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Managing aesthetic referrals in NHS Scotland: Outcomes from 1122 patients in the East of Scotland☆

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Abstract The Adult Exceptional Aesthetic Referral Protocol (AEARP) encompasses a series of aesthetic procedures which, as they do not treat an underlying disease process, are not routinely available within the National Health Service. Provision of these services can only be provided on an exceptional basis.

In this prospective study, we evaluated the referral process and outcomes of 1122 patients referred under the AEARP over a 3.5-year period. Referrals were screened by a vetting panel comprising of a plastic surgeon, clinical nurse specialist, and clinical psychologist. Following initial vetting, supported patients underwent psychological assessment. Patients supported by psychology were assessed in clinic, and if deemed clinically suitable, were offered surgery.

Overall, 20% (225/1122) of referrals were supported for surgery. Following primary vetting, 57% (640/1,122) of referrals were supported, 40% (197/492) of referrals to clinical psychology were supported, and 65% (225/345) of the remaining cases referred for consultation were supported for surgery. Unsupported referrals included those not fulfilling the referral guidelines or those with contraindications.

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The AEARP is simple and effective to implement, and has been instrumental in streamlining the referral-to-outcome process in a centralised, transparent, and fair manner. It reduces a potential high number of clinic appointments where patients do not meet the aesthetic criteria and/or fail to attend – thereby helping to streamline other surgical pathways by improving clinic efficiency. Moreover, it aids referring clinicians and patient education around aesthetic issues including a holistic approach. Wide adoption of such standards may reduce waiting times, facilitate cost savings, and ultimately enhance patient outcomes.

Introduction

Given the ever increasing demands on publically funded healthcare systems and government initiatives to reduce waiting times, there are increasing pressures to restrict public spending and limit the availability of services, thereby reducing the burden to the taxpayer.[1] Within the National Health Service (NHS) in the United Kingdom, one such area in which limits have been imposed is that of aesthetic or 'cosmetic' surgery.

Undergoing surgery for aesthetic reasons is not widely accepted amongst the general public.[2] However, in addition to the aesthetic benefit gained from such procedures, there are also benefits in physical and psycho-social functioning to be realised.[3-7] Rather than being regarded as merely 'cosmetic procedures', they may be medically necessary in those with physical disease or significant functional impairment. For example, reduction mammaplasty has been shown to improve functional capacity, and relieve neck, shoulder, and back pain in women with breast hypertrophy.[3] Foreman et al.[4] even objectively show that reduction mammaplasty results in a decrease in the compressive forces exhibited in the lower-back. Furthermore, in one of the longest follow-up studies examining psychosocial changes following cosmetic surgery, von Soest et al.[6] report that cosmetic surgery results in positive long-term effects on appearance. Interestingly, they show that high pre-operative rates of psychological problems and low self-esteem relate to negative changes in psychosocial measures following surgery – thereby suggesting a role for psychological intervention prior to, or in place of, surgery.

Although there is a lack of evidence to justify the continued provision of aesthetic surgery in the absence of physical disease or significant functional impairment,[8] third-party funders such as the NHS recognise that aesthetic surgery may enhance the lives of selected patients.[9-11] National guidelines have been produced which aim to identify those patients who will gain the most long-term benefit whilst also minimising the risks of complications, minimising costs, and reducing waiting times.[12]

Despite the introduction of national guidelines for the provision of aesthetic surgery within the NHS, a great deal of disparity still exists in their implementation between clinical commissioning groups (that have now replaced primary care trusts) responsible for local-level spending in England – therefore amounting to a 'postcode lottery'.[12-14] Henderson[15] reports that the majority of trusts implement their own guidelines, with only seven percent following national guidelines[11] and 12% excluding aesthetic procedures altogether (albeit specific individual cases may be subject to local panel assessment).

Guidelines need to be adhered to in order that they fulfil their intended purpose. Previous research has revealed that compliance with national guidelines for aesthetic surgery amongst plastic surgeons may be as low as 22%,[12] with the rate of surgical complications for those not adhering to guidelines as high as 55% compared to the 23% in those that do.[12] Therefore, there is clear benefit to be gained from implementing and adhering to such guidelines.

Within Scotland, the Adult Exceptional Aesthetic Referral Protocol (AEARP)[9] contains a series of aesthetic procedures which, as they do not treat an underlying disease process, are not routinely available within the NHS. Provision of these services can only be provided on an exceptional basis where investigation anticipates benefit to the patient. In one of the largest cohorts of prospectively followed patients we evaluate the referral process and patient outcomes under the AEARP. We further show its use as instrumental in streamlining referrals in a centralised, transparent, and fair manner.

Methods

This study was conducted with Caldicott Guardian approval for the analysis of anonymised data. We prospectively collected clinical data on 1122 patients referred under the AEARP[9] between January 2012 and June 2015 to NHS Tayside, Department of Plastic and Reconstructive Surgery (covering East Scotland: NHS Tayside and Fife). Data was collected via the departmental database and supplemented with clinical notes.

Inclusion criteria were as per the AEARP (http://www.sehd.scot.nhs.uk/mels/CEL2011_27.pdf).[9] In brief these were; age $\geq$ 16 years, body mass index (BMI) $\leq$ 27 kgm^{-2}, physical or functional impairment, significant and prolonged psychological distress, no adverse major life events within the preceding year, no episodes of self-harm within the last two years, no previous diagnosis of body dysmorphia, and no ongoing major psychiatric disorders.

Procedures covered included body contouring (such as liposuction and abdominoplasty), benign skin lesions, blepharoplasty, breast surgery (augmentation, reduction, mastopexy, implant complications, gynaecomastia, and inverted nipples), aesthetic facial surgery, hair transplanta-