoplasty (see above), the functional disturbance of skin excess in these sites tends to be less and so surgery is less likely to be indicated except for appearance: in which case it should not be available on the NHS.

3.10.3 Liposuction

Liposuction is not routinely available on the NHS and will only be commissioned in exceptional circumstances.

Rationale

Liposuction will not be commissioned simply to improve appearance by correcting the distribution of fat. Liposuction may be useful for contouring areas of localised fat atrophy or pathological hypertrophy (e.g. multiple lipomatosis, lipodystrophies). Liposcution is sometimes an adjunct to other surgical procedures.

3.11 Skin And Subcutaneous Lesions

See Policy No. 30 – Policy for Commissioning Interventions to remove Benign Skin Lesions.

3.12 Tattoo removal

See Poicy No. 23 – Policy for Commissioning Tattoo Removal.

3.13 Skin Hypo-pigmentation

The recommended NHS suitable treatment for hypo-pigmentation is Cosmetic Camouflage. Access to a qualified camouflage beautician should be available on the NHS for this and other skin conditions requiring camouflage.

3.14 Rhinophyma

The first-line treatment of this disfiguring condition of the nasal skin is medical. Severe cases or those that do not respond to medical treatment may be considered for surgery or laser treatment.

3.15 MISCELLANEOUS

3.15.1 Skin "resurfacing" techniques

See Policy No. 30 – Policy for Commissioning Interventions to remove Benign Skin Lesions.

3.15.2 Botulinum Toxin

Botulinum toxin has many uses within the NHS. It is available for the treatment of pathological conditions by appropriate specialists in cases such as:

- Frey's syndrome
- Blepharospasm
- Cerebal palsy
- Hyperhidrosis

Botulinum toxin is not available for the treatment of facial ageing or excessive wrinkles.

3.15.3 Hair depilation (hair removal)

See Policy No. 18 – Policy for Interventions for Hair Depilation

3.16 Gender reassignment surgery

Gender reassignment is a highly specialised area of clinical practice and should only be considered, assessed for and carried out as part of a recognised NHS programme of care. Each case should be considered on its individual merits.

3.17 The CCG may commission other cosmetic procedures on the advice of a consultant psychiatrist that the patient suffers severe mental illness that is caused by the cosmetic problem in question, and that would, on the balance of probability be substantially improved by the cosmetic procedure.

3.18 The CCG may commission other cosmetic procedures when the Commissioning Panel has invited and considered comments from the patient, the General Practitioner and any psychiatrist consulted about the level of distress suffered by the patient, and has concluded from the information provided that the level of distress that could be resolved by authorising the referral would be greater than the level of distress that could be resolved by the equivalent investment in other services competing for the development resources of the CCG.

4 Application

4.1 When requests for individual patient funding are received, the Commissioning Panel will consider whether the patient satisfies the criteria in one or more of the paragraphs in section 3 above. Before reaching its decision, the Commissioning Panel may also consider:

i Advice from the clinician who has physically examined the patient about the extent to which the cosmetic appearance is abnormal, and such that

a reasonable person would be unable to tolerate it. In interpreting this advice the Commissioning Panel Director may consider what is normal and tolerable in a person of the patient's age, gender and parity.

ii (When the grounds for providing funding are psychiatric or related to distress, relationship problems etc). Whether he/she is satisfied that the cosmetic matter is the primary problem, recognising that a surgical procedure may not be appropriate if it is likely to be a symptom of an underlying psychiatric illness, psychological problem or relationship difficulty.

iii The side effects, and complications of surgical procedures, and the extent to which the anticipated outcome of those procedures may meet the patient's expectations.

Iv Any other factor that he/she reasonably considers relevant.