NHS
Leeds
Clinical Commissioning Group

General Cosmetic Exceptions and Exclusions Policy including Benign Skin Lesions, Skin Tags, Scars and Keloids

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Name of responsible committee/individual:	Dr Simon Stockill, Medical Director, NHS Leeds Clinical Commissioning Group
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Target audience:	Primary and secondary care clinicians, individual funding request panels, and the public
Document History:	Leeds CCGs Cosmetic Exceptions and Exclusions Policy Feb 2014 Leeds CCG General Cosmetic Exceptions and Exclusions 2017-19

Produced on behalf of NHS Leeds Clinical Commissioning Groups Partnership

Executive Summary

This policy applies to all Individual Funding Requests (IFR) for people registered with General Practitioners in Leeds

This policy does not apply where NHS Leeds CCG is not the responsible commissioner.

The policy updates all previous policies and must (where appropriate) be read in association with the other relevant Leeds Clinical Commissioning Group commissioning policies, which are to be applied across Leeds , including but not limited to policies on cosmetic exceptions and non-commissioned activity.

All IFR and associated policies will be publically available on the internet for the CCG.

This policy relates specifically to :

General cosmetic exceptions and exclusions including viral warts, benign skin lesions, skin tags, lipomas, keloids and scars.

Contents

1 Introduction

The Clinical Commissioning Groups (CCGs) (NHS Leeds West CCG, NHS Leeds North CCG and NHS Leeds South and East CCG) were established on 1 April 2013 under the Health and Social Care Act 2012 as the statutory bodies responsible for commissioning services for the patients for whom they are responsible in accordance with s3 National Health Service Act 2006. As at 1 April 2018 these three CCGs have merged to become NHS Leeds Clinical Commissioning Group

As part of these duties, there is a need to commission services which are evidence based, cost effective, improve health outcomes, reduce health inequalities and represent value for money for the taxpayer. NHS Leeds CCG is accountable to their constituent populations and Member Practices for funding decisions.

In relation to decisions on Individual Funding Requests (IFR), NHS Leeds CCG has a clear and transparent process and policy for decision making. They have a clear CCG specific appeals process to allow patients and their clinicians to be reassured that due process has been followed in IFR decisions made by the Non Commissioned Activity Panel, Cosmetic Exclusions and Exceptions Panel, or Non NICE Non Tariff Drug Panel (the IFR panels).

Due consideration must be given to IFRs for services or treatments which do not form part of core commissioning arrangements, or need to be assessed as exceptions to Leeds CCG Commissioning Policies. This process must be equitably applied to all IFRs.

All IFR and associated policies will be publically available on the internet for the CCG. Specialist services that are commissioned by NHS England or Public Health England are not included in this policy.

2 Purpose

The purpose of the IFR policy is to enable officers of NHS Leeds CCG to exercise their responsibilities properly and transparently in relation to IFRs, and to provide advice to general practitioners, clinicians, patients and members of the public about IFRs. Implementing the policy ensures that commissioning decisions in relation to IFRs are consistent and not taken in an ad-hoc manner without due regard to equitable access and good governance arrangements. Decisions are based on best evidence but made within the funding allocation of the CCG.

The policy outlines the process for decision making with regard to services/treatments which are not normally commissioned by the CCG in Leeds, and is designed to ensure consistency in this decision making process.

The policy is underpinned by the following key principles:

- The decisions of the IFR panels outlined in the policy are fair, reasonable and lawful, and are open to external scrutiny.

- Funding decisions are based on clinical evidence and not solely on the budgetary constraints.
- Compliance with standing financial instructions / and statutory instruments in the commissioning of healthcare in relation to contractual arrangements with providers.

Whilst the majority of service provision is commissioned through established service agreements with providers, there are occasions when services are excluded or not routinely available within the National Health Service (NHS). This may be due to advances in medicine or the introduction of new treatments and therapies or a new cross-Leeds Clinical Commissioning Group statement. The IFR process therefore provides a mechanism to allow drugs/treatments that are not routinely commissioned by the NHS Leeds CCG to be considered for individuals in exceptional circumstances.

3 Scope

Policy development and review: consultation and engagement

The policy was developed to:

- ensure a clear and transparent approach is in place for exceptional/individual funding request decision making; and
- provide reassurance to patients and clinicians that decisions are made in a fair, open, equitable and consistent manner.

It was originally developed in line with NICE or equivalent guidance where this was available or based on a review of scientific literature. This included engagement with hospital clinicians, general practice, CCG patient advisory groups, and the general public cascaded through a range, mechanisms.

The policy review was undertaken using any updated NICE or equivalent guidance, and input from clinicians was sought where possible. Engagement sessions with patient leaders were undertaken and all policies individually reviewed. Patient leaders were satisfied with the process by which the policy was developed, particularly in light of the robust process (including extensive patient engagement) by which NICE guidance are developed, and acknowledging their own local role in providing assurance. No concerns were raised with regard to the policy

NHS Leeds CCG has established the processes outlined in this policy to consider and manage IFRs in relation to the following types of requests:

General cosmetic exceptions and exclusions including viral warts, benign skin lesions, skin tags, lipomas, keloids and scars.

NHS Leeds CCG *does not routinely commission* aesthetic (cosmetic) surgery and other related procedures that are medically unnecessary.

Providing certain criteria are met, the CCG will commission aesthetic (cosmetic) surgery and other procedures to improve the functioning of a body part or where medically necessary even if the surgery or procedure also improves or changes the appearance of a portion of the body.

Please note that, whilst this policy addresses many common procedures, it does not address all procedures that might be considered to be cosmetic. The CCG reserve the right not to commission other procedures considered cosmetic and not medically necessary. This policy is to be used in conjunction with the Individual Funding Requests (IFR) Policy for NHS Leeds CCG and other related policies.

NHS Leeds CCG routinely commission interventional procedures where National Institute for Health and Care Excellence (NICE) guidance arrangements indicate "normal" or "offered routinely" or "recommended as option(s)" and the evidence of safety and effectiveness is sufficiently robust.

NHS Leeds CCG *do not* routinely commission interventional procedures where NICE guidance arrangement indicates "special", "other", "research only" and "do not use".

The commissioning statements for individual procedures are the same as those issued by NICE. (www.nice.org.uk).

An individual funding request (IFR) may be submitted for a patient who is felt to be an exception to the commissioning statements as per the Individual Funding Request Policy.

The CCG accept there are clinical situations that are unique (five or fewer patients) where an IFR is appropriate and exceptionality may be difficult to demonstrate.

Whilst the CCG is always interested in innovation that makes more effective use of resources, in year introduction of a procedure does not mean the CCG will routinely commission the use of the procedure.

An individual funding request is not an appropriate mechanism to introduce a new treatment for a group or cohort of patients. Where treatment is for a cohort larger than five patients, that is a proposal to develop the service, the introduction of a new procedure should go through the usual business planning process. CCG will not fund interventional procedures for cohorts over 5 patients introduced outside a business planning process.

Endpoints

Following completion of the agreed treatment, a proportionate follow up process will lead to a final review appointment with the clinician where both patient and clinician agree that a satisfactory end point has been reached. This should be at the discretion of the individual clinician and based on agreeing reasonable and acceptable clinical and/ or cosmetic outcomes.

Once the satisfactory end point has been agreed and achieved, the patient will be discharged from the service.

Requests for treatment for unacceptable outcomes post treatment will only be considered through the Individual Funding Request route. Such requests will only be considered where a) the patient was satisfied with the outcome at the time of discharge and b) becomes dissatisfied at a later date. In these circumstances the patient is not automatically entitled to further treatment. Any further treatment will therefore be the Clinical Commissioning Group's discretion, and will be considered on an exceptional basis in accordance with the IFR policy.

NHS Leeds CCG are committed to supporting patients to stop smoking in line with NICE guidance in order to improve short and long term patient outcomes and reduce health inequalities. Referring GPs and secondary care clinicians are reminded to ensure the patient is supported to stop smoking at every step along the elective pathway and especially for flap based procedures (in line with plastic surgery literature: abdominoplasty, panniculectomy, breast reduction, other breast procedures).

4 Definitions

The CCG is not prescriptive in their definitions. Each IFR will be considered on its merits, applying this Policy.

Routinely commissioned – this means that this intervention is routinely commissioned as outlined in the relevant policy, or when a particular threshold is met. Prior approval may or may not be required, refer to the policy for more information.

Exceptionality request – this means that for a service which is not routinely commissioned, or a threshold is not met, the clinician may request funding on the 'grounds of exceptionality' through the individual funding request process. Decisions on exceptionality will be made using the framework defined in the overarching policy 'Individual Funding Requests (IFR) Policy for the Clinical Commissioning Group in Leeds'.

5 Duties

The CCG will delegate its decision making in relation to IFRs to a delegated decision maker/s in accordance with its own scheme of delegation.

A delegated decision maker will attend the relevant IFR panel and will also have responsibility for approving the triage process. The triage process is the process of screening requests to see whether the request meets the policy criteria and which referrals need to be considered by an IFR panel; see sections on IFR panels for more information. This will be detailed in the CCG Scheme of Delegation

6 Main Body of Policy

Exceptionality funding can be applied for in line with the overarching policy through the IFR process if you believe your patient is an exception to the commissioning position. Please refer to the overarching policy for more information.

6.1 Routinely commissioned

Status: do not need prior approval or individual funding request approval:

- Trauma and injury: acute repair and reconstruction
- Burns: acute care and reconstruction
- Reconstruction following cancer treatment
- Reconstruction following defined congenital abnormalities
- Reconstruction following female genital mutilation.

6.2 Routinely commissioned in specific circumstances

Status: prior or exceptionality approval is not required unless the patient does not meet the criteria below:

6.2.1 Immunodeficiency states including organ transplant patients with severe symptomatic viral warts should be referred to a Dermatologist in secondary care for assessment, although any recommended treatment may be provided in the community.

6.2.2 Excision of lipomas

6.2.2i Consider an urgent direct access ultrasound scan (to be performed within 2 weeks) to assess for soft tissue sarcoma in adults with an unexplained lump that has any of the following features:

- >7cm
- Deep to deep fascia Fixed
- Growing rapidly
- Is at site of previous surgical resection (for Sarcoma)

Referral to the sarcoma service may be recommended following the scan and this must be made using the current 2ww form.

Cutaneous lesions should first follow Melanoma/Non Melanoma pathway. Suspected Groin/Axilla/Neck lymph nodes should follow the Lymphoma Pathway.

6.2.2ii Suspected lipomas which do not meet these criteria may be referred to the minor surgery service for excision if considered medically necessary (see below).

Smaller superficial lipomas, WHICH MEET THE CRITERIA BELOW AND following ultra sound clarification, can be referred directly to any appropriate surgeon and do **not** need sarcoma MDT and should **not** be referred as a cancer.

6.2.2iii The excision of confirmed benign lipomas is considered medically necessary in the following situations. Prior approval is **not** usually required if the following criteria are met:

- Significant PAIN OR restriction of range of movement on examination OR
- Discomfort preventing a complete night's sleep on a regular basis DESPITE PRESCRIBED ANALGESIA OR
- Requiring modification to usual clothing

6.2.3 Repair of scars that result from major/minor surgery is considered medically necessary (normally within 2 years of surgery) if they cause significant symptoms or functional impairment.

6.2.4 Keloid and hypertrophic scars can be considered for excision if symptomatic – i.e. resulting in physical impairment due to contractures, tethering, severe pain/pruritus or recurrent breakdown, and the relevant criterion should be recorded on the referral form :

6.3 Removal of Benign Skin Lesion

Status: removal of lesions is only after prior approval unless the criteria below are evidenced at referral[1]

This policy refers to the following benign lesions when there is diagnostic certainty:-

- benign moles (excluding large congenital naevi)
- solar comedones
- corn/callous
- dermatofibroma
- milia
- molluscum contagiosum (non-genital)
- epidermoid & pilar cysts (sometimes incorrectly called sebaceous cysts)
- seborrhoeic keratoses (basal cell papillomata)
- skin tags (fibroepithelial polyps) including anal tags
- spider naevi (telangiectasia)
- non-genital viral warts in immunocompetent patients
- xanthelasmata
- neurofibromata

[1] https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf (accessed 05.02.19)

The benign skin lesions, which are listed above, must meet at least ONE of the following criteria to be removed, and the relevant criterion should be recorded on the referral form:

- The lesion is unavoidably and significantly traumatised on a regular basis with evidence of this causing regular bleeding or resulting in infections such that the patient requires 2 or more courses of antibiotics (oral or intravenous) per year
- There is repeated infection requiring 2 or more antibiotics per year
- The lesion bleeds in the course of normal everyday activity
- The lesion causes regular pain
- The lesion is obstructing an orifice or impairing field vision
- The lesion significantly impacts on function e.g. restricts joint movement
- The lesion causes pressure symptoms e.g. on nerve or tissue
- If left untreated, more invasive intervention would be required for removal
- Facial viral warts
- Facial spider naevi in children causing significant psychological impact

For lipomas, please refer to section 6.2.2 above.

The following are *outside* the scope of this policy recommendation:

- Lesions that are suspicious of malignancy should be treated or referred according to NICE skin cancer guidelines.
- Any lesion where there is diagnostic uncertainty, pre-malignant lesions (actinic keratoses, Bowen disease) or lesions with pre-malignant potential should be referred or, where appropriate, treated in primary care.
- Removal of lesions other than those listed above.

Referral to appropriate speciality service (eg dermatology or plastic surgery):

- The decision as to whether a patient meets the criteria is primarily with the referring clinician. If such lesions are referred, then the referrer should state that this policy has been considered and why the patient meets the criteria.
- This policy applies to all providers, including general practitioners (GPs), GPs with enhanced role (GPwer), independent providers, and community or intermediate services.

For further information, please see:

- https://www.nice.org.uk/guidance/csg8
- https://www.nice.org.uk/guidance/ng12

6.3.2 Rhytidectomy (including meloplasty, face lift) is considered medically necessary when there is functional impairment that cannot be corrected without surgery – evidence of a sustained period of unsuccessful non-medical treatment should be provided.

6.3.3 Arm and thigh reductions following significant weight loss

Leeds CCGs consider arm and thigh reductions following significant weight loss medically necessary where, in addition to the primary eligibility criteria listed above:

- There is persistent and recurrent skin breakdown or ulceration which the GP has been treating for 3 months or more OR
- Intertrigo which is resistant to at least 6 months medical treatment

6.3.4 The medical and surgical treatment of the following conditions is considered cosmetic and will not be routinely commissioned:

- Skin wrinkling or textural changes
- Solar lentigines
- Xanthelasma
- Chloasma/Melasma
- Post burns pigmentation
- Spider Angiomas in adults
- Cherry angiomas or Campbell de Morgan spots
- Telangiectasia of legs due to or associated with varicose veins
- Hirsutism in women at non-facial sites
- Hypertrichosis unrelated to metabolic disorders or medication
- Hair growth in men not associated with scarring folliculitis
- Acne scarring
- Decorative tattoos

6.3.5 The following procedures are considered cosmetic and will not be routinely commissioned

- excision of excessive skin on thigh, leg, hip, buttock, arm, forearm or hand, submental fat pad, fatty tissue in other areas including eyelids (for eyelids see also eyes policy)
- Fat grafting
- Suction assisted lipectomy (liposuction) for any purpose including lipoedema except for chronic lymphoedema in line with NICE IPG588
- Correction of diastasis recti abdominis (divarication of the recti)
- Chin implants (genioplasty, mentoplasty)
- Cheek implants (malar implants).
- Cosmetic rhinoplasty
- Collagen implants
- Lipoedema specialist interventions except for chronic lymphoedema in line with NICE IPG588
- Mastopexy (breast lift)
- Otoplasty (prominent ear correction) in adults (over 16)
- Removal of decorative tattoos
- Botulinum toxin for the following indications:Wrinkles, frown lines; or Aging neck; or Blepharoplasty (eyelid lift)
- Poly-L-lactic acid injection (Sculptra), or calcium hydroxylapatite (Radiesse), or fat injections for HIV lipoatrophy
- Body contouring

6.4 Psychological Exceptions

Cosmetic procedures are popular and sought after and the limited data available suggests that the majority of patients can expect good psychosocial adjustment in the short to medium term.

Honigman et al reviewed 37 studies suggesting that poor psychosocial adjustment prior to the procedure is probably the best indicator of a poor psychosocial outcome after the procedure.

There is no literature on what might constitute a psychological exception to warrant NHS funding of cosmetic medical and surgical procedures.

A psychological exception might suggest an unusual case, a more deserving set of circumstances, or an appearance feature which causes pain or other functional impairment which contributes to distress.

The CCGs understand that the most psychologically distressed patients requesting cosmetic procedures often have very complex emotional problems. They often focus their distress upon an appearance feature which is to the lay observer within the normal range. They may have features that would suggest a poor psychosocial outcome after the procedure

Psychological exceptions are determined on a case by case basis taking into account the particular context of the individual and his/her life. Exceptions tend to have proportionate and reasonable concerns about an appearance feature which is to a lay observer abnormal or outside the normal range.

Individuals who function very poorly, have unrealistic expectations of the effect of the procedure on their life or who seem desperate to change features which are within the normal range are unlikely to qualify.

Occasionally it may be necessary to decline a request for surgery that might normally be funded, where the patent's psychological profile predicts a poor outcome from surgery (e.g. revision of visible scars in the context of ongoing self-harm).

Inability to establish a relationship, or failure of an established relationship, are not normally grounds for a psychological exception.

Note on psychological treatment for body dysmorphic disorders

Access to psychological treatment for body dysmorphic disorder is through an initial assessment through the local Increasing Access to Psychological Therapies (IAPT) service. Treatment at steps 1-4 will be offered as required from this initial assessment including onward referral to step 4 if required (through the Single Point of Access to LYPFT (Psychological Therapy Service) which offers treatment for body dysmorphic disorder).

7 Equality Impact Assessment (EIA)

This document has been assessed, using the EIA toolkit, to ensure consideration has been given to the actual or potential impacts on staff, certain communities or population groups, appropriate action has been taken to mitigate or eliminate the negative impacts and maximise the positive impacts and that the and that the implementation plans are appropriate and proportionate.

Include summary of key findings/actions identified as a result of carrying out the EIA. The full EIA is attached as Appendix A.

8 Implications and Associated Risks

This policy and supporting frameworks set evidence based boundaries to interventions available on the NHS. It may conflict with expectations of individual patients and clinicians.

9 Education and Training Requirements

Members of the panels will undergo training at least every three years, particularly in relation to the legal precedents around IFRs. Effective policy dissemination is required for local clinicians.

10 Monitoring Compliance and Effectiveness

Each IFR panel will maintain an accurate database of cases approved and rejected, to enable consideration of amendments to future commissioning intentions and to ensure consistency in the application of the CCGs in Leeds Commissioning Policies.

The financial impact of approvals outside of existing Service Level Agreements will be monitored to ensure the Leeds CCGs identify expenditure and ensure appropriate value for money. Member Practice clinicians need to be aware that all referrals will ultimately be a call on their own CCG budgets.

11 Associated Documentation

This policy mus be read in conjunction with the underpinning Leeds CCGs decision making frameworks.

12 Additional References

Seborrheic keratoses are non-cancerous growths of the outer layer of skin. They are usually brown, but can vary in colour from beige to black, and vary in size from a fraction of an inch to more than an inch in diameter. They have the appearance of being glued or stuck on to skin. Seborrheic keratoses are most often found on the chest or back, although, they can also be found almost anywhere on the body. These become more common with age, and most elderly patients develop one or more of these lesions. Seborrheic keratoses can get irritated by clothing rubbing against them, and their removal may be medically necessary if they itch, get irritated, or bleed easily. Although seborrheic 13 keratoses are non-cancerous, they may be difficult to distinguish from skin cancer if they turn black. Seborrheic keratoses may be removed by cryosurgery, curettage, or electrosurgery.

Moles (naevi) can appear anywhere on the skin. They are usually brown in colour, but can be skin coloured or pink, light tan to brown, or blue-black. Moles may be flat or raised and can be various sizes and shapes. Most appear during the first 20 years of a person's life, although some may not appear until later in life. Sun exposure increases the number of moles. The majority of moles are benign. However, moles that raise suspicion of malignancy are those that change in size, shape or colour, and those that bleed, itch, or become painful. Atypical moles (dysplastic naevi) have an increased risk of developing into melanoma. Atypical moles are larger than

average (greater than 6 mm) and irregular in shape. They tend to have uneven colour with dark brown centres and lighter, sometimes reddish, uneven borders or black dots at edge. The most common methods of removal include shaving and excision.

A sebaceous (keratinous) cyst is a slow-growing, benign cyst that contains follicular, keratinous, and sebaceous material. The sebaceous cyst is firm, globular, movable, and non-tender. These cysts seldom cause discomfort unless the cyst ruptures or becomes infected. Ranging in size, sebaceous cysts are usually found on the scalp, face, ears, and genitals. They are formed when the release of sebum from the sebaceous glands in the skin is blocked. Unless they become infected and painful or large, sebaceous cysts do not require medical attention or treatment, and usually go away on their own. Infected cysts can be incised and drained, or the entire cyst may be surgically removed.

A skin tag (arochordon) is a benign, soft, moveable, skin-coloured growth that hangs from the surface of the skin on a thin piece of tissue called a stalk. The prevalence of skin tags increases with age. They appear most often in skin folds of the neck, armpits, trunk, beneath the breasts or in the genital region. They are painless, but may become painful if thrombosed or if irritated. They may become irritated if they occur in an area where clothing or jewellery rubs against them. Skin tags may be removed by excision, cryosurgery, or electrosurgery.

Many people suffer from warts. Incidence figures estimated from the fourth National Morbidity Survey (1991–2) suggest that almost 2 million people in England and Wales see their GP per year about this condition, at a cost of at least £40 million per annum. Cryotherapy delivered by a doctor is an expensive option for the treatment of warts in primary care. Alternative options such as GP-prescribed SA and nurse-led cryotherapy clinics provide more cost-effective alternatives, but are still expensive compared with self-treatment.

Given the minor nature of most cutaneous warts, coupled with the fact that the majority spontaneously resolve in time a shift towards self-treatment is warranted.

The overall framework on ‘Aesthetic (cosmetic) Surgery and Other Related Procedures’ is based on the following references:

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21. Beljaards RC, de Roos KP, Bruins FG. NewFill for skin augmentation: A new filler or failure? Dermatol Surg. 2005;31(7 Pt 1):772-776; discussion 776.
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Smoking references

1. Bikhchandani J, Varma SK, Henderson HP. Is it justified to refuse breast reduction to smokers? J Plast Reconstr Aesthet Surg. 2007;60(9):1050-4. Epub 2007 May 21.
2. Chan LK, Withey S, Butler PE. Smoking and wound healing problems in reduction mammoplasty: is the introduction of urine nicotine testing justified? Ann Plast Surg. 2006 Feb;56(2):111-5.
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4. Sørensen LT. Wound healing and infection in surgery. The clinical impact of smoking and smoking cessation: a systematic review and meta-analysis. Arch Surg. 2012 Apr;147(4):373-83. Doi: 10.1001/archsurg.2012.5.
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Psychological exceptions:

Honigman RJ, Phillips KA, Castle DJ. A Review of Psychosocial Outcomes for Patients Seeking Cosmetic Surgery Plast Reconstr Surg. 2004; 113: 1229-1237.

Appendices

A Equality Impact Assessment

Title of policy	Cosmetic Exceptions and Exclusions including benign skin lesions	
Names and roles of people completing the assessment	Fiona Day Consultant in Public Health Medicine, Helen Lewis, Head of Acute Provider Commissioning	
Date assessment started/completed	26.6.16	25.7.16

1. Outline	
Give a brief summary of the policy	The purpose of the commissioning policy is to enable officers of the Leeds CCGs to exercise their responsibilities properly and transparently in relation to commissioned treatments including individual funding requests, and to provide advice to general practitioners, clinicians, patients and members of the public about IFRs. Implementing the policy ensures that commissioning decisions are consistent and not taken in an ad-hoc manner without due regard to equitable access and good governance arrangements. Decisions are based on best evidence but made within the funding allocation of the CCGs. This policy relates to requests for cosmetic exceptions and exclusions including benign skin lesions.
What outcomes do you want to achieve	We commission services equitably and only when medically necessary and in line with current evidence on cost effectiveness.

2. Evidence, data or research	
Give details of evidence, data or research used to inform the analysis of impact	See list of references

3. Consultation, engagement	
Give details of all consultation and engagement activities used to inform the analysis of impact	Discussion with clinicians and patient representatives on the principles of decision making. Discussion with patient leaders relating to changes in the content of the policy and advice on proportionate engagement. The policy review was undertaken using any updated NICE or equivalent guidance, and input from clinicians was sought where possible. Engagement sessions with patient

	leaders were undertaken and all policies individually reviewed. Patient leaders were satisfied with the process by which the policy was developed, particularly in light of the robust process (including extensive patient engagement) by which NICE guidance are developed, and acknowledging their own local role in providing assurance. No concerns were raised with regard to the policy Local clinical commissioning and clinical providers have had the opportunity to comment on the draft policies.

4. Analysis of impact			
This is the core of the assessment, using the information above detail the actual or likely impact on protected groups, with consideration of the general duty to; eliminate unlawful discrimination; advance equality of opportunity; foster good relations			
	Are there any likely impacts? Are any groups going to be affected differently? Please describe.	**Are these negative or positive?**	**What action will be taken to address any negative impacts or enhance positive ones?**
Age	No		
Carers	No		
Disability	No		
Sex	No		
Race	No		
Religion or belief	No		
Sexual orientation	No		
Gender reassignment	No		
Pregnancy and maternity	No		
Marriage and civil partnership	No		
Other relevant group	No		

If any negative/positive impacts were identified are they valid, legal and/or justifiable? **Please detail.**	

5. Monitoring, Review and Publication			
How will you review/monitor the impact and effectiveness of your actions	Annual report of IFR activity reported through relevant committees to Governing Bodies of the 3 CCGs. A limited equity audit is undertaken as part of this. Complaints and appeals monitoring.		
Lead Officer	Simon Stockill	**Review date:**	Dec 2019

6.Sign off			
Lead Officer			
Director on behalf of the 3 Leeds CCG Medical Directors	Dr Simon Stockill, Medical Director, Leeds West CCG	**Date approved:**	12.0716

B Policy Consultation Process:

Title of document	General Cosmetic Exceptions and Exclusions Policy including Benign Skin Lesions, Skin Tags, Scars and Keloids
Author	F Day
New / Revised document	Revised
Lists of persons involved in developing the policy	F Day Consultant in Public Health Medicine, Leeds City Council Donald Dewar, Consultant Plastic Surgeon, LTHT V Goulden, G Stables, Consultant Dermatologists LTHT
List of persons involved in the consultation process:	See appendix A

C Version Control Sheet

Version	Date	Author	Status	Comment
Draft v1	7.7.16	FDay, D Dewar, V Goulden, G Stables	Draft v1	Addition of new criteria: fatty tissue in other areas including eyelids Changes to lipoma – on advice from consultant plastic surgeon - Excision of lipomas is considered medically necessary if the lipoma is tender on palpation and inhibiting the patient's ability to perform daily activities due to its location on body parts that are subject to regular contact (via minor surgery service). Lipomas greater than 7cm in diameter have a small risk of undergoing sarcomatous change and should be referred via the sarcoma service. Unexplained lumps should be managed in line with the NICE guidance on suspected cancer[2]. Changes to viral warts criteria 'immunodeficiency states with 'severe symptomatic' viral warts routinely commissioned on advice from consultant dermatologists.
Draft v2	9.11.16	F Day	Draft v2	Lipoma section Adjusted following advice from plastic surgeons
Draft v3	12.7.17	F Day	Draft v3	6.3.4 changed and added 6.3.5
Draft v 4	18.10.17	F Day	V 4	Addition of chronic lymphoedema in line with NICE IPG588
Draft v5	18.10.17	F Day	Draft v5	6.2.2 Lipoma all sections adjusted following advice from Plastic surgeons and Consultant Clinical Oncologists

[2] https://www.nice.org.uk/guidance/NG12/chapter/1-Recommendations-organised-by-site-of-cancer#sarcomas (accessed 7/7/16)

Updated policy 2019-22	5.2.19	F Day	Updated policy	Updated section 6.3 in line with NHSE Evidence Based Interventions : Response to the public consultation and next steps (November 28th 2018)