NHS
Cheshire and Merseyside

Clinical Commissioning Policy

CMICB_Clin056
Tattoo – laser removal
Category 1 Intervention - Not routinely commissioned -

Contents

Last Reviewed: May 2025
This policy statement will be reviewed 5 years from the date of the last review unless new evidence or technology is available sooner.

1. Policy statement

1.1 Laser tattoo removal is not routinely commissioned.

2. Exclusions

2.1 None

3. Core Eligibility Criteria

3.1 There are several circumstances where a patient may meet a 'core eligibility criterion' which means they are eligible to be referred for this procedure or treatment, regardless of whether they meet the policy statement criteria, or the procedure or treatment is not routinely commissioned.

3.2 These core clinical eligibility criteria are as follows:

- Any patient who needs 'urgent' treatment will always be treated.
- All NICE Technology Appraisals Guidance (TAG), for patients that meet all the eligible criteria listed in a NICE TAG will receive treatment.
- In cancer care (including but not limited to skin, head and neck, breast and sarcoma) any lesion that has features suspicious of malignancy, must be referred to an appropriate specialist for urgent assessment under the 2-week rule.
  NOTE: Funding for all solid and haematological cancers are now the responsibility of NHS England.
- Reconstructive surgery post cancer or trauma including burns.
- Congenital deformities: Operations on congenital anomalies of the face and skull are usually routinely commissioned by the NHS. Some conditions are considered highly specialised and are commissioned in the UK through the National Specialised Commissioning Advisory Group (NSCAG). As the incidence of some cranio-facial congenital anomalies is small and the treatment complex, specialised teams, working in designated centres and subject to national audit, should carry out such procedures.
- Tissue degenerative conditions requiring reconstruction and/or restoring function e.g. leg ulcers, dehisced surgical wounds, necrotising fasciitis.
- For patients expressing gender incongruence, further information can be also be found in the current ICB gender incongruence policy and within the NHS England gender services programme - https://www.england.nhs.uk/commissioning/spec-services/npc-crg/gender-dysphoria-clinical-programme/

4. Rationale behind the policy statement

4.1 There are few (if any) clinical reasons to support laser removal of tattoos.

4.2 This procedure is considered to be cosmetic in nature and thus is assigned low clinical priority.

5. Summary of evidence review and references

5.1 Data from the USA (in 2015) suggest that 14% of citizens had tattoos and in those aged 25 – 40 years, this was as high as 40%. According to the same data, 17% regretted their decision and 50% were planning to remove their tattoos. In one year alone (2011) there had been a 14% increase in the number of removal procedures. [1] The prevalence seems to be increasing rapidly, especially in younger people and despite this, individuals may experience stigma, stereotyping and discrimination in their personal and professional lives. [2]

5.2 Reasons for removal include creating a new self-image in a new social environment and also negative emotional perceptions of the old tattoo. Approaches for removal have included dermabrasion, electrocauterisation, cryosurgery and chemical peeling. However, these are often unsatisfactory and can result in scar formation. Laser, therefore, has become the cornerstone of modern-day tattoo removal.[1] A systematic review suggested that lasers are now the gold standard. However, selecting the best treatment modality can be challenging.[3,4]

5.3 The goal of therapy is to increase tattoo clearance whilst minimising adverse effects. Various factors will affect the efficacy of this procedure such as skin type, nature and colour of tattoo, and the laser parameters itself (wavelength, energy density and pulse frequency). Currently, the QS (quality switched) lasers are the most commonly used but other types such as PS (picosecond) lasers are in development.[1] In fact, PS have demonstrated superior efficacy when treating blue, green and yellow tattoos.[3]

5.4 The number of sessions required for full removal is highly variable. Generally, between 12 – 16 sessions are required but this could be up to 20 or even fewer sessions. The Kirby Desai scale was developed to estimate the number of sessions required and this takes into account skin type, location, colour, ink intensity, scar tissue/damage and presence of layering tattoo.[1] Although the Kirby Desai has proven useful, it doesn't take into account the type of laser used.[4]

5.5 With respect to local commissioning policies, the current Cheshire CCG policy states that laser tattoo removal is only commissioned under specified circumstances. In contrast, Mersey, North Staffordshire and Shropshire CCGs are all "not routinely commissioned". However, the Greater Manchester EUR policy statement on: Tattoo removal (GM 067, 2020) states that tattoo removal isn't routinely commission for aesthetic purposes unless there are clinically exceptional circumstances. Although the Greater Manchester policy goes on to list a number of scenarios where removal might be appropriate, it concludes that there are very few clinical reasons for removing a tattoo and this procedure is therefore considered predominantly aesthetic and not routinely commissioned outside of the criteria detailed in the Commissioning Statement.

5.6 This apparent blurring of "not routinely commissioned" policy with specified "prior approval criteria" has perhaps been initiated by NHS England in its interim clinical commissioning policy on tattoo removal (2013). [5] This document classifies tattoo removal as a procedure of low clinical priority and therefore not routinely funded. Requests for removal of tattoos will be considered in cases of allergic reaction/infection or the person has been given the tattoo against their will (so-called "rape tattoo"). However, it should be emphasised that this suite of commissioning policies was written by the armed forces commissioning policy task and finishing group and the policies do not apply to the NHS in England.

5.7 In addition to the 2 reasons cited above, greater Manchester give other reasons why tattoo removal might be considered. These are:

- *The patient was not Gillick competent, and therefore not responsible for their actions, at the time of the tattooing.*
- *The patient has disfiguring "tribal" or similar tattoos which now either place the individual at risk of violence or act as an unpleasant reminder of a difficult past particularly those that are distinctive facial tattoos.*
- *Tattoos inflicted under duress during adolescence or disturbed periods where it is considered that psychological rehabilitation, break up of family units or prolonged unemployment could be avoided, given the treatment opportunity.*

5.8 The policy is clear that requests will be considered only where the tattoo causes marked limitations of psycho-social function. It is unfortunate that the Greater Manchester policy states that tattoo removal will only be funded in exceptional circumstances on one hand yet it then goes on to give a list of criteria where it might be funded on the other.

5.9 This apparent conflict, perhaps, is resolved in West Suffolk CCG's policy which classifies tattoo removal as "low priority" and then gives a similar list of appropriate criteria (as above). However, West Suffolk make it abundantly clear that these are not referral criteria and are simply supporting guidance for the IFR panel to consider when searching for evidence of exceptionality.

5.10 In conclusion, it is therefore recommended that the new ICB policy for tattoo removal should be "not routinely commissioned". This, of course, will mean any patient can still apply for removal on grounds of exceptionality and these would be considered by the IFR panel. It also means that the policy will be consistent with for Mersey, North Staffordshire and Shropshire CCGs.

REFERENCES

1. Kurniadi I, Tabri F, Madjid A, et al. Laser tattoo removal: Fundamental principles and practical approach. *Dermatologic therapy* 2020;**34**(1):e14418. doi: 10.1111/dth.14418
2. Farley CL, Van Hoover C, Rademeyer C-A. Women and Tattoos: Fashion, Meaning, and Implications for Health. *Journal of midwifery & women's health* 2019;**64**(2):154-69. doi: 10.1111/jmwh.12932
3. Gurnani P, Williams N, Alhetheli G, et al. Comparing the efficacy and safety of laser treatments in tattoo removal: a systematic review. *Journal of the American Academy of Dermatology* 2020 doi: 10.1016/j.jaad.2020.07.117
4. Naga LI, Alster TS. Laser Tattoo Removal: An Update. *American journal of clinical dermatology* 2017;**18**(1):59-65. doi: 10.1007/s40257-016-0227-z
5. Interim clinical commissioning policy: Tattoo removal. *Armed Forces commissioning policy task and finish group* 2013; N – SC/032. https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC032.pdf.

6. Advice and Guidance

6.1 Aim and Objectives

6.1.1 This policy aims to ensure a common set of criteria for treatments and procedures across the region. This is intended to reduce variation of access to NHS services in different areas and allow fair and equitable treatment for all patients.

6.1.2 This policy relates to the commissioning of interventions which optimise clinical effectiveness and represent value for money.

6.1.3 This document is part of a suite of policies which the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy is a separate public document in its own right but should be considered alongside all the other policies in the suite as well as the core principles outlined.

6.1.4 At the time of publication, the evidence presented per procedure/treatment was the most current available.

6.1.5 The main objective for having healthcare commissioning policies is to ensure that:
- Patients receive appropriate health treatments
- Treatments with no or a very limited evidence base are not used; and
- Treatments with minimal health gain are restricted.

6.1.6 Owing to the nature of clinical commissioning policies, it is necessary to refer to the biological sex of patients on occasion. When the terms 'men' and 'women' are used in this document (unless otherwise specified), this refers to biological sex. It is acknowledged that this may not necessarily be the gender to which individual patients identify.

6.2 Core Principles

6.2.1 Commissioning decisions by ICB Commissioners are made in accordance with the commissioning principles set out as follows:

- Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment.
- Commissioners require clear evidence of cost effectiveness before NHS resources are invested in the treatment.
- Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment.
- Commissioners will balance the needs of an individual patient against the benefit which could be gained by alternative investment possibilities to meet the needs of the community.
- Commissioners will consider all relevant national standards and consider all proper and authoritative guidance.
- Where a treatment is approved Commissioners will respect patient choice as to where a treatment is delivered, in accordance with the 'NHS Choice' framework.
- Commissioning decisions will give 'due regard' to promote equality and uphold human rights. Decision making will follow robust procedures to ensure that decisions are fair and are made within legislative frameworks.

6.3 Individual Funding Requests (Clinical Exceptionality Funding)

6.3.1 If any patients are excluded from this policy, for whatever reason, the clinician has the option to make an application for clinical exceptionality. However, the clinician must make a robust case to the Panel to confirm their patient is distinct from all the other patients who might be excluded from the designated policy.

6.3.2 The ICB will consider clinical exceptions to this policy in accordance with the Individual Funding Request (IFR) Governance Framework consisting of: IFR Decision Making Policy; and IFR Management Policy available on the C&M ICB website: https://www.cheshireandmerseyside.nhs.uk/your-health/individual-funding-requests-ifr/

6.4 Cosmetic Surgery

6.4.1 Cosmetic surgery is often carried out to change a person's appearance to achieve what a person perceives to be a more desirable look.

6.4.2 Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore not routinely commissioned by the ICB Commissioner.

6.4.3 A summary of Cosmetic Surgery is provided by NHS Choices. Weblink: Cosmetic procedures - NHS

6.5 Diagnostic Procedures

6.5.1 Diagnostic procedures to be performed with the sole purpose of determining whether or not a restricted procedure is feasible should not be carried out unless the eligibility criteria are met, or approval has been given by the ICB or GP (as set out in the approval process of the patients responsible ICB) or as agreed by the IFR Panel as a clinically exceptional case.

6.5.2 Where a General Practitioner/Optometrist/Dentist requests only an opinion the patient should not be placed on a waiting list or treated, but the opinion given and the patient returned to the care of the General Practitioner/Optometrist/Dentist, in order for them to make a decision on future treatment.

6.6 Clinical Trials

6.6.1 The ICB will not fund continuation of treatment commenced as part of a clinical trial. This is in line with the Medicines for Human Use (Clinical Trials) Regulations 2004 and the Declaration of Helsinki which stipulates that the responsibility for ensuring a clear exit strategy from a trial, and that those benefiting from treatment will have ongoing access to it, lies with those conducting the trial. This responsibility lies with the trial initiators indefinitely.

7. Monitoring and Review

7.1 This policy remains in force until it is superseded by a revised policy or by mandatory NICE guidance or other national directive relating to this intervention, or to alternative treatments for the same condition.

7.2 This policy can only be considered valid when viewed via the ICB website or ICB staff intranet. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one published.

7.3 This policy may be subject to continued monitoring using a mix of the following approaches:
- Prior approval process
- Post activity monitoring through routine data
- Post activity monitoring through case note audits

7.4 This policy will be kept under regular review, to ensure that it reflects developments in the evidence base regarding effectiveness and value.

8. Quality and Equality Analysis

8.1 Quality and Equality Impact Analyses have been undertaken for this policy at the time of its review.

9. Clinical Coding

9.1 Office of Population Censuses and Surveys (OPCS)

SO91 Laser destruction of lesion of skin of head or neck
SO92 Laser destruction of lesion of skin NEC
S10.8 Other specified
S10.9 Unspecified
S60.1 Dermabrasion of skin of head or neck
S60.2 Dermabrasion of skin NEC
S60.3 Tattooing of skin

9.2 International classification of diseases (ICD-10)

With

L81.8 Other specified disorders of pigmentation
Iron pigmentation
Tattoo pigmentation

Document Control

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Version 0.2 – June 2021 – Restriction
Version 0.3 – September 2023 – Reference to Cheshire CCG in paragraph 6.10 in literature review changed to ICB
Version 0.4 – May 2025 – This policy was part of a public engagement exercise, there was no feedback received.