Frimley Clinical Commissioning Group

Thames Valley Priorities Committee Commissioning Policy Statement

Policy No. TVPC16 **Aesthetic treatments for adults and children**

Recommendation made by the Priorities Committee: **March 2015, updated July 2017/July 2018[1]/ May 2019[2]/November 2019[3]**

Date of issue: **November 2020**

The Thames Valley Priorities Committee has considered the evidence for the clinical and cost effectiveness of aesthetic treatments. The Committee found insufficient evidence of clinical and cost effectiveness to warrant the commissioning of aesthetic treatments and therefore these procedures are **not normally funded**. Adults and children will not normally be offered aesthetic treatments in either specialist, secondary or primary care.

Aesthetic or cosmetic interventions are intended to change aspects of a person's appearance. There has been a general policy of non-purchase of aesthetic treatments since 1996. However, procedures continue to be carried out without the prior approval of NHS commissioners. It has been re-confirmed by the Thames Valley Priorities Committee that no referrals should be made by GPs, or other clinicians, for any aesthetic procedure. Referring patients for treatments that can only be funded in exceptional circumstances may raise false expectations.

If clinicians consider that their patient's case for an aesthetic intervention provides grounds for funding as an exception to policy, then an application for individual funding should be submitted to their NHS Clinical Commissioning Group

However, clinicians and patients making individual funding requests should be aware that:

- aesthetic surgery procedures will normally only be considered in patients with a BMI in the range 18.5-27 (unless weight is not a relevant factor)
- previous NHS-funded breast surgery does not guarantee further NHS surgery
- aesthetic surgery for the removal of redundant skin as a result of NHS funded weight loss programmes or bariatric surgery will not normally be funded
- Local CCG policies relating to smoking cessation and surgical procedures will apply.

A list of examples of aesthetic interventions that are not commissioned is provided below. It should be noted, however, that this list is **illustrative** and **not exhaustive**.

[1] Clarification of points 5 and 6 'Breast surgery'.
[2] Clarification of risk reducing surgery; Guidance note 5.
[3] Addition of facial hirsutism following evidence review and TVPC discussion

Examples of aesthetic procedures not normally funded

Breast surgery

1. Breast lift (mastopexy)
2. Correction of inverted nipple
3. Removal of supernumerary nipples (polymastia)
4. Prosthesis for breast - except reconstruction as part of the breast cancer care pathway
5. Removal of breast prosthesis is not permitted except as part of the breast cancer care pathway, ruptured/leaking implants, hardened/painful prosthesis, late onset seroma or any suspicion of BIA-ALCL and known PIP-implants as per DoH guidelines.
6. Revision of breast prosthesis, except as indicated by (4) above (patients having prosthesis removed for other medical reasons should be advised that replacement is **not** funded)
7. Breast augmentation
8. Breast reduction with no concurrent breast pathology (*see Guidance note 1*)
9. Revision of breast reduction or augmentation
10. Male breast tissue reduction (gynaecomastia) (*see Guidance note 2*)
11. Risk reducing breast surgery (*see Guidance note 5; risk reducing surgery*)

Skin and hair

1. Destructive interventions to treat benign skin lesions (*see Guidance note 3*)
2. Excision of redundant skin, subcutaneous tissue or fat, including abdominoplasty, apronectomy, buttock lift, thigh lift, upper arm reduction (brachioplasty); buttock augmentation and body contouring procedures, e.g., following weight loss interventions/surgery
3. Liposuction of subcutaneous tissue
4. Surgery for divarication/diastasis of the abdominal recti[4]
5. Aesthetic operations on umbilicus
6. Tattoo removal
7. Dermabrasion
8. Cosmetic revision of scars (keloid and hypertrophic scars)
9. Hair transplantation / hair graft / intralace for hair loss
10. Laser hair removal
11. Vaginal tightening and vaginoplasty*
12. Refashioning of the vaginal labia*
13. Treatments for facial hirsutism

***Please note**: Clinicians must be assured that there is a clear clinical rationale for any potential intervention as all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons are defined as Female Genital Mutilation and as such are against the law. (The Female Genital Mutilation Act 2003).*

Clinicians must be alert to the possibility that some patients who seek revision surgery may do so as a result of previous interventions which are classed as unlawful under the Act.

Surgery to the face

1. Laser / Pulse Dye Laser Treatment of 'Port Wine Stains' and other skin lesions
2. Surgery for prominent / bat ears (pinnaplasty / otoplasty)

[4] Evidence review update January 2020. No change to policy position.

3. Liposuction of neck and jowls (submental lipectomy)
4. Face lift (rhytidectomy)
5. Brow lift
6. Eyelid surgery (blepharoplasty), including ptosis of eyelid *(see Guidance note 4)*
7. Nose reshaping (rhinoplasty/septorhinoplasty)
8. Non-urgent repair of lobe of external ear
9. Surgery to correct a bulbous/ruddy nose (rhinophyma)
10. Tooth whitening and dental veneers
11. Botox for anti-aging
12. Laser eye surgery for the avoidance of wearing glasses
13. Treatments for facial hirsutism

- For management of ectropion and entropion, see Policy Statement; Ectropion and entropion
- For the treatment of hyperhidrosis (excessive sweating), see TVPC Policy Statement; Hyperhidrosis.
- For the treatment of varicose veins, see TVPC Policy Statement; Varicose veins.
- For dental implants, contact NHS England area team or NHS England website for Primary Dental Services.

NOTES:

- Potentially exceptional circumstances may be considered by a patient's CCG where there is evidence of significant health status impairment (e.g. inability to perform activities of daily living) and there is evidence that the intervention sought would improve the individual's health status.
- This policy will be reviewed in the light of new evidence or new national guidance, e.g. from NICE.
- Thames Valley clinical policies can be viewed at http://www.fundingrequests.cscsu.nhs.uk/

These Guidance notes are based on the experience of Thames Valley IFR Panels and local clinical opinion:

1. Guidance for applicants for breast reduction surgery. Applications for funding as an exception to the policy will normally only be considered in patients in whom all of the following apply:

- The individual patient's breast development is considered to be complete
- Where the BMI is stable below 27kg/m2 for 9 months prior to referral
- Bra cup size of greater than GG
- Where medically documented evidence of a clinically significant history of back, neck or shoulder pain, which has not resolved despite treatment(s), has been provided ;
- Medically documented evidence of a clinically significant history of intertrigo or ulceration which has not responded to treatment;

Please note the above are not criteria for funding. However if these criteria are not met it is unlikely that a clinician could sustainably argue that an individual had an exceptional capacity to benefit from breast reduction.

2. Guidance for applicants for breast reduction surgery for gynaecomastia. Applications for funding as an exception to the policy will normally only be considered in patients if they meet all the following:

- Who have completed puberty;
- Whose BMI is ≤ 25kg/m2 (or the gynaecomastia is not caused by the weight alone)
- No treatable cause is likely to reduce/reverse the gynaecomastia;
- In cases of idiopathic gynaecomastia in men under the age of 20, a period of at least 2 years has been allowed for natural resolution.

Please note the above are not criteria for funding. However if these criteria are not met it is unlikely that a clinician could sustainably argue that an individual had an exceptional capacity to benefit from breast reduction for gynaecomastia.

3. Guidance for considering applications for removal of symptomatic skin lesions and lipomata.

Destructive interventions to treat benign asymptomatic skin lesions are not normally funded.

This includes warts (plantar warts); seborrhoeic keratoses (benign skin growths, basal cell papillomas, warts); spider naevi; thread veins; benign pigmented naevi (moles); dermatofibromas (skin growths); skin tags; 'sebaceous' cysts (pilar and epidermoid cysts); lipomata (fat deposits underneath the skin); xanthelasmas (cholesterol deposits underneath the skin); vitiligo i.e. loss of skin pigmentation.
Removal of benign **symptomatic skin lesions** can be considered for patients where the lesion is associated with any one of the following:

- repeated infection, inflammation or discharge
- bleeding in the course of normal everyday activity
- obstruction of an orifice to the extent that function is or is likely to become impaired
- pressure symptoms e.g. on an organ, nerve or tissue

Removal of **lipomata** can be considered for patients where the lipomata is associated with any one of the following:

- >5cm in diameter
- deep seated
- there is functional impairment
- the lump is rapidly growing or abnormally located (e.g. sub-fascial, sub-muscular)

In case of clinical concern regarding malignant change usual referral guidance applies.

4. Guidance for considering applications for referral for eyelid surgery (blepharoplasty), including blepharoptosis (an abnormal low-lying upper eyelid margin) and dermatochalasis (skin redundancy of the upper lid).

Surgery can be considered for patients with the following symptoms:

- down-gaze ptosis impairing reading and other close-work activities
  AND
- a chin-up backward head tilt due to visual axis obscuration

OR any one of the following:

- margin reflex distance 1 (MRD(1)) of 2mm or less
- eyelid skin fold to reflex distance of 2mm or less
- superior visual field loss of at least 12 degrees or 24%
- central visual interference due to upper eyelid position

5. Guidance on risk reducing breast surgery for people with or without personal history of breast cancer.

Risk reducing surgery can be offered as per NICE CG164 (2013) Familial breast cancer: classification, care and managing breast cancer and related risks in people with a family history of breast cancer Clinical guideline.

‘Bilateral risk-reducing mastectomy is appropriate only for a small proportion of women/men who are from high-risk families and should be managed by a multidisciplinary team’.