



**Outcome of the Public Consultation on**

**A Policy to Make Best Use of Resources in Plastic**

**Surgery and Related Specialties**

**23 November 2006**



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## **Background to the Consultation**

1. On 17 August 2006, the four Health and Social Services Boards, in agreement with the Department of Health and Personal Social Services, launched a regional public consultation on a proposal to limit access to some routine, non-urgent procedures so that plastic surgery and related services can focus on treating patients with greatest clinical need. The proposed policy was driven by a need to make best use of finite health and social care resources and brings Northern Ireland more into line with existing practice in Great Britain.

## **Consultation Process**

2. The Consultation Document was approved by each of the four Boards and the ten-week Consultation was formally launched on 17 August 2006, closing 26 October 2006.
3. On behalf of the four Boards, the Northern Health and Social Services Board issued a press release to regional television, radio and print media. Each Board issued press releases to their local newspapers and radio stations and also placed a Public Notice in local papers, with contact details for anyone seeking more information. The story was carried by a number of regional and local media outlets.
4. The Consultation Document was sent to a range of individuals and organisations and specifically by each Board to its
  - Members of Parliament, Members of the Northern Ireland Assembly, and Councillors
  - Health and Social Services Council

- General practices
- Consultants in the affected specialties – Plastic Surgery, Dermatology, General Surgery, and Ear, Nose and Throat surgeons
- Area Medical Advisory Committee and Sub-Committees
- Local Medical Committee for General Practitioners
- Trust Chief Executives
- A range of voluntary and community groups representative of the Section 75 categories.

5. Boards' representatives attended meetings with Area Medical Advisory Committees or their Surgical Sub-Committees, and if requested, with their Local Medical Committees. No other requests for meetings were received.

### **Profile of Responses Received**

6. Thirty responses were received by the closing date, from 4 Borough Councils, 2 Health and Social Services Councils, 4 patient/voluntary groups, 5 Trusts, 8 Medical Groups, and 7 individuals (Appendix 3). Of the 24 responses that gave a view, 16 generally supported the proposed policy, 2 did not support it and in 6, it was unclear.

### **Process for Analysing Responses**

7. All responses were discussed by representatives from the four Health and Social Services Boards and consensus reached on how to address any issues raised (see below).

## **Issues Raised in Responses and Recommended Changes to the Draft Policy**

### *Overall*

8. Among responses that expressed specific comments, there was broad support for the principle that treating patients with serious or life-threatening conditions should take priority over treating patients with more routine conditions. Several welcomed this initiative to improve access to elective care in plastic surgery, though some were concerned that the proposed policy did not go far enough in ensuring that low clinical priority conditions would no longer be referred to secondary care. Others were concerned that patients with genuine clinical needs that do not strictly meet the criteria for surgery should still be able to be referred for assessment and possible treatment.

### *Additional Investment in Plastic Surgery*

9. A number of responses emphasised strongly the importance of the planned investment in additional plastic surgeons. The Boards accept that view fully and therefore, the commitment to extra investment and redesign of plastic surgery services is restated here

- Development of a single integrated Plastics service for Northern Ireland
- A commitment to increase the number of plastic surgeons in Northern Ireland from 7 to 10, bringing the number of surgeons into line with regions in England
- Investment in support staff to provide more operating time and outpatient clinics

- Extra new clinics by Specialist Nurses and General Practitioners with a Specialist Interest, and
- Improvements in waiting list and other management arrangements.

### *Use of the Term 'Cosmetic'*

10. Two responses felt that the term 'cosmetic' undervalued the health benefits that some of these procedures can bring to patients. The term 'cosmetic' will therefore not be used in the final document. The Boards recognise the clinical expertise and specialist skills of plastic surgeons. The Boards also recognise that if a patient meets the criteria for surgery, then the procedure is meeting a clinical need.

### *Assessing Psychological Impairment*

11. While some responses sought reassurance that surgery would still be available for patients whose condition causes significant psychological impairment, others expressed concern about the potential impact on psychological services and the difficulties in making an objective psychological assessment.

12. These divergent concerns will be addressed as follows.

- In line with practice in some Primary Care Trusts in England, patients will be assessed psychologically against the standard whereby "*a reasonable person would be unable to tolerate*" the abnormality in appearance.
- It should be clear to the assessor that the perceived abnormality in appearance is the primary problem for the patient and the patient has

no underlying psychological problem that would not be resolved through surgery.

- In the case of young children, the *potential* for serious psychological impairment will be added as an additional criterion.
- Through development of Integrated Clinical Assessment and Treatment Services (ICATS), an assessment service will provide a preliminary assessment of patients referred from general practice. This assessment service will help to mitigate variation in psychological assessment of patients to ensure that the criteria are applied consistently.

#### *Primary/Secondary Care Interface*

13. A concern was raised that the policy might result in a shift of work, particularly removal of benign skin lesions, from secondary care to primary care. In response to this concern, it should be understood that the proposed policy only relates to conditions which cannot be treated by primary care and are currently referred to secondary care. There should therefore be no impact on primary care as primary care will not be expected to treat patients that it cannot currently treat.
14. The Boards recognise that the proposed policy introduces an anomaly whereby simple skin lesions can be treated in primary care, but some lesions that primary care cannot treat will no longer be treated by secondary care. The regulations which set out the minor surgery service delivered within general practices are agreed at national level. Boards cannot change these. It is possible that this issue will be raised in future discussions on the General Medical Services (GMS) contract.

15. A number of responses sought more detail on the specific conditions that would fall within umbrella terms like “benign skin lesions”. To address this, guidance which describes the conditions and criteria for surgery in more detail, will be provided for use by GPs and Consultants. In addition, local Board ICATS Services are required to develop guidelines on the clinical management of common conditions, including those not covered by the policy e.g. common skin rashes. Those guidelines will also assist general practitioners in determining the appropriate management of dermatological and other conditions.

#### *Arrangements for a Second Opinion*

16. Further details on arrangements for a second opinion were sought by several respondents. As a result, the Consultation document will be amended to explain that a second opinion can be sought when a patient does not agree with the outcome of their assessment against the criteria for surgery. The assessment may have been done by their General Practitioner, or in an ICATS or traditional hospital outpatient service. In addition, the Document will emphasise that the decision on who should be asked to provide a second opinion is a matter for discussion between the patient and their clinician. It will also highlight the other options available to patients who are unhappy with their care, including the Complaints procedure and the advocacy and monitoring role of the Health and Social Services Councils.

#### *Definition of Exceptional Cases*

17. Detail on what constitutes an exceptional case was sought by some respondents. However, the nature of exceptional cases means that it is

difficult to give further detail of what constitutes 'exceptional'. Instead, the Consultation document will be amended to show that if a GP feels that a patient's circumstances are exceptional, they should state clearly in the referral letter the factors that make that patient's case materially different from other patients. Such referrals will then be considered on a case-by-case basis by the service to which the patient was referred.

18. One respondent asked that the criteria should be such that they allow for clinical judgement and exceptions. The criteria as they stand and the provision for exceptional cases, accommodate this request.

#### *Waiting List Issues*

19. In response to questions about the urgency of patients already on the plastic surgery waiting lists, all referral letters were read by a doctor and prioritised according to clinical urgency. Information on urgency is not computerised and therefore, a breakdown of the urgent and routine categories is not available for the 6,000 patients on the outpatient list. Nevertheless, the prioritisation process helps to ensure that urgent referrals are seen before more routine referrals. Of the 6000 people on the plastic surgery outpatient waiting list at July 2006, three-quarters had been waiting for more than 6 months and it is not unreasonable to assume that these had been assessed clinically as non-urgent.
20. If the policy is introduced, patients who have already been referred for one of the procedures in the proposed policy and are currently waiting for a first outpatient appointment will be seen at an assessment service. An information leaflet summarising the criteria for surgery will be sent to

patients prior to their appointment. The assessment service will apply the criteria for surgery and will explain the outcome of their assessment and the reasons for that outcome, to the patient.

### *Stakeholder Group*

21. One respondent suggested that a Stakeholder group be established with representatives from patient groups, commissioners and service providers. The Boards support this suggestion and will highlight it to those involved in discussions on the new organisational arrangements for health and social services in Northern Ireland. The Stakeholder group could take the lead in monitoring the impact of the proposed policy and the extent to which the criteria are being applied consistently.

### *BMI Thresholds*

22. Some responses expressed concerns regarding the BMI (Body Mass Index) thresholds set as criteria for surgery, citing that, with the obesity levels of the population, a large proportion of patients would not meet the criteria. Others queried whether or not equality between men and women in setting the thresholds, was appropriate. One queried the difference in thresholds for abdominoplasty (tummy tuck operations) compared to breast reductions. Several mentioned the need for support services to patients who want to lose weight.

23. The threshold for abdominoplasty was taken directly from the Modernisation Agency Guidance for Commissioners and in that Guidance, was different from the threshold for breast reduction.

24. The Modernisation Agency Guidance on BMI thresholds for breast reduction was 30 for women and 25 for men. There were a number of reasons for setting the BMI threshold at 25 for breast reduction in NI

- Patients with a BMI over 25 are classified as being overweight. For these patients, being overweight can make their symptoms worse. Similarly, reaching a normal weight can sometimes mean that a patient no longer needs surgery. The proposal therefore is that patients should first of all achieve a normal weight and if they still have symptoms, they will be treated within the waiting times set by the Minister
- A second reason is that even with a BMI threshold of 25, the plastic surgery service would have to more than double the number of these operations it normally does each year. The investment in extra surgeons and other staff will help the service to achieve that
- There is also a need to treat men and women equally by having the same BMI threshold for each.

25. However, the Boards recognise the concerns raised and would therefore aspire to increase the BMI threshold for breast reduction in the future. The impact of the additional investment and the service redesign will therefore need to be monitored closely and the demand and capacity of the service reviewed on a regular basis. If the service can treat all patients with a BMI of less than 25 in a timely way, commissioners may be able to review the threshold in the future. If that can be done, the final BMI threshold will be no greater than 30.

26. A range of support services are available for patients who want to lose weight, particularly advice from primary care staff on healthy eating and lifestyle choices. Primary care can also refer patients to other services, such as dietetics, as required.

### *Clinically Benign Skin Lesions*

27. In response to concerns about the process for assessing whether or not a skin lesion is benign, the final Document will explain that, where there is diagnostic uncertainty, skin lesions will be assessed clinically through examination of the lesion by a doctor or other appropriately qualified professional. If there is any doubt about whether or not a lesion is benign, the patient should be referred to the appropriate service for further assessment.

### *Tattoo Removal*

28. In response to concerns that the criteria for tattoo removal do not take account of the potential nature of some tattoos, the criteria for tattoo removal will be adjusted to show that tattoos will be removed if the tattoo is visible in a person's normal daily life and either the tattoo may put the patient's life, health or livelihood at risk or the tattoo was inflicted without the patient's valid consent.

### *Breast Revision Surgery*

29. Some respondents felt that revision surgery for breast augmentation should not depend on whether or not the previous operation was carried out under the HPSS. The criteria will be adjusted to distinguish between removal and replacement surgery. Removal surgery will be performed if

there is a clinical reason for removal. The reference to previous surgery under HPSS will be removed as HPSS has a duty of care to patients in clinical need. The criteria will also be adjusted to show that replacement will only be performed if the patient meets the criteria for augmentation in place at the time of assessment for augmentation.

### *Breast Augmentation and Breast Lift*

30. To clarify questions about eligibility of patients who have undergone mastectomy, the criteria for breast augmentation and breast lift will now explicitly include *post-mastectomy and other reconstruction* as criteria for surgery.

31. The Consultation Document has been amended to reflect these recommendations and the revised version will be considered by each Board on 23 November 2006.

### **Equality Screening Process**

32. An Equality Screening template has been completed, taking account of responses received during the Consultation. The completed template is given in full in Appendix 4.

### **Process for Giving Feedback to Respondents to the Consultation**

33. All respondents will receive a letter acknowledging their response and explaining that they will receive a final version of the proposed policy document following Ministerial approval.

34. Assuming all Boards approve the amended policy document, the final version, including Board members' comments, will be submitted to DHSSPS for Ministerial consideration.

35. Contingent upon Ministerial approval, the final policy document will then be issued and a copy sent to each person or organisation who responded to the Consultation. In addition, Guidance for General Practitioners will be distributed to all General Practitioners and relevant hospital and independent sector staff in hardcopy laminate form and electronically.

**HEALTH BOARDS CONSULT ON THE BEST USE OF RESOURCES IN PLASTIC SURGERY**

The four Health and Social Services Boards have launched a regional public consultation on a proposal to limit access to some largely 'cosmetic' procedures so that plastic surgery services can focus on treating patients with greatest clinical need.

Plastic surgeons treat a wide range of conditions from life-threatening burns, trauma, cancers and congenital abnormalities, to relatively minor conditions that could be called 'cosmetic' such as tummy tucks and tattoo removal.

Demands on emergency plastic surgery services have increased substantially in recent years. Improved techniques and new technologies mean that plastic surgeons can offer more treatment options than before, particularly in the treatment of cancers, serious burns and surgery to reattach severed limbs. Currently, there are many more people referred to plastic surgery than the service can see.

Dr Carolyn Harper, Consultant in Public Health, Northern Health and Social Services Board, explained the need for the proposed new policy:

“Patients with serious or life-threatening conditions must take priority and be treated before those waiting for more routine or non-urgent operations. As a result, patients with some routine conditions have very little real prospect of ever being treated.

“To help alleviate this problem, a package of changes has already been agreed. This includes substantial new investment to increase the number of plastic surgeons from seven to ten, extra support staff and clinics, development of a single integrated plastics service and improvements in waiting list management.

“However, even with these changes, the expanded service still could not see all the patients currently referred to plastic surgery.”

Dr Harper continued:

“We are therefore seeking comments on a proposal to limit the number of ‘cosmetic’ procedures done in the future by using clear clinical criteria to determine whether or not a patient should have surgery. Patients who

meet the criteria will be operated on within the waiting times set by the Minister for Health, Social Services and Public Safety. Patients who do not meet the criteria will not be referred or operated on, to enable the service to focus on patients with greatest clinical need.”

The procedures that will be affected by this policy are at the ‘cosmetic’ end of the type of work undertaken by plastic surgeons and some other specialties like Dermatology, General Surgery and ENT (Ear, Nose and Throat) services. Limiting access to these, more routine procedures, is the only feasible way of ensuring that patients who really need to see a plastic surgeon – those with serious injuries, burns, cancer, congenital abnormalities – are seen quickly.

Comments from the public are welcomed on this consultation. The consultation document can be accessed via the Northern Health and Social Services Board website at [www.nhssb.n-i.nhs.uk](http://www.nhssb.n-i.nhs.uk). A copy of the document can also be requested by contacting Louise Ward, Strategic Planning and Commissioning Directorate, Northern Health and Social Services Board, County Hall, 182 Galgorm Road, Ballymena BT42 1QB, tel: 028 2531 1184 or email: [louise.ward@nhssb.n-i.nhs.uk](mailto:louise.ward@nhssb.n-i.nhs.uk) or by using the textphone number

028 2531 1001. The document can also be made available in an alternative format upon request.

Responses to the consultation must be received no later than 5.00 pm on Thursday, 26 October 2006.

**- ENDS -**

For further information, please contact Elizabeth Owen/Nataleen Surgenor/Sinead Downey,  
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Email: elizabeth.owen@nhssb.n-i.nhs.uk or nataleen.surgenor@nhssb.n-i.nhs.uk or  
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**Note to Editors:**

All patients who have already been seen by a specialist and placed on a waiting list for surgery will receive their surgery unless they no longer want it or medical reasons why they should not have surgery. Patients who have been referred by their GP and are currently waiting to be seen for the first time in Outpatients will be called for assessment and the proposed new criteria will be applied to each case.

**Consultation on Best Use of Resources in Plastic Surgery  
and Related Specialties**

The four Health and Social Services Boards are launching a regional public consultation on “A Policy to Make Best Use of Resources in Plastic Surgery and Related Specialties”.

In order to enable plastic surgeons to focus on treating patients with the greatest clinical need, it is proposed to limit access to some ‘cosmetic’ procedures. Comments from the public on the consultation document are welcomed.

The consultation document can be accessed via the Northern Health and Social Services Board website at [www.nhssb.n-i.nhs.uk](http://www.nhssb.n-i.nhs.uk) or by contacting: Louise Ward, Strategic Planning and Commissioning Directorate, Northern Health and Social Services Board, County Hall, 182 Galgorm Road, Ballymena BT42 1QB. Telephone: (028) 2531 1184 or Email: [louise.ward@nhssb.n-i.nhs.uk](mailto:louise.ward@nhssb.n-i.nhs.uk) or Textphone: (028) 2531 1001

The document can also be made available in an alternative format upon request.

All comments must be received by **5.00pm on Thursday, 26 October 2006.**

## List of Respondents

## Appendix 3

Age Concern Northern Ireland  
Ards Borough Council  
Armagh City and District Council  
Banbridge Coronary Support Group  
Belfast City Council  
Belfast City Hospital Trust  
British Dietetic Association  
British Medical Association  
Causeway Health and Social Services Trust  
Eastern Local Medical Committee through the Eastern Health and Social Services Board  
Down Borough Council  
Down Lisburn Trust  
Dr David Eedy, Consultant Dermatologist  
Eastern Health and Social Services Council  
EHSSB Surgical Sub-Committee of Area Medical Advisory Committee  
Equality Commission for Northern Ireland  
Green Park Healthcare Trust  
Help the Aged  
Lisburn City Council  
Mr Cedric Quick, Consultant in Otolaryngology, Head and Neck Surgery  
Mr Derek Gordon, Consultant Plastic Surgeon  
Mr Eamon Mackle, Consultant Surgeon  
Mr Michael Donaldson, Consultant in Dental Public Health  
Mr Stephen Sinclair, Consultant Plastic Surgeon

Ms Roslyn McMullan, Consultant Orthodontist  
Northern Area Medical Advisory Committee  
Northern Health and Social Services Council  
Regional Dermatology Audit and Clinical Governance Group  
Southern Area Medical Advisory Committee  
Southern Local Medical Committee through the Southern Health and Social  
Services Board  
United Hospitals Trust  
Western Local Medical Committee through the Western Health and Social  
Services Board

**Name and purpose of Policy being screened**

A policy to make best use of resources in plastic surgery and related specialties

**1. Is there any evidence of higher or lower participation or uptake by different groups in relation to this policy?**

<i>Group</i>	<i>Yes</i>	<i>No</i>	<i>Not known</i>
<b>Religious belief</b>			<b>x</b>
<b>Political opinion</b>			<b>x</b>
<b>Racial group</b>			<b>x</b>
<b>Age</b>	<b>x</b>		
<b>Marital status</b>			<b>x</b>
<b>Sexual orientation</b>			<b>x</b>
<b>Gender</b>	<b>x</b>		
<b>Disability</b>			<b>x</b>
<b>Dependency</b>			<b>x</b>

*Comments:* Some of the procedures mentioned in this policy are more relevant to women (e.g. breast related procedures) and children (e.g. correction of prominent ears). We have no evidence to indicate that there is a higher or lower uptake of the various procedures by any of the other groups.

**2. Do different groups have different needs, experiences, issues and priorities in relation to this policy?**

<i>Group</i>	<i>Yes</i>	<i>No</i>	<i>Not known</i>
<b>Religious belief</b>			<b>x</b>
<b>Political opinion</b>			<b>x</b>
<b>Racial group</b>			<b>x</b>
<b>Age</b>	<b>x</b>		
<b>Marital status</b>			<b>x</b>
<b>Sexual orientation</b>			<b>x</b>
<b>Gender</b>	<b>x</b>		
<b>Disability</b>	<b>x</b>		
<b>Dependency</b>			<b>x</b>

*Comment:*

- The breast procedures listed in the policy are more likely to be carried out on women and therefore reducing access to some of these procedures will affect more women than men.
- The correction of prominent ears is more likely to be availed of by children, but the policy has provided that this procedure should be available to adults as well, acknowledging that it is, for some people, not until they reach adulthood that they can take responsibility for their own healthcare choices.
- Some people with a disability may not be able to achieve or maintain a stable BMI because of their particular condition. Where the GP accepts that this is the case, the GP may still refer the patient for

surgery if it is considered that the patient's circumstances make them an exceptional case.

**3. In relation to implementing this policy, is there an opportunity to better promote equality of opportunity or good relations by altering the policy or by working with others in Government or in the larger community?**

Please tick      Yes                      No    ✓

**4. Have consultations with relevant groups, organisations or individuals indicated that this policy creates, or may create, specific problems?**

<i>Group</i>	<i>Yes</i>	<i>No</i>	<i>Not known</i>
<b>Religious belief</b>			<b>x</b>
<b>Political opinion</b>			<b>x</b>
<b>Racial group</b>			<b>x</b>
<b>Age</b>	<b>x</b>		
<b>Marital status</b>			<b>x</b>
<b>Sexual orientation</b>			<b>x</b>
<b>Gender</b>	<b>x</b>		
<b>Disability</b>	<b>x</b>		
<b>Dependency</b>			<b>x</b>

*Comment:* Some respondents questioned the need to have the same BMI threshold for breast reduction for men and women. In the absence of clear

biological reasons for having different thresholds for men and women, these groups should be treated equally.

In addition, a few respondents were concerned that some people with a disability or a particular medical condition may not be able to achieve or maintain a stable BMI to be eligible for breast reduction or abdominoplasty. However, the policy allows that, if the GP agrees that this is a factor, the GP has the flexibility to refer the patient as an exceptional case.

#### **5. Indicate what groups/individuals you have consulted and how?**

The document was issued by each Board to a range of interested individuals and organisations including:

- Members of Parliament, Members of the Northern Ireland Assembly, and Councillors
- Health and Social Services Council
- General practices
- Consultants in the affected specialties – Plastic Surgery, Dermatology, General Surgery, and Ear, Nose and Throat surgeons
- Area Medical Advisory Committee and Sub-Committees
- Local Medical Committee for General Practitioners
- Trust Chief Executives
- A range of voluntary and community groups representative of the Section 75 categories.

#### **6. Were any particular Equality issues identified by this consultation?**

Please see responses above.

**7. Any other comments on the policy and/or screening exercise?**

The Boards recognises that the impact of this policy across the nine categories will need to be monitored, bearing in mind the limited information on the Section 75 categories. This will involve monitoring those who have been referred for surgery and also those who have not been referred. In addition, monitoring will need to take account of people who present as “exceptional cases” and of people who request a second opinion at any stage in the process. This information gathering will allow those commissioning and delivering the service to be more fully informed of any impact of the policy on individuals across the community.

**8. On the basis of answers to previous questions (and in particular positive answers), do you recommend that the policy should be subjected to a full impact assessment?**

Please tick      Yes                      No    ✓

*Comment:* The four Board group does not recommend an equality impact assessment. This will be reviewed as and when more information becomes available during implementation of the policy.