NHS
Bromley
Clinical Commissioning Group

A meeting of the Integrated Governance Committee of NHS Bromley Clinical Commissioning Group 8 June 2017

ENCLOSURE 7

INDIVIDUAL FUNDING REQUESTS ANNUAL REPORT

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TO BE CONSIDERED BY:

Bromley Clinical Commissioning Group

INVOLVEMENT REQUIRED:

For information and endorsement

SUMMARY

The report explains the process for managing Individual Funding Requests received by Bromley CCG in 2016/17 and includes an overview of the activity of the Bromley CCG IFR Panel.

KEY ISSUES

Bromley CCG retains the independent management of IFR process and this is administrated within the Contracts team by a Contract Support Manager with assistance from a Commissioning Support Officer. South East CSU manages the IFR process for the other CCGs in our area.

A comprehensive review of the South East London Treatment Access Policy is underway.

INTRODUCTION

In this report is an explanation of the IFR process, and an introduction to a wider Public Health report on applications to Bromley CCG for cosmetic procedures 2013-16.

Bromley is the only CCG in South East London to independently manage an IFR Panel and process with North East London Commissioning Support Unit providing this function elsewhere.

DEFINITIONS

IFRs are requests for procedures which are **not routinely funded by the NHS**. The majority of requests are for cosmetic or plastic surgery but also include requests for high cost drugs and specialist treatments or devices. These episodes of healthcare may be funded if a patient meets certain clinical **eligibility criteria**. If a patient does not meet the criteria but their GP or NHS consultant believe they may have **exceptional clinical circumstances** to take into consideration, then an IFR Panel can review the case made for exceptionality.

The eligibility criteria for these types of procedures are included in the ***South East London Treatment Access Policy (TAP)***. For example, breast reduction surgery, by far the most common request, is available to women who have a Body Mass Index (BMI) of 25 kg/m2 or under and a cup size of H or more. The TAP is reviewed annually by the South East London Public Health Commissioning Support Group whose chair reports to the Directors of Commissioning and Finance in our sector.

Exceptionality, as defined in the ***South London IFR Policy***, is "an unusual clinical circumstance about the patient that suggests that they are:

- Significantly different from the general population of patients with the condition in question; and
- Likely to gain significantly more benefit from the intervention than might be normally expected for the average patient with the condition.

The fact that a treatment is likely to be efficacious for a patient is not, in itself a basis for exceptionality."

An IFR Panel are determining whether they can make an exception to the rule and fund an episode of healthcare which would benefit an individual (or in cases of rarity less than 5 in the population). The IFR Panel must be sure the individual does not represent **a cohort of patients** in similar circumstances who would similarly benefit from the proposed treatment. This would constitute a "commissioning decision" which IFR Panels are not empowered to take but can refer issues to commissioners for them to consider a **service development**.

THE SOUTH EAST LONDON TREATMENT ACCESS POLICY (TAP)

When considering a patient's request for a treatment which is not routinely funded by the NHS this is the policy a GP or consultant can check to see if it is included. Section one of the TAP outlines eligibility criteria for procedures that require prior approval even if the patient's clinical circumstances meet the threshold for funding. Section two outlines the procedures which do not require prior approval if the patient meets the criteria (but would require an IFR if they didn't).

The aim of the TAP is to reduce regional variation in availability of and access to treatment. The policy sets out the clinical circumstances in which funding may be available for treatments not routinely funded by the NHS. The IFR process aims to take ethical, consistent, and equitable decisions by applying the terms of the policy to the individual clinical situation without regard to financial or social factors.

The TAP covers Lambeth, Southwark, Lewisham, Bexley, Bromley, and Greenwich CCGs. Bromley CCG is fully compliant with the TAP. Greenwich CCG independently went ahead with a public consultation earlier this year asking for feedback on; whether patients should be required to quit smoking or attend cessation services prior to surgery; or participate in weight loss service prior to surgery, and on a number of procedures they would like to add to the TAP including removal of cataracts and treatment for snoring.

THE IFR PROCESS

- **Screening**

The IFR Process is managed within the Contracts and Commissioning teams by a Contract Support Manager and a Commissioning Support Officer with IFR responsibilities. Applications are screened to ensure **the patient has signed the form confirming their consent for Bromley CCG to use their information in the decision making process**. If applications are incomplete applicants are given a full explanation in writing of the evidence needed to progress their request. The main reason for returned applications is that the referrer has not explained how the patient meets the eligibility criteria.

- **IFR Triage Panel**

Complete applications are referred to the IFR Triage team (the IFR team and a designated Consultant in Public Health, a clinician). Requests for High Cost Drug are triaged by Bromley CCG's in-house Medicine Management team. Requests are assessed for whether there is sufficient information to make a decision about a patient's eligibility for treatment or if they have exceptional clinical circumstances for a full Panel to consider. The IFR Triage Panel may:

  - request further information from referrer if necessary
  - to refer the request to a full IFR Panel
  - to agree or refuse a request without reference to full IFR Panel.

- **IFR Panel**

Only applications which have been reviewed by the Triage panel and considered to be based on exceptional clinical circumstances will be discussed at the IFR Panel meetings. Meetings are scheduled monthly and two lay members are chair and deputy chair. Membership of the Panel is completed by a GP, a Consultant in Public Health, a representative of the Medicines Management Team, and the Commissioning directorate are represented by a Senior Contract Manager and the Contract Manager with IFR Responsibilities. For the meeting to be quorate there must be a GP, and representatives from Public Health and Medicines Management Team present.

Medical or Public Health reviews of proposed treatments are initiated and the pharmacists and registrars who compile the reports attend Panel to discuss their findings.

- **Appeals Panel**

Applicants have a further right of appeal by applying to Bromley CCG Appeals Panel (chaired by a Governing Lay Member) on the following grounds:-

a) The applicant considers that there was a shortcoming in the process of consideration of the request, that is, they wish to question our procedures and /or
b) New and material evidence has come to light that was not considered in the process.

One of the aims of IFR in general is to provide a formal process by which patients can have their requests carefully considered by clinicians. In line with the NHS Constitution the IFR process offers the CCG the opportunity to explain in writing their reasons or rationale not to fund episodes of healthcare and such decisions are supported by publicly available policies.

CONCLUSION AND FURTHER INFORMATION

Enclosed with this paper is a report on the cosmetic procedures applications to the Bromley CCG Panel made during 2013-16 carried out by a registrar in Public Health. They concluded:

"The IFR panel is an important service that aims to give patients equal opportunities to access treatments that are not routinely available on the NHS. At a time where financial issues are strife it is important to ensure that NHS funds are being spent appropriately. It also gives a good platform to patients where their condition or treatment is considered rare, and Public Health will provide detailed evidentiary evaluation of a given treatment. Without its use, there would be a large cohort of patients who would not have a method for requesting certain treatments, both cosmetic and drug related."

The report identified certain trends including:

- Only 10% of requests came from consultants. Many general practitioners make referrals on behalf of specialists despite the guidance advising against this (the request is expected from the "treating clinician").

- The majority of requests are following a consultation with a specialist that has recommended a procedure, however this does not seem to correlate to a successful outcome. Referrals come from a variety of sources so are not always located in the borough; however South London relies on the same Treatment Access Policy and so it would be expected that specialists working in these areas would have knowledge of its contents.

- General practitioners and specialists want to support patients and maintain their good relationship so referring seems in the best interests of that goal. However, managing expectations within primary and secondary care would significantly help the work load of other departments and avoid falsely raising expectations of service users.

For more details on trends and the recommendations to address these issues please refer to the Cosmetic Procedures 2013-16 document enclosed.

Individual funding requests for cosmetic procedures

Background

South East CSU (Commissioning Support Unit) manages the majority of Individual funding requests for the other CCGs in this area. Bromley CCG has retained the independent management of the process and so is the only CCG in South East London to do so.

Bromley CCG receives many requests for individual funding, the majority of which are for funding for cosmetic procedures. Other requests include procedures, drugs and specialised treatments. These requests are not routinely funded on the NHS but can be funded based on exceptionality or on fulfilling certain criteria. There is increasing strain and as a result there are limited resources within the NHS to fund these procedures. Therefore resources need to be used in an effective way. Historically, few applications for cosmetic procedures are successful and take considerable time to process. The cosmetic sections of the Treatment Access Policy (TAP) have recently been reviewed and as documented in the TAP "[in general] are considered to be of low priority by local commissioners and will only be funding in exceptional circumstances."

Despite this, many referrals are continually made to the CCG. This report aims to identify patterns of these referrals over the last 3 years and to what extent do the applications received meet the criteria set out in the TAP. It will also aim to identify sources of referrals and to therefore increase the understanding of these referrers via feedback and recommendations for future requests.

Aims

- Review applications for Individual Funding request panel for cosmetic procedures over the previous 3 years
- Identify patterns of referrals and trends in type of cosmetic procedure referred
- Identify sources of referrals I.e. from general practice, hospital specialists or individuals
- Increase level of understanding of referrers about individual funding request process including the treatment access policy

Objectives

- Collect data from the last 3 years of all applications for IFR for cosmetic procedures
- Analyse data on Excel to assess whether there are trends in:
    - Type of procedure applied for
    - Sources of referrals
    - Number of applications approved
    - Number of applications rejected, reasons and relation to Treatment Access Policy
- Present this data in IFR panel meeting
- Feed this information back to referrers including GPs, hospital specialists and individuals

Methods

Data was collected with the help of the Individual Funding Request Manager at the CCG. An Access database search was conducted to identify all referrals that had been made between April 2013 and March 2016. This included cosmetic procedures, drug procedures and treatments. From here, applications for cosmetic procedures were filtered and only these applications were studied. The data that was available from this search was:

- Date of application
- Treatment
- Decision
- Current stage
- Surgery name

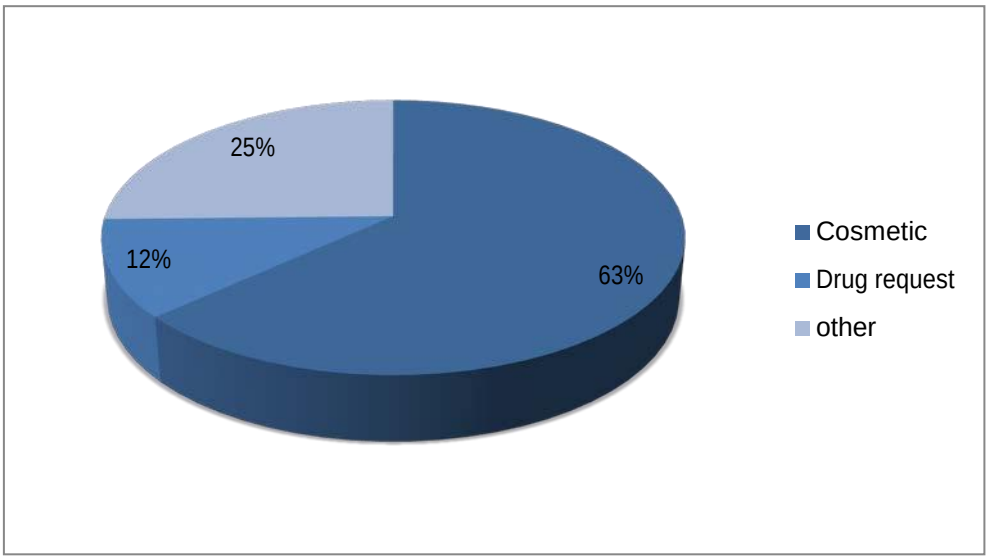
For the purpose of the study, only cases that had been given a decision were included. Subsequently, a manual search of paper records was completed. A random selection of cases that were managed in triage and panel across the 3 years was assessed. A proforma was completed on each case to see who the original requester was, which hospital or department they had been referred to, whether the GP was requested to make the referral and the outcome with details.

Type of procedure applied for

Referrals to the IFR panel were studied between April 2013 and March 2016. This was to include as many “completed” cases as possible. There were a total of 517 requests in total, including drug treatments. Some examples of the type of “other procedures” requested included embryo storage at Kings and BSL interpreter counselling for deafness. Some of these referrals were made before the dissolution of the South London NHS trust in October

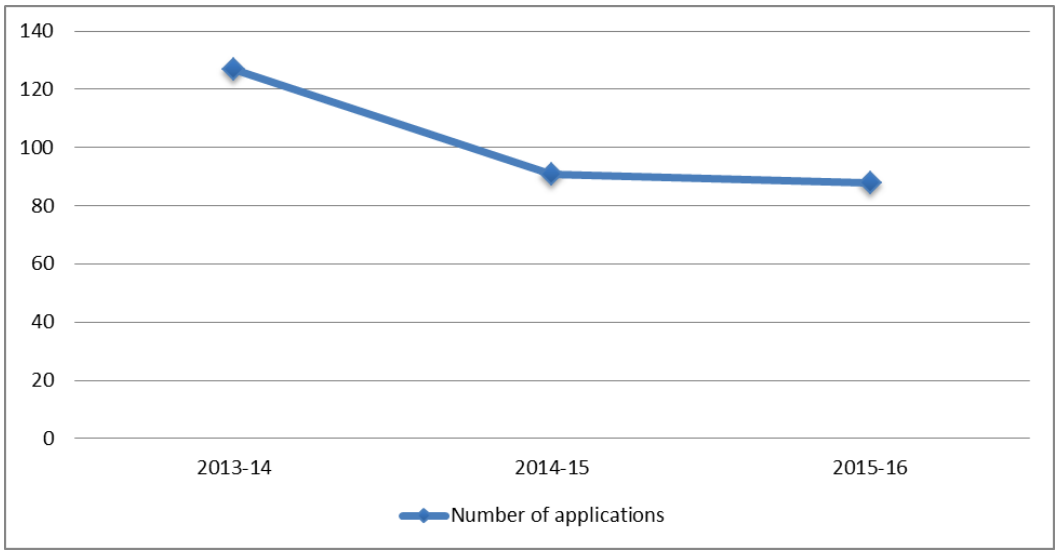
2013. It is clear that the CCG receives far more applications for cosmetic procedures than any other treatment. There were 336 requests for cosmetic procedures during this time period; this includes cases that were cancelled, further information requested or consent. For the purpose of this report we will only look at cases that have had a decision made.

Graph 1: Graph to show numbers of applications by type between 2013-2016



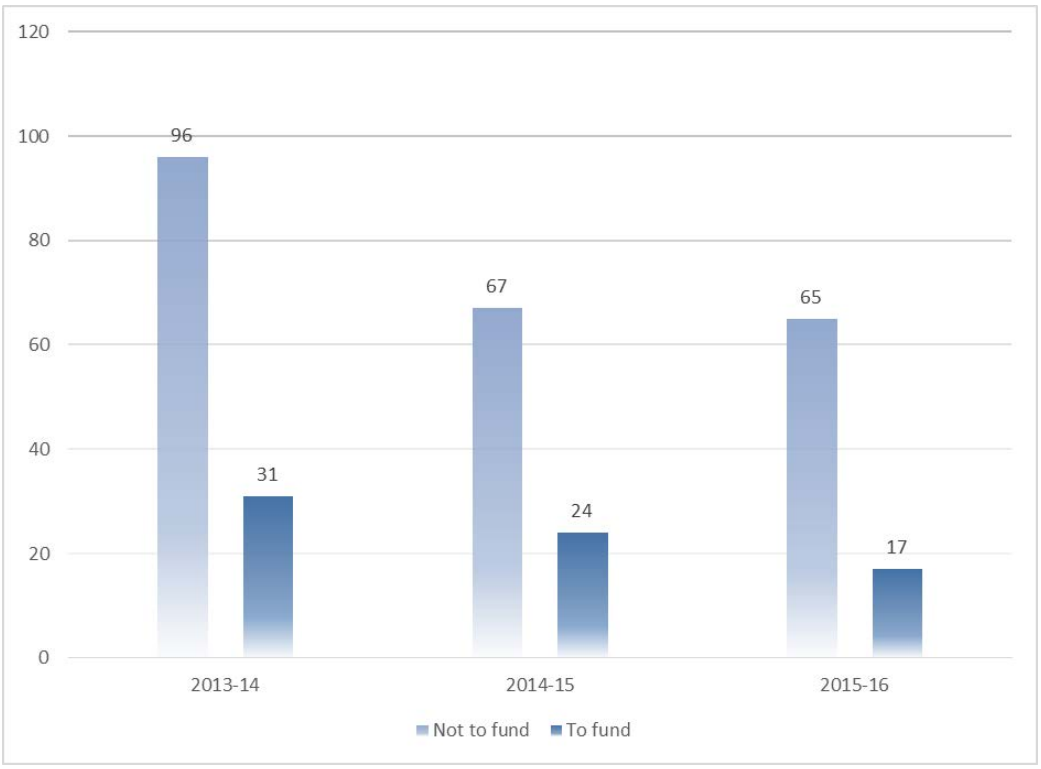
The number of applications has been gradually falling over the past three years. There may be several contributing factors towards this reduction in applications. The NHSE took over applications for specialised commissioning in April 2013 which previously had been dealt with locally, this mainly impacted drug applications especially cancer drug applications. It is hoped that another reason for decreasing applications is the accessibility of the IFR team to GP's and other medical staff when considering making IFR requests. The IFR group continues to strongly encourage all applicants to liaise closely with the team before and during their applications.

Graph 2: Graph to show number of applications for cosmetic procedures by year



As the number of requests decreased, the number of proportionate funded cases to not unfunded cases also decreased. There were 6 outstanding cases in 2015-16 which included 4 cases classes as “other”.

Graph 3: Graph to show trends in funding by year between 2013-2014



The most common cosmetic procedures requested varied between the years. Breast reduction is a procedure that is commonly requested over the 3 years. Whilst these are the most commonly requested procedures, it must be remembered that many different surgeries are available under certain categories and individuals may request two procedures at the same time, for example abdominoplasty and breast reduction. Also, the same procedure can be listed under different names.

For example, there were 81 procedures requested for breast surgery procedures during this time period. Some of these are for the same procedure but filed under different names such as Breast Augmentation for asymmetry”, “Breast reduction – asymmetry” and Breast reduction to correct asymmetry”.

For this reason, we have aimed to group together clusters of similar procedures in order to make analysis of trends clearer. The clusters we have proposed are:

- Breast surgery – including breast reduction, breast reduction for asymmetry, implants
- Body contouring – including abdominoplasty, removal of excess skin and liposuction
- Laser and hair removal – including treatments for hirsutism and scar removal

- Excision of lesion – including lipomas, cysts and cryotherapy

- Septorhinoplasty and rhinoplasty
- Pinnaplasty
- Varicose vein surgery
- Cosmetic genital surgery
- Gynaecomastia

- Facial cosmetic surgery – including face lift, blepharoplasty
- Dual – breast surgery and body contouring together

- Botox
- Transgender reassignment surgery

Graph 4: Graph to show the number of applications received frequently for cosmetic procedures between 2013-2016 by category

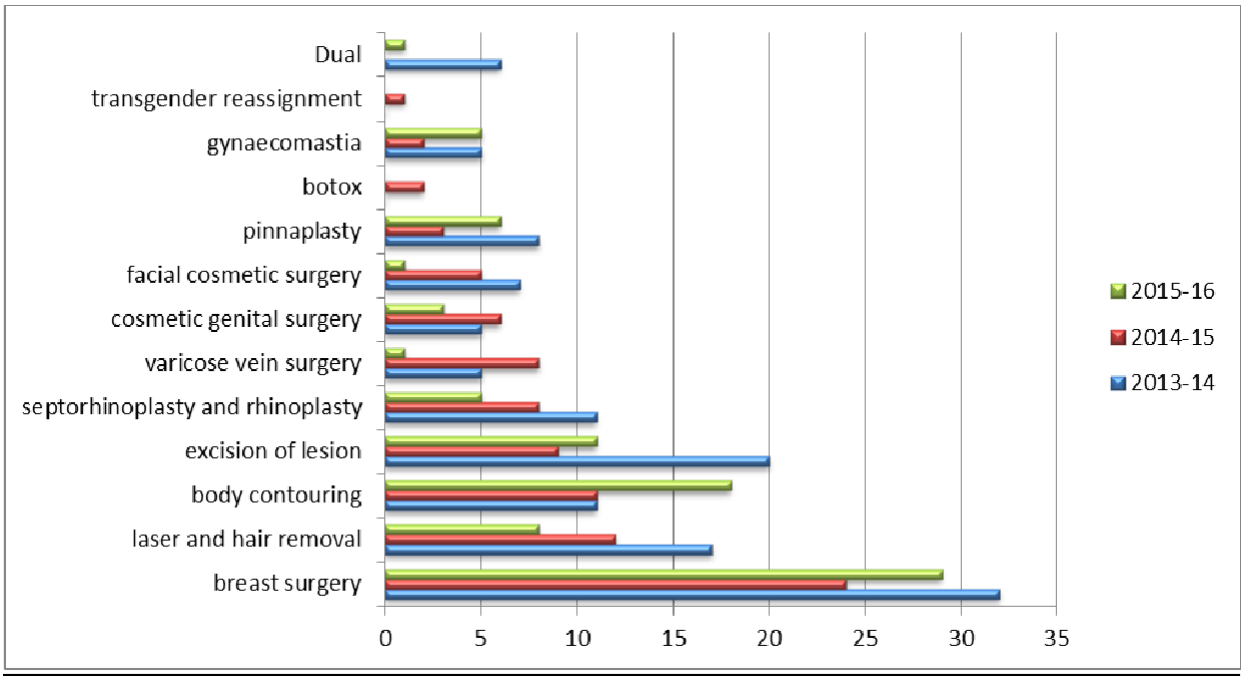


Table 1: Table to show most commonly requested procedures during April 2013-March 2016 by year:

Most commonly requested procedures	1	2	3	4
2013-14	Breast surgery	Excision of lesion	Laser and hair removal	Septorhinoplasty and rhinoplasty
2014-15	Breast surgery	Laser and hair removal	Body contouring	Excision of lesion
2015-16	Breast surgery	Body contouring	Excision of lesion	Laser and hair removal

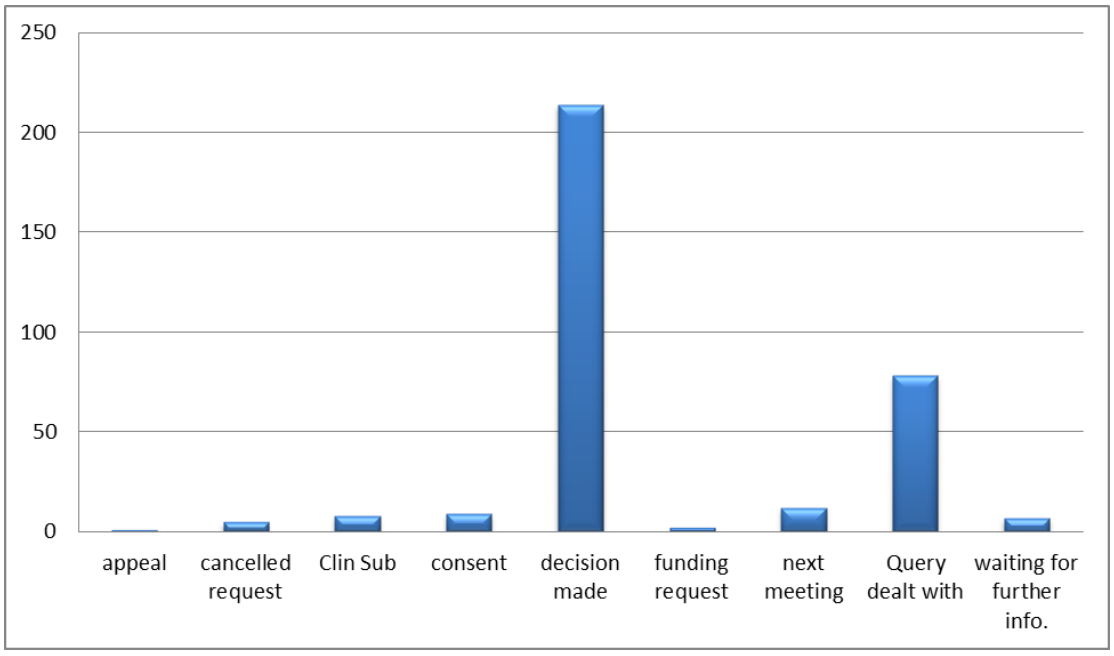
Some requests are decreasing – these include varicose vein surgery, facial cosmetic surgery and laser and hair removal. It is hoped that this is because expectations are being managed more effectively in the community rather than these procedures being completed without having prior approval.

The graph below shows the current stage of all of the applications made. One appeal was made to the panel. 306 cosmetic applications cases are deemed to have a decision made, in 300 cases the decision was to fund or not to fund. When an application is made there are several options. The clinical triage group can decide to;

- Agree to fund (circumstances meet the criteria)
- Not agree to fund (circumstances do not meet criteria)
- Cancel the request (patient/referrer withdraws the application).
- Refer to the IFR Panel (case does not meet criteria but there are exceptional circumstances that need to be considered)
- Request further information from the referrer (Applications that do not provide enough information are referred back with an explanation)
- Query dealt with (i.e. letter or application received, but unable to process through IFR due to incomplete application or referrer is just seeking clarity).

Appendix 1 details the full list of requested procedures and the decision made in each case.

Graph 5: Graph to show current documented outcome of cosmetic procedure requests 2013-2016



The access database currently stores an electronic file of all cases. This has been managed to two different people since 2013 that have both used the database in different ways.
Cancelled request is synonymous with query dealt with. It is difficult therefore from the data

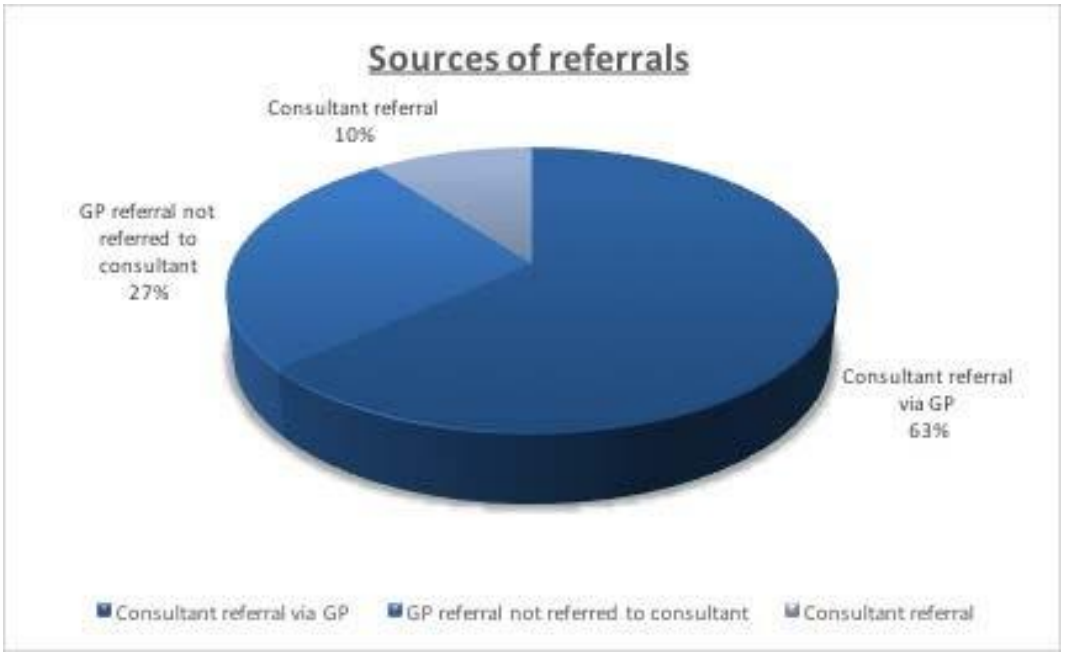
yielded from this search to provide accurate representation about the stages that each case reached. It is also worthwhile to note that this represents a “current stage”, there were more appeals received in this time period than is documented here and so does not accurately represent that data. It is hoped from April a new Excel based database will used which will allow this information to be more clearly documented.

Trends by requester

Individual funding requests can be made to the CCG by a variety of different people including GPs and specialists. Individuals are not encouraged to make applications and the IFR guidance recommends that the physician proposing the treatment should ideally make the referral. This report wanted to assess the main source of requesters in order to target feedback to these groups. Due to the current storage of paper files, it was not possible to access every paper case file. For this reason, we took a random sample of a selection of cases that were dealt with both in triage and panel which included cases that were funded and not funded over the three years being studied. This was approximately 50 cases. The patterns seen were similar to trends observed in the full audit data.

The majority of referrals that were received by the CCG were from GPs, after being prompted to refer by hospital specialists. The next most common method of referral was via the GP when the GP had decided not to first refer to specialist department. Only 10% of referrals were made directly from hospital consultants proposing the treatment. The source of the referrer did not seem to impact the decision to whether treatment funding was successful. No referrals were made by individuals.

Graph 6: Graph to show sources of referrals from sample data 2013-2016



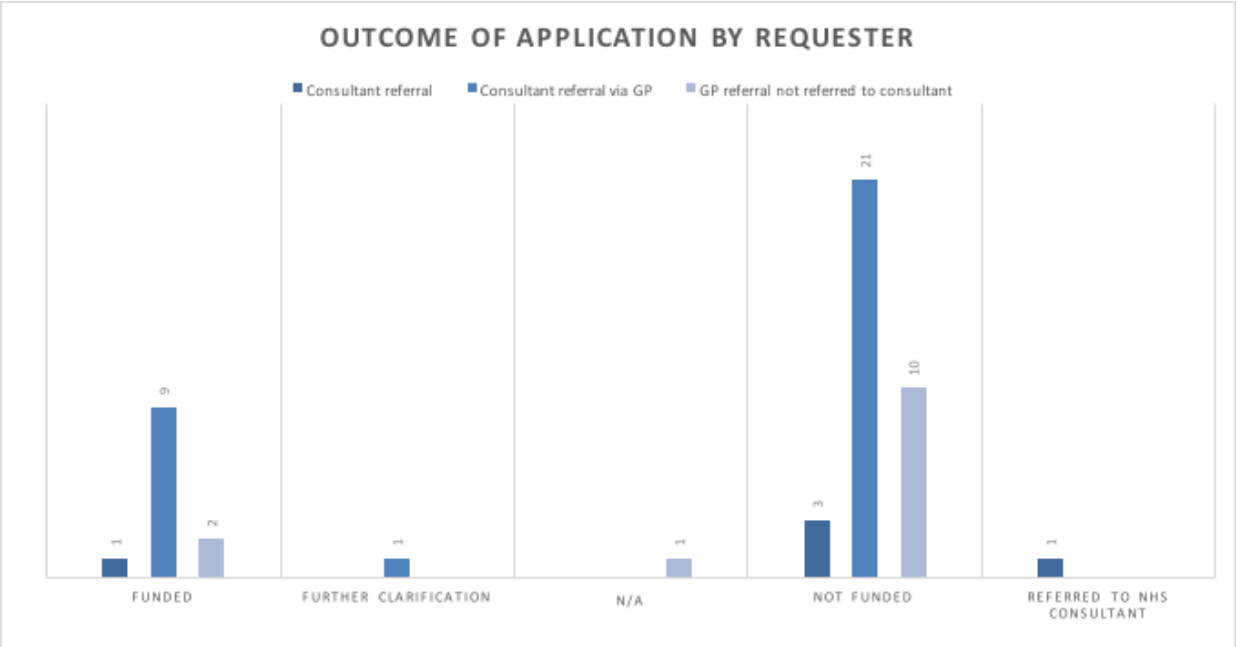
The three most common sources of referrals were:

1. Plastics department, St Thomas' Hospital
2. Breast Surgery, Princess Royal Hospital
3. ENT, Princess Royal Hospital

The majority of these requests were not funded. 2 of the requests from the above requesters out of a total of 15 were funded from this sample.

The graph below shows the trend of the outcome of application by type of requester. There are similar patterns of decision outcomes regardless of the source of the requesting clinician.

Graph 7: Graph to show outcome of application by requester in sample data



It is worth noting that in IFR guidance that it states that “It is the responsibility of the clinician administering the treatment /intervention to complete the IFR application form and to submit all relevant clinical information and supporting evidence needed for the consideration of the application.” This guidance does not seem to be adhered to regularly with specialists frequently asking general practitioners to make applications on their behalf. One potential method of reducing the amount of inappropriate referrals is to work to discourage this practice and ask that referrals are made from the treating clinician. There were proportionately more unsuccessful applications in the cases that were not referred to treating clinicians, which suggests either, that secondary care are filtering out applications unlikely to be accepted or these referrals are being made by GPs without good knowledge of the IFR process.

Rationale of outcomes of referrals

The final aspect that was assessed is rationale behind the outcomes of each case. The following table demonstrates the rationale behind the decisions of applications from the sample data. From the sample studied, the majority of requests that were funded met the criteria set out in the TAP. There were two cases of benign asymptomatic cyst removal that were approved for unclear reasons. There were no cases identified during this audit of cases being funded on the basis of “exceptionality” – which is defined by the IFR policy to be that a patient is:-

- Significantly different from the general population of patients with the condition in question;
- Likely to gain significantly more benefit from the intervention than might be normally expected for the average patient with the condition

The efficacy of a treatment in itself is not a basis for exceptionality.

Table 2: Table to show rationale behind funding decisions from sample data 2013-2016

Funded	**12**
Met criteria	10
Unclear	2
Further clarification	**1**
Further information requested	1
N/A	**1**
Not IFR request	1
Not funded	**34**
Did not meet criteria	13
No exceptionality	21
Referred to NHS consultant	**1**
Further information requested	1
Grand Total	**49**

Cases were not funded for either that they did not meet criteria as set out in the TAP or that it was decided that there was no exceptionality. This information may be useful to potential referrers who are unsure to whether make an application for an IFR and would like some information about whether the application may be successful.

There were several instances where it was agreed to amend the guidance set out in the TAP i.e. agreeing on a higher acceptable BMI in a breast reduction application due to clinical circumstance. This would have been labelled however as a “not funded” case. Again, future referrers may consider contacting the IFR team prior to referring to ask for information regarding this and should be encouraged to make an application if felt that there patient had circumstances where the criteria could be amended.

Many cases claim psychological issues to why they are exceptional in relation to the general population. Despite this, none of these procedures were approved on the basis that most people would have a psychological component to their condition. However, some NHS documentation still refers to physiological issues relating to a cosmetic procedure being a basis for exceptionality which is out of date information.

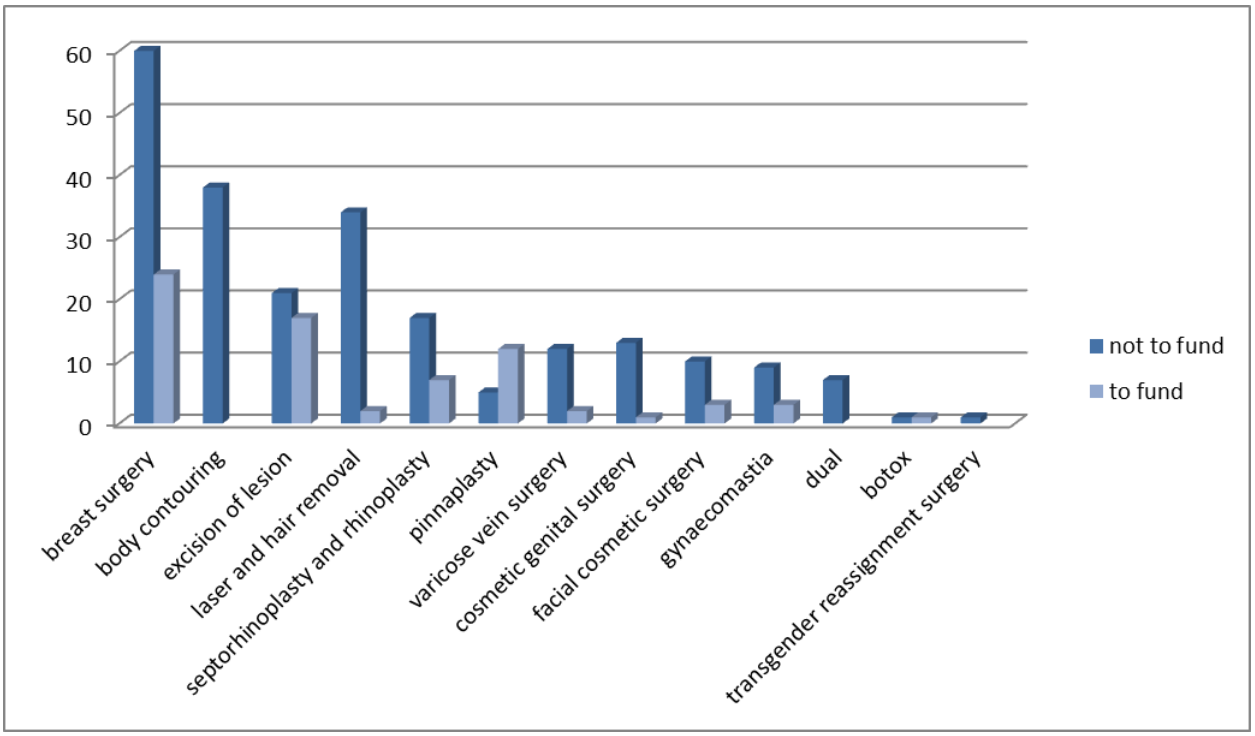
72 of these applications were approved for funding. The main procedures that were funded were surgery, excision of lesion and pinnaplasty. As discussed previously, the likely rationale behind funding for these procedures is that they met the criteria set out in the TAP and there were proportionately more applications received for these procedures. Other funded procedures are listed in Appendix 1.

It is therefore important to have a good knowledge of the criteria set out in the TAP prior to submitting a referral. This may help to cut down inappropriate referrals and help tailor referrals to ensure that they include the relevant information this is required by the guidelines, for example to ensure including the BMI in the application in order to prevent further delays during the process.

As there are many types of procedures that have been entered into the database separately, we have grouped these into common categories for ease. The table below shows the number of procedures that were agreed for funding between this time period and the number of procedures by category. We have only included cases that have a “funded” or “not funded” decision. There are some procedures that are commonly requested but not funded routinely. Such procedures include cosmetic genital surgery, laser and hair removal and varicose vein surgery. Of course, in these categories there are many different procedures and also the same procedure under different names. We would suggest going forward that consistent terminology is used. A full list of requested procedures and the outcomes in each application are detailed in appendix 1.

The graph below illustrates the outcomes of referrals by category over the 3 year time period. We have only included cases that have a “funded” or “not funded” outcome for ease.

Graph 8: Graph to show outcomes of referrals by category 2013-2016



Conclusions and recommendations

The IFR panel is an important service that aims to give patients equal opportunities to access to treatments that are not routinely available on the NHS. At a time where financial issues are strife it is important to ensure that NHS funds are being spent appropriately. It also gives a good platform to patients where their condition or treatment is considered rare, and Public Health will provide detailed evidentiary evaluation of a given treatment. Without its use, there would be a large cohort of patients that needs would not have a method for requesting certain treatments, both cosmetic and drug related. Whilst maintaining this fundamental basis, it is important to regularly review how the provision is being used in order to provide the most efficient service.

There are many requests for cosmetic procedures via the CCG; many of which are not approved. The two reasons why applications were not approved were that they either did not meet criteria or there was no exceptionality. Procedures that were approved largely were so as they met criteria. During the sample assessment, no cases were made on the basis of rarity – although this may be more applicable to drug treatments and wasn't assessed during this report. Many cases are submitted on the basis of exceptionality; however the sample data shows that none were approved on this basis. Whilst the CCG conveys its sympathy to unsuccessful applicants, the NHS is currently under currently strain. The Kings Fund estimates that 1 fifth of CCGs are forecasting a deficit for the current financial year with NHS trust estimating a deficit of around £2.3 billion. Therefore are there grounds for further restricting access to cosmetic procedures when current cancer waiting times have been missed for 8 consecutive quarters?

The majority of requests are following a consultation with a specialist that has recommended a procedure, however this does not seem to correlate to a successful outcome. Referrals come from a variety of sources so are not always located in the borough; however South London relies on the same Treatment Access Policy and so it would be expected that specialists working in these areas would have knowledge of its contents. One suggestion could be to circulate a copy of the TAP to

practitioners that are referring high numbers of patients to remind them of the criteria. It would be useful to correlate the findings in this report to local data in corresponding areas to assess whether there is large variation in successful applications.

Many general practitioners make referrals on behalf of specialists despite the guidance advising against this. Similarly it may be worthwhile to ensure that GP's also have access to the updated version of TAP to ensure that referrals that are being made in their name are appropriate. It is understandable that many applications are made, in spite of the guidance provided by the TAP. General practitioners and specialists want to support patients and maintain their good relationship so referring seems in the best interests of that goal.

However, managing expectations within primary and secondary care would significantly help the work load of other departments and avoid falsely raising expectations of service users. One possibility is to arrange to send a "Treatment Access Policy" and supporting guidelines to all GP practices in the borough.

During this report, we had to use a random sample of cases to look at where referrals were coming from and reasons for outcomes. Ideally it would have been useful to have had that information for all the requests received during this time. This was difficult as the access database that is currently being used does not have the functionality to include the full range of information that was required including original requester and rationale behind decision made.

It would be recommended to include all of these details on the new spreadsheet to allow for easier re-auditing in the future including grouping procedures into types when entering onto new database system for the purpose of audit. For example, breast surgery includes various procedures such as augmentation for asymmetry, mastopexy and breast reduction. It could be suggested to continue to use the categories generated during this report in order to maintain continuity in re-audit.

In summary some suggestions following this report are as follows:

Circulating copy of TAP (with guidelines) to GPs and high referring secondary care specialists

- Feeding back outcomes of this report to same cohort
- Encourage clinician undertaking procedure to make application
- Replacing current access database with Excel spreadsheet to include details of original referrer, brief rationale of decision made, and whether an appeal was made
- Suggests using a grouping system when accessing data and using consistent names for similar procedures
- Suggest filing cosmetic applications, drug treatments and other separately to ensure all cases can be accounted for on reassessment
- Consider similar audit of applications of CCGs using South East CSU to compare findings

In conclusion, the IFR process is well established and has an invaluable role to providing access to treatments that are not routinely available on the NHS but are sought after. Many applications are not successful and the primary reason is that they do not meet the criteria set out in the TAP or are not deemed exceptional. By raising awareness of this within both primary and secondary care, it may increase the number of appropriate referrals and help manage expectations of applicants to the IFR. There are also improvements that can be made when storing information centrally, whether this is electronically or with paper files to allow for more efficient re-audit with a great depth of information.

Appendix 1
Complete list of applications by type and outcome

not to fund	**228**
Breast Reduction	18
Septorhinoplasty	13
Abdominoplasty	12
Scar Revision	10
Varicose vein surgery	9
Labiaplasty	8
Breast Augmentation	5
Gynaecomastia	4
Apronectomy	3
Excision of sebaceous cyst	3
Cryotherapy	2
Breast Reduction Surgery	2
mastopexy	2
Bilateral breast reduction	2
Brow Lift	2
Blepharoplasty	2
Repair of external ear lobe	2
Breast asymmetry	2
Breast Implants	2
Pinnaplasty	2
Laser treatment for hair removal - hirsutism	1
Abdominoplasty (Body Contouring)	1
Bilateral Nipple Eversion	1
Body contouring - excision of redundant skin	1
Abdominoplasty and breast reduction	1
Botox Treatment	1
Body contouring - apronectomy	1
Abdominoplasty, removal of excess skin, thigh etc	1
Rhinoplasty	1
Breast asymmetry - augmentation to correct	1
Tattoo removal - M-F gender reassignment	1
Abdominoplasty - Appeal	1
Laser & electrolysis - scrotal hair urethroplasty	1
Breast augmentation - M-F transgender	1
Liposuction - symmetrical both axillae	1
Breast augmentation and mastopexy	1
Removal of excess skin post weight loss	1
Breast Augmentation for asymmetry	1
Revision Bariatric Surgery	1
Breast Augmentation to Correct Asymmetry	1
Scar Revision - Ombudsman letter	1

Breast augmention (for small breasts)	1
Surgical removal of lipoma & "cystic structure"	1
Abdominoplasty and mastopexy	1
Varicose veins	1
Breast implants (old ones ruptured and removed)	1
Abdominoplasty & breast augmentation	1
Abdominoplasty - new appeal	1
Laser treatment for cigarette burns scars	1
Breast reduction - asymmetry	1
Laser treatment for severe acne	1
Breast reduction - for asymmetry	1
Mastopexy (one side for asymmetry)	1
Breast reduction - post bariatric surgery	1
Removal of excess skin after bariatric surgery	1
Breast Reduction and Abdominoplasty	1
Removal of tattoos (gender reassignment)	1
Augmentation/mastopexy	1
Replacement breast implants (following rupture)	1
Breast Surgery	1
Revision Labial Surgery	1
Breast surgery left mastopexy & right augmentation	1
Scalp surgery to cover bald patch	1
Breast surgery to correct asymmetry	1
Scar Revision surgery	1
Bilateral augmentation and mastopexy	1
Septorhinoplasty (re review)	1
Carbon Dioxide Laser treatment - Scar Revision	1
Surgical removal of subaceous cyst	1
Circumferential Body Lift	1
Abdominoplasty / apronectomy	1
Coleman fat transfer x 3	1
Xanthelasmata (other benign skin lesions)	1
Abdominoplasty, liposuction, scar revision	1
Labia "Refashioning"	1
Cryotherapy for excision of lesion?	1
Labioplasty	1
Cryotherapy for wart on hand (young boy)	1
laser hair removal	1
Exchange of implants	1
laser treatment for hair growth (Alexandrite laser	1
Nipple change - inversion	1
Laser treatment for hirsuitism - PCOS	1
Pulse Dye Laser Therapy	1
Light assisted hair removal	1
Pulsed laser treatment for rosacea	1
Abdominoplasty, mastopexy, brachioplasty etc	1
Recti Devarification repair via abdominoplasty	1

Mastopexy and augmentation	1
Referral to plastic surgeon - laser treatment	1
Removal of Excess Skin	1
Exchange of implants- bigger size & mastopexy	1
Pulsed dye laser - severe psorias & rosacea	1
Excision of accessory breast tissue	1
Pulsed Light laser treatment for rosacea	1
Excision of accessory nipple	1
reduction right side enlarged labia majora	1
Excision of digital mucous cyst	1
Removal and replacement of breast implants	1
Excision of fatty tissue (axilla)	1
Removal of excess skin (all over body)	1
Excision of lesion	1
Removal of excess skin fold	1
Excision of lesion (ear lobe)	1
Removal of gynaecomastia ? Small amount of tissue	1
Excision of lesion (lipoma)	1
Repair of ear lobe	1
Excision of lesion (seborrhoeic wart)	1
Repair of Lobe External Ear	1
Excision of lesion (xanthelasma)	1
Replacement implants	1
Excision of lump	1
revision bilateral pinnaplasty	1
Revision Pinnaplasty (right ear)	1
Abdominoplasty for divarification of rectus	1
Revision pinnplasty	1
Rhinophyma - Laser resurfacing treatment	1
Excision of skin tag from right eyelid	1
Rhinoseptoplasty	1
excision of skin tags	1
Abdominoplasty & Mastopexy	1
Excision of Skin Tags - other benign skin lesions	1
Scar Revision and apronectomy	1
Excision of skin under armpits	1
Scar revision/laser to treat chick pox scars	1
Excision of Subaceous cyst	1
Septo-rhinoplasty	1
Face lift	1
Surgical correction (Abdominoplasty?)	1
Facial electrolysis - M-F	1
Surgical removal of redundant skin	1
F-M transgender, hysteretomy & oophorectomy	1
Tattoo Removal	1
Further augmentation (to other side)	1
Varcose Vein Surgery	1

abdominoplasty & brachioplasty revision	1
Varicose Vein treatment (not specified)	1
Gynaecomastia (removal)	1
Vulvoplasty	1
Gynaecomastia removal	1
Yag laser treatment	1
Gynaecomastia removal (15 yr old boy)	1
Gynaecomastia removal (liposuction)	1
to fund	**72**
Breast Reduction	11
Pinnaplasty	10
Septorhinoplasty	6
Gynaecomastia	2
Excision of sebaceous cyst	2
Blepharoplasty	2
surgical removal of cyst	2
excision of growth	2
Excision of lesion (skin tag)	2
Excision of lesion (lipoma)	2
Breast Augmentation (Poland's Syndrome)	1
Removal of warts on face & eyelid - autistic boy	1
Breast Augmentation (reduction and mastopexy)	1
Breast reduction to correct asymmetry	1
Surgical removal - other benign skin lesion	1
Breast Surgery	1
Labiaplasty - new application	1
Breast surgery to correct asymmetry	1
Pinnaplasty (ear surgery to correct cryptotia)	1
Breast surgery, correct asymmetry, one breast only	1
Septal Rhinoplasty	1
Exchange and replacement of implant (private)	1
Varicose vein surgery	1
Excision of Cyst	1
Gynaecomastia (Breast Reduction)	1
Breast Augmentaion	1
Laser treatment for severe hirsuitism	1
Excision of lesion	1
Pinnaplasty - one ear only	1
Varicose veins surgery	1
Removal of implants	1
Bilateral upper lid blepharoplasty	1
Scar Revision - following trauma & complications	1
Breast Augmentation	1
Breast Mastopexy	1
Excision of lesions (plastic surgery 2 ops)	1
Botox Treatment	1
Excision of lesions (skin tags)	1

Breast Reduction Surgery	1
Breast augmentation - to correct asymmetry	1
Excision of lesion (mole)	1
other	**4**
Surgical removal	1
Scar Revision	1
Capsulotomy, exchange of implant, mastopexy,	1
Other benign skin lesion	1
commissioning issue	**1**
Removal of epidermoid cyst	1
awaiting decision	**1**
Abdominoplasty (Body Contouring for excess skin)	1
Grand Total	**306**