NHS
Cheshire and Merseyside

Clinical Commissioning Policy

CMICB_Clin052
Correction of hair loss: Alopecia areata and Alopecia androgenetica

Category 1 Intervention – Not routinely commissioned
&
Category 2 Intervention - Only routinely commissioned when specific criteria are met

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 The scope of this policy includes the following conditions: Alopecia areata (including universalis and totalis); Alopecia androgenetica (male pattern baldness and other forms of hair loss).

1.2 **Alopecia areata (including universalis and totalis) hair loss, surgical correction**

Surgical correction of hair loss for alopecia areata (including totalis and universalis) is not routinely commissioned.

1.3 **Alopecia androgenetica hair loss, surgical correction (e.g. hair transplantation or scalp-reduction)**

Surgical correction for male pattern baldness (alopecia androgenetica) is not routinely commissioned.

Nonsurgical treatments for male pattern baldness (alopecia androgenetica) are not routinely commissioned.

1.4 **Wig Provision**

Wig provision is provided by the NHS via the commissioned pathway:
http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Wigsandfabricsupports.aspx

1.5 **Hair Intralace Systems**

Hair intralace systems are not routinely commissioned.

2. Exclusions

2.1 Surgical correction of hair loss for all other indications will only be considered when this is due to previous surgery or as a result of trauma (including burns).

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 Alopecia areata is a common cause of nonscarring hair loss and is an autoimmune mediated condition. Spontaneous recovery (without any treatment) is possible in up to 50% of cases. Because of this, there is a reluctance to prescribe many pharmaceutical agents because of the possibility of adverse effects. This stance is augmented by the fact that there is no direct impact of alopecia on general health (although some people can suffer serious psychological effects).

4.2 The NHS modernisation agency specifies that surgical correction of hair loss should be available on the NHS only in exceptional cases such as previous surgery or trauma including burns. Hair transplantation for male pattern baldness will not be allowable on the NHS, regardless of gender. This approach is also confirmed by the British Association of Dermatologists.

4.3 Medications used to treat hair loss e.g. minoxidil are not recommended to be routinely prescribed at NHS expense.

5. Summary of evidence review and references

5.1 First reported in ancient Egypt [1] , ***alopecia areata*** is a chronic, inflammatory disease which affects the hair follicle, sometimes the nail [2] and even the beard.[3] It usually presents as patches of hair loss on the scalp, but any hair-bearing skin can be involved. Hair follicles tend to be preserved and spontaneous recovery after one year is reported to occur in 34% – 50% of cases and even as high as 80%.[2] Although the disease may have serious psychological effects [4], there is no direct impact on general health and, as stated, whilst recovery is possible, around 14% – 25% can progress to a total loss of scalp hair (*alopecia totalis*) or loss of both scalp and body hair (*alopecia universalis*).

5.2 Alopecia areata has a lifetime prevalence of around 2% of the general population [5-7] and is the 2nd most common cause of non-scarring hair loss after androgenetic (“male pattern”) alopecia. [5] Most patients are younger than 30 years with only 20% aged 40 years or older. The prevalences of alopecia totalis or universalis are <0.1%.[8]

5.3 A wide variety of pharmacological treatments is available which includes: - topical steroids, intralesional steroids, systemic steroids, contact immunotherapy, PUVA, minoxidil, dithranol, cyclosporin and biologics. [2] Other novel and/or emerging treatments include autologous platelet-rich plasma [5] , antihistamines, cryotherapy & low dose naltrexone [9] , janus kinase inhibitors, faecal transplants and cytokine targeted therapy with ustekinumab and dupilumab [6] . A 2008 Cochrane review concluded that few treatments for alopecia areata have been well evaluated in randomised trials and there was a desperate need for large, well conducted studies which evaluated the long-term effects of therapies on quality-of-life.[10]

In the intervening years, there doesn't appear to be a consensus on the best form of management based on current evidence. [5,11,12]

5.4 The 2012 British Association of Dermatologists' guideline [2] for the management of alopecia areata lists many recommendations, all based on low quality evidence. This guideline is a revised version of one published previously [13] and although nearly 10 years old, is still due to be reviewed. None of the reviews discussed above recommends hair transplantation or other surgical interventions to address the hair loss. However, in 2005, the NHS modernisation agency in its information for commissioners of plastic surgery services states that correction of hair loss (alopecia) is available on the NHS when it is a result of previous surgery or trauma including burns. [14]

5.5 In summary, *alopecia areata* is a common cause of nonscarring hair loss with a lifetime prevalence of 2% and occurs mainly in younger people. The condition is an autoimmune mediated response and even with no treatment at all can spontaneously recover in at least 50% of cases. Because of the chance of spontaneous recovery, there is a reluctance to prescribe many pharmaceutical agents because of the possibility of adverse effects. This stance is augmented by the fact that there is no direct impact of alopecia on general health (although some people can suffer serious psychological effects).

5.6 It is not surprising that many immune system modifying interventions are used although the underpinning evidence is of low quality. There is no consensus regarding the preferred therapy.

5.7 **Androgenetic alopecia or male pattern baldness** is characterised by androgen-related progressive thinning of hair in a defined pattern.[15] This distinctive pattern of hair loss occurs gradually along the frontal and parietal areas in an M shaped pattern, followed by a loss at the top of the head.[16] The condition is extremely common and may affect up to 80% of males by the age of 80 years. It may result in diminished self-esteem, depression, reduced confidence and distress, irrespective of age or stage of baldness.[15,16] To date, there isn't a single "hair loss" classification system which is both practical and reproducible.[17]

5.8 The 2 main recommended treatments in primary care to address hair loss are topical minoxidil or oral finasteride.[16] However, although these are said to be effective in arresting the progression of the disease, they only allow partial regrowth of hair at best and early treatment achieves a more optimal outcome.[15] In addition, any benefit is lost following discontinuation of treatment. Neither product is available to prescribe on the NHS[1]

5.9 The NHS modernisation agency's guideline (2005) for commissioners of plastic surgery services stated that correction of hair loss due to male pattern baldness is excluded from treatment by the NHS.[14] Such surgery includes hair transplantation or scalp reduction (where a section of the bald area is removed, and the remaining hair-bearing scalp is stretched to cover the gap). In addition, the Agency further specifies that hair transplantation will not be allowable on the NHS, regardless of gender, other than in exceptional cases such as reconstruction of the eyebrow following cancer or trauma. According to the British Association of Dermatologists (2016)[18], neither of these options is available on the NHS which confirms the NHS modernisation agency's stance. All neighbouring CCGs operate a "not routinely commissioned" policy for correction of male pattern baldness.

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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: Advice about 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)

Any in primary position
S211 Hair bearing flap of skin to scalp for male pattern baldness
S212 Hair bearing flap of skin to scalp NEC
S331 Hair bearing punch graft to scalp for male pattern baldness
S332 Hair bearing strip graft to scalp for male pattern baldness
S333 Hair bearing graft to scalp for male pattern baldness NEC
S338 Other specified hair bearing graft of skin to scalp
S339 Unspecified hair bearing graft of skin to scalp

S218 Other specified hair bearing flap of skin
S219 Unspecified hair bearing flap of skin

9.2 **International classification of diseases (ICD-10)**

Must include any of the following
L63.0 Alopecia (capitis) totalis
L63.1 Alopecia universalis
L63.2 Ophiasis
L63.8 Other alopecia areata
L63.9 Alopecia areata, unspecified

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Version 0.2 – January 2022 There is little effective change to the policy. The section on gender dysphoria has been removed as this is now covered in a separate policy. Title changed
Version 0.3 – August 2023 Statements on wig provision and hair intralace systems added. Statement on gender reassignment in “Core eligibility” will be reviewed in line with all policies according to Gender incongruence working group recommendations Statements on pilonidal sinus and burns patients added to exclusions criteria
Version 0.4 – July 2024 – re-formatted
Version 0.5 – April 2025 – amendment to section 4.3 to reflect updated prescribing position, and updated link in section 6.4.3