Equality Analysis

(Health Inequalities, Human Rights, Social Value)

Policy for the use of Non-Cosmetic Body Contouring Surgery

Before completing this equality analysis it is recommended that you:

- ✓ Contact your equality and diversity lead for advice and support
- ✓ Take time to read the accompanying policy and guidance document on how to complete an equality analysis

NHS Birmingham and Solihull Clinical Commissioning Group
NHS Sandwell and West Birmingham Clinical Commissioning Group

1. Background

EA Title	Policy for the use of Non-Cosmetic Body Contouring Surgery		
EA Author	David King	**Team**	Equality and Diversity
Date Started		**Date Completed**	
EA Version	1	**Reviewed by E&D**	

What are the intended outcomes of this work? Include outline of objectives and function aims

Body Contouring Surgery

The Surgical Procedures included in Body Contouring

- Full abdominoplasty

For patients who have significant skin laxity, excess fat and separation of the muscles, a classic tummy tuck is the most common procedure. Performed under general anaesthetic, this operation can require patients to be in hospital for two or three days.

During the operation, an incision is made from hip to hip and around the umbilicus. The excess skin and fat is excised from the umbilicus to just above the pubic hair. The muscles above and below the umbilicus are tightened. The skin is then sewn up to give a circular scar around the umbilicus and a long scar across the lower abdomen. Although this operation leaves a large scar, it does provide the greatest improvement in abdominal shape.

Patients who are thinking about becoming pregnant should not undergo this procedure and should wait until they are sure they are not having any more children. All the skin and fat below the umbilicus can be removed in a standard abdominoplasty. This results in a scar across the lower abdomen and a scar around the umbilicus.

- Mini abdominoplasty

For patients with only a small amount of excess skin a lesser abdominoplasty might be appropriate. A general anaesthetic is still needed.

During the operating, a wedge of skin and fat is excised from the lower tummy leaving a horizontal scar above the pubic hair. Sometimes the muscles will also be tightened. No scar is left around the umbilicus, which may be stretched slightly to become a different shape.
A mini abdominoplasty will give a smaller effect than a full abdominoplasty.

- Extended abdominoplasty

Surplus skin and fat of the loins and back are removed at the same time as the abdomen.

- Endoscopic abdominoplasty

Tightens the muscles of the abdominal wall. Skin is not removed but liposuction can be carried out at the same time.

- Apronectomy (Panniculectomy)

An Apronectomy is a modified mini-abdominoplasty, mainly for patients who have a large excess of skin and fat hanging down over the pubic area and only the surplus skin and fat is removed. A modification to an abdominoplasty might also be necessary when the patient has problems with scars from previous operations.

A panniculus is excess adipose tissue hanging downward from the abdomen and resembles an "apron of skin" overlying the front of the pelvic girdle. A large panniculus can interfere with normal activities such as walking, and lead to serious medical problems. The heavy overhanging tissue can cause chronic skin inflammation under the flap, and subsequently, skin breakdown and infection.

The panniculus hanging below the symphysis pubis when the individual is standing normally can cause significant functional impairment and other complications such as intertrigo.

- Arm reduction and lift (Brachioplasty)

Brachioplasty, or upper arm reduction or arm lift is a surgical procedure which removes and tightens loose skin and excess fat in the upper arm. It is usually performed under a general anaesthetic. The surgeon makes a long incision between the elbow and axilla. Segments of skin and fat are removed and the remaining skin and tissue lifted resulting in a tight, smooth look.

- Buttock and/or Thigh lift (Thighplasty)

Thighplasty is aesthetic reshaping surgery with the removal of excess skin and fat. Buttock or thigh lift surgery is performed to lift the excess skin to firm and tighten the skin around the buttocks and/or thighs. Liposuction may also be performed during this procedure. Sometimes a buttock lift is combined with this procedure.

- Liposuction / Liposculpture / Suction Assisted Lipectomy

Liposuction is also known as liposculpture or suction assisted lipectomy. It is a technique most commonly performed to remove unwanted fat deposits. Liposuction can be performed on other areas of the body, including the neck, arms, tummy, loins, thighs, inner side of the knees and the ankles.

Evidence Review

The results from the search strategy found 3 systematic reviews, 1 economic systematic review and 4 clinical trials & guidance which directly informed ‘Body

Contouring' in reference to the effectiveness measurable by physical, physiological, and/or qualitative patient reported outcomes.

The BAPRAS UK Commissioning Guide 2017 highlights an expert interpretation of various papers to inform NICE and clinical commissioners in the UK health care sector. All results highlighted in the evidence review are also utilised within the commissioning guide.

The 'BODY-Q' systematic review is strong evidence to support the method in measuring the effectiveness of body contouring from patient-reported outcomes (PRO. 'BODY-Q' method is the framework of the BODY-Q scales, presented below, is comprised of three overarching themes as follows: 1) Appearance; 2) Health-Related Quality of Life; and 3) Patient Experience. Under these domains, there are 18 independently functioning scales that measure important COI. In addition to the 18 scales, there is 1 obesity-specific symptom checklist.

Due to the statistically significant health improvement benefits both in relation to QoL and clinical outcomes of more than 30%, and that the evidence has demonstrated the potential of removal of excess skin to prevent both 1st and 2nd prevention of future illness such as mobility, QoL concerns, infection, lymphoedema and other illnesses, it was deemed within certain clinical circumstances that excess skin removal could be an effective surgical intervention.

Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc.

Eligibility Criteria: Restricted

Removal of excess skin is commissioned in the following clinical circumstances:
The patient is 18 or over at the time of application.

AND

The patient has lost at least 50% of their original excess weight and maintained their weight for at least two years, both of which have been recorded and documented by a clinician in the patient's medical notes.

AND the patient has one of the following:

- Skin folds are causing severe functional impairment which is impacting on the patient's ability to carry out activities of daily living.

OR

- Recurrent skin infections in the skin folds which fail to resolve, despite appropriate medical treatment for at least 6 months.

N.B. Functional impairment is defined as preventing activities of daily living to be undertaken independently, i.e. sleeping; eating; walking.

Funding is for procedures to remove excess skin from an area of the body, which is causing functional impairment / recurrent skin infections. Procedures to aid weight loss or muscle tightening e.g. full abdominoplasty are not commissioned under this policy.

Investigations for suspected or proven malignancy are outside the scope of this policy and should be treated in line with the relevant cancer pathway.

Other procedures **which are not included** within the Body Contouring Surgery policy are:

- Breast Surgery
- Liposuction
- Cosmetic Surgery

This means **(for patients who DO NOT meet the above criteria)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG

2. Research

What evidence have you identified and considered? This can include national research, surveys, reports, NICE guidelines, focus groups, pilot activity evaluations, clinical experts or working groups, JSNA or other equality analyses.

Research/Publications	Working Groups	Clinical Experts
Guidance		

[1] British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS), Royal College of Surgeons: UK Commissioning Guide: Massive Weight Loss Body

Contouring, 2017. http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/2017--draft-for-consultation--body-contouring-surgery-commissioning.pdf?sfvrsn=0

[2] Measuring Quality of Life and Patient Satisfaction After Body Contouring: A Systematic Review of Patient-Reported Outcome Measures, Patrick L. Reavey et al, Aesthetic Surgery Journal September 2011 vol. 31 no. 7 807-813
https://academic.oup.com/asj/article/31/7/807/176334

[3] Recommendations on the most suitable quality-of-life measurement instruments for bariatric and body contouring surgery: a systematic review. C.E.E. de Vries, et al. –
https://www.ncbi.nlm.nih.gov/pubmed/29883059

[4] Quality of life among adults following bariatric and body contouring surgery: a systematic review. J. Gilmartin, et al. JBI Database of Systematic Reviews and Implementation Reports November 2016 vol.14 no.11 240-270
https://journals.lww.com/jbisrir/Abstract/2016/11000/Quality_of_life_among_adults_following_bariatric.16.aspx

[5] Diverse approaches to the health economic evaluation of bariatric surgery: a comprehensive systematic review. J.A. Campbel, et al.
https://www.ncbi.nlm.nih.gov/pubmed/27383557

[6] Body image and quality of life in patients with and without body contouring surgery following bariatric surgery: a comparison of pre- and post-surgery groups. M. de Zwaan, et al -
https://www.frontiersin.org/articles/10.3389/fpsyg.2014.01310/full

[7] The impact of reconstructive procedures following bariatric surgery onpatient well-being and quality of life. Van der Beek ES, et al. -
https://www.ncbi.nlm.nih.gov/pubmed/19688408

[8] The BODY-Q: A Patient-Reported Outcome Instrument for Weight Loss and Body Contouring Treatments. A.F. Klassen, et al. -
https://www.ncbi.nlm.nih.gov/pubmed/27200241

[9] Body-Q User Manual, Royal College of Surgeons -
https://tinyurl.com/y53b9xmn

[10] Body Image and Quality of Life in Post Massive Weight Loss Body Contouring Patients. AY. Song, et al. - https://www.ncbi.nlm.nih.gov/pubmed/17030974

[11] Mukherjee,S.,Kamat,S.,Adegbola,S.,andAgrawal,S.(2014). Funding for post-bariatric body contouring (bariplastic) surgery in England: a post code lottery. Plast.Surg.Int. 2014:153194. doi:10.1155/2014/153194 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3980931/

[12] NHS Digital: Statistics on Obesity, Physical Activity and Diet - England, 2018 [PAS] https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-obesity-physical-activity-and-diet/statistics-on-obesity-physical-activity-and-diet-england-2018

3. Impact and Evidence:

In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should also include any identified health inequalities which exist in relation to this work.

Age: Describe age related impact and evidence. This can include safeguarding, consent and welfare issues:

Age range data is not available for the profile of patients requesting the procedure. Some link may be identified between obesity, reduced mobility and the occurrence of the condition if it's a genetic disorder.

Disability: Describe disability related impact and evidence. This can include attitudinal, physical, communication and social barriers as well as mental health/ learning disabilities, cognitive impairments:

As with age obesity is itself a life limiting condition and is commonly found as a co morbidity with other conditions. It has not been shown that restricting this treatment

3. Impact and Evidence:
will impact on this group negatively since those who would benefit and are eligible can access surgery. It is noted that exercise may be more difficult / impossible for patients with some conditions which reduce mobility. In such case the approach would give due regard to reasonable adjustments.
Gender reassignment (including transgender): Describe any impact and evidence on transgender people. This can include issues such as privacy of data and harassment: No impact identified
Marriage and civil partnership: Describe any impact and evidence in relation to marriage and civil partnership. This can include working arrangements, part-time working, and caring responsibilities: No impact identified
Pregnancy and maternity: Describe any impact and evidence on pregnancy and maternity. This can include working arrangements, part-time working, and caring responsibilities: Due to the surgical procedures involved within some of the body contouring techniques across the stomach area such as the full abdominoplasty, it is not advisable to have surgery for patients who are thinking about becoming pregnant. Also, if condition has arisen from a genetic disorder such as lymphoedema, there may be a link to conditions worsening at the time of hormone changings such as pregnancy.
Race: Describe race related impact and evidence**.** This can include information on different ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures, and language barriers: No impact identified
Religion or belief: Describe any religion, belief or no belief impact and evidence. This can include dietary needs, consent and end of life issues: No impact identified

3. Impact and Evidence:
Sex: Describe any impact and evidence on men and women. This could include access to services and employment: No impact identified
Sexual orientation: Describe any impact and evidence on heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers: No impact identified
Carers: Describe any impact and evidence on part-time working, shift-patterns, general caring responsibilities: No impact identified
Other disadvantaged groups: Describe any impact and evidence on groups experiencing disadvantage and barriers to access and outcomes. This can include lower socio-economic status, resident status (migrants, asylum seekers), homeless, looked after children, single parent households, victims of domestic abuse, victims of drugs / alcohol abuse: (This list is not exhaustive) No impact identified

4. Health Inequalities	Yes/No	Evidence
Could health inequalities be created or persist by the proposals?	No	This condition could be linked to a health inequality due to the prevalence of obesity. As the surgical procedures remain available it is not anticipated that a health inequality will be made worse.

Is there any impact for groups or communities living in particular geographical areas?	Yes	A limited link between obesity and areas of high deprivation has been made.
Is there any impact for groups or communities affected by unemployment, lower educational attainment, low income, or poor access to green spaces?	Yes	The ability to access better diet and exercise may be reduced for those in low socio economic groups. Due regard to this will need to be given in supporting such patients.

How will you ensure the proposals reduce health inequalities?

The intention of the policy is to support patients who have managed to maintain their weight for at least two years and where they have lost at least 50% of their original excess weight. It is also to support those patients where a genetic fault is the underlying issue and through the procedure the quality of life for all patients can be improved.

5. FREDA Principles/ Human Rights	Question	Response
Fairness – Fair and equal access to services	How will this respect a person's entitlement to access this service?	Yes, this decision has been made in line with clinical recommendation and NICE
Respect – right to have private and family life respected	How will the person's right to respect for private and family life, confidentiality and consent be upheld?	No evidence of impact for this policy
Equality – right not to be discriminated against based on your protected characteristics	How will this process ensure that people are not discriminated against and have their needs met and identified?	No discrimination identified
	How will this affect a person's right to freedom of thought, conscience and religion?	N/A
Dignity – the right not to be treated in a degrading way	How will you ensure that individuals are not being treated in an inhuman or degrading way?	Policy will be applied with due Regard to this consideration.

Autonomy – right to respect for private & family life; being able to make informed decisions and choices	How will individuals have the opportunity to be involved in discussions and decisions about their own healthcare?	An individual can discuss the impact with their GP and has the option for an IFR request to be made
Right to **Life**	Will or could it affect someone's right to life? How?	No evidence of impact for this policy
Right to **Liberty**	Will or could someone be deprived of their liberty? How?	No evidence of impact for this policy

6. Social Value

Consider how you might use the opportunity to improve health and reduce health inequalities and so achieve wider public benefits, through action on the social determinants of health.

Marmot Policy Objective	**What actions are you able to build into the procurement activity and/or contract to achieve wider public benefits?**
Enable all people to have control over their lives and maximise their capabilities	None
Create fair employment and good work for all	None
Create and develop health and sustainable places and communities	None
Strengthen the role and impact of ill-health prevention	None

7. Engagement, Involvement and Consultation

If relevant, please state what engagement activity has been undertaken and the date and with which protected groups:

Engagement Activity	**Protected Characteristic/ Group/ Community**	**Date**

For each engagement activity, please state the key feedback and how this will shape policy / service decisions (E.g. patient told us …. So we will …..):

As part of the process further targeted engagement is planned with representative groups from among Sandwell, Birmingham and Solihull Patients. In addition, it has been identified that patient and clinician information is key in ensuring that the harmonised treatment policies review delivers effective outcomes. To this end an information briefing sheets on each procedure will be developed to give more information on the procedure, eligibility criteria and signposting to further information sources, such as NHS Choices. These information sheets are also designed to help facilitate discussions between GPs and patients. Information briefing sheets have already been tested and uploaded onto the GP systems for the first 45 harmonised treatment policies for Birmingham and Solihull. Due regard will be given to both the

accessible information standard and the potential need to translate such leaflets into relevant local languages.

8. Summary of Analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work:

The restriction of this policy will have limited impact on those who would wish to receive the treatments, this must be balanced against the need to adhere to the clinical effectiveness evidence, overall health improvements in relation to quality of life for the patient and clinical outcomes.

The opportunity for any exceptional cases to be considered via IFR remains and will ensure treatment is available in an exceptional case.

9. Mitigations and Changes :

Please give an outline of what you are going to do, based on the gaps, challenges and opportunities you have identified in the summary of analysis section. This might include action(s) to mitigate against any actual or potential adverse impacts, reduce health inequalities, or promote social value. Identify the **recommendations** and any **changes** to the proposal arising from the equality analysis.

Consideration will need to be given to what additional support patients from a low socio economic background will require and how due regard can be given to reasonable adjustments in approach for disabled persons.

10. Contract Monitoring and Key Performance Indicators

Detail how and when the service will be monitored and what key equality performance indicators or reporting requirements will be included within the contract (refer to NHS Standard Contract SC12 and 13):

This policy is not linked to a contract however, prospective providers remain bound by their contracts with the CCG.

11. Procurement

Detail the key equality, health inequalities, human rights, and social value criteria that will be included as part of the procurement activity (to evaluate the providers ability to deliver the service in line with these areas):
N/A

12. Publication

How will you share the findings of the Equality Analysis? This can include: reports into committee or Governing Body, feedback to stakeholders including patients and the public, publication on the web pages. All Equality Analysis should be recommended for publication unless they are deemed to contain sensitive information.
Publication on the CCG's website.
Following approval all finalised Equality Analysis should be sent to the Communications and Engagement team for publication: bsol.comms@nhs.net

13. Sign Off

The Equality Analysis will need to go through a process of **quality assurance** by the Senior Manager for Equality Diversity and Inclusion or the Manager for Equality Diversity and Inclusion prior to approval from the delegated committee

	Name	Date
Quality Assured By:		
Which Committee will be considering the findings and signing off the EA?		

Minute number (to be inserted following presentation to committee)		

Please send to Balvinder Everitt or Michelle Dunne, Equality, Diversity and Inclusion for Quality Assurance.

Once you have committee sign off, please send to Caroline Higgs, Communications & Engagement Team for publication: bsol.comms@nhs.net