

Corporate	ICBP040 Value Based Clinical Commissioning
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Version Number	Date Issued	Review Date
V15	September 2026	March 2027

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Consultation Process:	Value Based Clinical Commissioning Policy (VBCCP) Steering Group ICB Leadership Committee ICB Quality and Safety Committee
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Approved By:	Quality and Safety Committee

EQUALITY IMPACT ASSESSMENT

Date	Issues
March 2024	No issues identified

POLICY VALIDITY STATEMENT

Policy users should ensure that they are consulting the currently valid version of the documentation. The policy will remain valid, including during its period of review. However, the policy must be reviewed at least once in every 3-year period.

ACCESSIBLE INFORMATION STANDARDS

If you require this document in an alternative format, such as easy read, large text, braille or an alternative language please contact necsu.comms@nhs.net

Version Control

Version	Release Date	Author	Update comments
V.14	June 2025	NECS Elective Services Team.	VBCC Policy reviewed twice yearly ICB Executive Committee have approved 3 versions of the VBCCP since July 2022.
V.15	September 2026	ICB Medical Team	VBCC Policy

Approval

Role	Name	Date
Approver	VBCCP Steering Group	3 rd June 2025
Approver	ICB Executive Committee	10 th June 2025
Approver	Quality and Safety Committee	10 th September 2026

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1. Introduction

Across the country most, if not all, ICBs have a set of policies and procedures for limiting the number of low clinical value interventions. The Audit Commission's report 'Reducing expenditure on low clinical value treatments' analyses variation on approaches to this work. This approach was based on the 'Save to Invest' programme developed by the London Health Observatory incorporating the 'Croydon List' of 34 low priority treatments.

The Value Based Clinical Commissioning Policy ensures that decisions are evidence-based and informed by up-to-date resources, including NICE guidelines, Royal College guidance, and approaches used by other Integrated Care Boards with similar population sizes.

While the Evidence Based Interventions (EBI) Programme has been widely used in recent years, it has not been fully reviewed since 2024. We have therefore decided to remove this evidence base resource from our Standard Operating Procedure while we engage with colleagues to understand when a review may take place.

1.1 Status

This policy is a corporate policy.

1.2 Purpose and scope

This policy sets out a consistent approach by the North East and North Cumbria Integrated Care Board (ICB) to reduce unwarranted variation in access to NHS services and allow fair and equitable treatment for all local patients. Revisions to the policy are managed and co-ordinated by a clinically led Value Based Clinical Commissioning Policy Group.

For clarity there are two differing processes in place to apply for NHS funding for these procedures:

BlueTeq – This is a web-based system, which incorporates specific modules for both aspects of this policy. BlueTeq enables primary and secondary care clinicians to obtain Prior Approval Tickets (PAT) where the patient meets the clinical criteria for the procedure. A patient does not need to follow the Individual Funding Request (IFR) process in these circumstances. The BlueTeq system manages IFR submissions.

Individual Funding Request (IFR) – The IFR process is to be used in circumstances when a patient does not meet the clinical criteria for a procedure as set out in this policy document but can demonstrate exceptionality in accordance with the definition.

Exceptionality is defined as:

'The patient or their circumstances are significantly different from the general population of patients with the condition in question and the patient is likely to gain significantly more benefit from the intervention than might normally be expected for patients with that condition.'

Where procedures do not require prior approval to be obtained for NHS funding before the treatment takes place, these are identified as 'Monitored Approval' within the policy document. Further information on this category of policy is included within the FAQ section.

- **Section 1: IFR and Prior Approval Policies**

This section includes all policies, which require approval to be confirmed prior to the treatment taking place.

- **Section 2: Monitored Approval Policies**

This section includes all policies, which do not need approval to be confirmed prior to the treatment taking place.

2. Frequently Asked Questions (FAQs)

Why do we need policies?

NHS resources come under ever greater pressures each year. Ensuring that treatment and care is focused where it can make the biggest difference is a key part of making best use of these resources. This is a key challenge for all NHS organisations, and a prime focus for commissioning among ICB's. These policies help clinicians identify interventions with limited benefit, thereby providing potential for reinvesting elsewhere, where potential benefits are greater.

The alternative to having policies of this kind is to leave each decision to individual GPs, to manage individual dilemmas without guidance and without the context of the health needs of the wider population.

In 2016 the Academy of Medical Royal Colleges (AOMRC) launched a Choosing Wisely Campaign <https://www.choosingwisely.co.uk/> to help ensure a national approach to quality improvement and reduce unwarranted variation across the healthcare system. This is aligned to the North-East and North Cumbria ICB's approach to increasing value and improving population health. The AOMRC guidance was last reviewed extensively in the Autumn of 2024 with no plans to review this guidance again at this time.

At the heart of the Choosing Wisely initiative is a call to both doctors and patients to have a fully informed conversation about the risks and benefits of treatments and procedures. As well as releasing resources for other activities, it says patients should always ask five key questions when seeking treatment. They are:

1. Do I really need this test, treatment, or procedure?
2. What are the risks or downsides?
3. What are the possible side effects?
4. Are there simpler, safer options?
5. What will happen if I do nothing?

What do these policies cover?

These cover interventions where there is significant risk that patients undergoing them will gain little health benefit.

The procedures have low rather than no clinical value. Some may be effective but may have low value because other (medical) treatments could be tried first. Other effective procedures may provide large benefits for some patients but less to those with few symptoms, where risks and benefits are closely balanced. There are interventions which are effective in some but give no clinical value in others.

Finally, there are those interventions that whilst effective, are undertaken for primarily cosmetic reasons, which commissioners often consider as providing low clinical value.

Who are they for?

They are to assist clinicians in making referral decisions, where the principal reason for referral is for surgical intervention. They are also to assist providers of treatment and surgical services and are a statement about what the NHS will routinely pay for.

How has the policy been compiled and developed?

The policies have been compiled by a group of clinical decision-makers, GPs, and Public Health specialists, with advice and guidance from clinical specialists and regional networks. The group has used published evidence and guidance, alongside expert opinion to develop and refine this set of policies.

These policies are kept under constant review to ensure the policies are in-line with evidence and best practice. This process is managed and coordinated across the North-East and Cumbria to ensure that there is consistency in the policies and their application.

How often will this policy be reviewed?

We have recently completed a full comprehensive review of all VBC Policies. Following the review, policies fall into three categories; those approved with no changes, those requiring only minor amendments and those identified for further deep dive reviews, which will be carried out during the 2026/27 financial year.

Moving forward, we have established assurance and governance processes, utilising North East & North Cumbria ICBs existing Northern Treatment Advisory Group (NTAG) as a horizon scanning system, alongside recognised evidence based public health recourse whereby any changes to NICE Guidelines or pathways/services will trigger a full review of the relevant policy. These reviews will be completed and take place as part of the Value Based Clinical Commissioning Policy Group – full details and SOP templates can be seen in the Value Based Clinical Commissioning Policy Group Terms Of Reference.

Are the policies categorised in any way?

Yes - Procedures within this policy are categorised and identified into 3 cohorts.

The first two categories are those procedures/interventions, which require approval to be confirmed prior to the treatment taking place. This will be either through an Individual Funding Request, which must be submitted for consideration by the relevant commissioner, or a Prior Approval, which can be generated at the point of assessing the patient, provided that the patient clearly demonstrates meeting the relevant criteria. All procedures/interventions that fall into these two categories are contained within the first section of the policy.

The final category of policies is identified as 'Monitored Approval'. These are procedures/interventions that do not need any form of approval to be confirmed prior to the treatment taking place. These policies relate predominantly to treatments that have been identified as best practice pathways, rather than treatments that have limited clinical benefit. It can also include treatments that are very small in volumes carried out. Whilst these policies do not require approval prior to treatment, the pathways are subject to review in relation to activity levels and any variation observed. The 3 cohorts of activity are specified below:

- **Category 1 (IFR):** Interventions that are not routinely commissioned, with patients only able to access such treatments where an Individual Funding Request (IFR) is agreed.
- **Category 2 (Prior Approval):** Interventions that should only be performed where specific criteria are met. These procedures should only be carried out where prior approval (PAT) is obtained from Commissioners to demonstrate compliance with the criteria.
(NB: Prior Approval Tickets (PATs) are valid for 24 months from the date of issue and the same will apply for IFR's.)
- **Category 3 (Monitored Approval):** Interventions that should only be performed where specific criteria are met. These procedures can take place without the need to first obtain prior approval from Commissioners, but it is the provider's responsibility to ensure that all clinicians are compliant with policy criteria and have appropriate monitoring mechanisms in place.

Is securing funding a guarantee of treatment?

Approval for NHS funding is NOT the same as a guarantee of treatment. Funding (the role of the commissioner for a whole population) is often requested before specialist assessment. The ultimate decision about safety and appropriateness of treatment is a clinical one which must be discussed with the patient.

What about treatments that have already started under private arrangements? If treatments have already been started under private arrangements, the overarching assumption is that a whole package of care has been purchased and its potential complications taken account of and explained to the patient. Therefore, it would be unreasonable to expect the NHS to pick up the costs associated with private treatment unless there is a medical emergency, or some other exceptional circumstance – see specific policies for further details. Running out of funds, whilst unfortunate, is not exceptional.

Notwithstanding this point, it is recognised that an individual, who has commenced treatment that would have been routinely commissioned by the NHS on a private basis can, at any stage, request to transfer to complete the treatment within the NHS. However, at the point

that the patient seeks to transfer back to NHS care, the patient would be required to be reassessed by an NHS clinician in line with the relevant current policy to ensure compliance with the latest criteria. In addition, where the criteria is met, the patient will not be given any preferential treatment by virtue of having accessed part of their care privately and will be subject to standard NHS waiting times.

Likewise, if a device has been privately purchased and initiated, the NHS will not pick up the costs of consumables or maintenance, unless the patient meets NHS criteria. For example, a patient, who has purchased a continuous glucose monitor would be expected to have sufficient funds to purchase consumables for the life of the device unless they meet the NHS criteria for the device.

What about treatments that have been started and completed under private arrangements?

Funding is not provided retrospectively. If treatment has been completed under private arrangement it is assumed that the patient has sufficient funds to cover this treatment.

What about the continuation of experimental treatments/loaned device trials?

The continuation of experimental treatments/loaned device trials will not be routinely funded. Initiating patients on treatments without clear evidence of safety, efficacy, effectiveness, or cost-effectiveness raises patient expectations that the treatment will be continued. Where treatments are initiated by providers on a loan/ experimental basis this is done at the provider's own risk. The provider must be clear with the patient about the end point/exit strategy for the trial and/or continuing care.

This excludes formal clinical research trials for which there are separate arrangements between funders and providers.

What if surgeons undertake procedures outside the indications in these policies?

There is no guarantee of payment in accordance with the legally binding contract.

BlueTeq Frequently Asked Questions

What is BlueTeq Prior Approval Ticket Process?

BlueTeq holds a module within the online system, which enables primary and secondary care clinicians to obtain instant funding approval where the patient meets the clinical criteria for the procedure.

What should Prior Approvals Tickets be used for?

Prior Approval Tickets should be used in the first instance for any patients being referred or treated for any procedures documented within this policy.

Which part of the policy is governed by the Prior Approval Ticket & Individual Funding Requests process?

The whole policy document forms part of the Prior Approval Ticket and Individual Funding Request requirements. There are no exclusions to this.

Who can make an application for funding through BlueTeq?

BlueTeq is available to use by both primary and secondary care. If the procedure required is known at the point of referral it is expected that the prior approval ticket (PAT) will be generated by the GP. If the GP refers for an opinion and secondary care clinicians advise that a specific procedure is needed, then the PAT should be generated by secondary care.

What happens if the patient does not meet the criteria?

If the patient does not meet the specific policy criteria and the clinician believes that the patient can demonstrate exceptionality, then the Individual Funding Request (IFR) process should be followed. Those submitting an IFR (typically the patient's GP) will be able to do so using the IFR request module, which is also contained within the BlueTeq system.

What if a GP makes a referral outside the criteria outlined in these policies? Secondary Care have the option to reject the referral back to primary care for completion of the funding approval or complete the PAT themselves. Both options are supported by ICB's.

Individual Funding Request (IFR) Frequently Asked Questions

When should we use the IFR Process?

The IFR process is to be used in circumstances when a patient does not meet the clinical criteria for a procedure as set out in this policy document but can demonstrate exceptionality in accordance with the definition. Exceptionality is defined as:

'The patient or their circumstances are significantly different from the general population of patients with the condition in question and the patient is likely to gain significantly more benefit from the intervention than might normally be expected for patients with that condition.'

Can psychological considerations be taken into account within the definition of exceptionality?

Accounting for psychological factors in arriving at a decision about eligibility for NHS funding is hard to do in a clear and fair way. These considerations have been removed from this policy as psychological distress unfortunately does not constitute clinical exceptional circumstance.

NICE guidance indicates that clinicians should consider the possibility of Body Dysmorphic Syndrome when making referral for plastic surgery (NICE Guidance 31).

Should photographs be submitted with the IFR?

Photographs are not used in consideration of exceptionality - and handling them presents significant risks of compromising confidentiality. Please do NOT submit photographs. Any photographs received will be returned to sender upon receipt and an incident will be logged on Safeguard Incident and Risk Management System (SIRMS).

How can pain and significant functional impairments/ limitations to activities of daily living endured by patients be demonstrated in an IFR case?

Pain has been defined as an “unpleasant sensory and emotional experience arising from actual or potential tissue damage” with clinical pain being “whatever the person says he or she is experiencing whenever he or she says it occurs” and is therefore subjective.³

There is insufficient evidence to use questionnaire derived scores to evidence pain in individuals. Therefore, in lieu of a standard assessment tool, alternative clear and objective evidence must be provided when demonstrating patient pain and significant functional impairments/ limitations to activities of daily living.

This evidence should include documented assessments and/ or patient history, including:

- A description of the pain and which daily activities are no longer achievable;
- Prescribing history;
- Recorded sickness/ absence due to pain/ functional impairment;
- Evidence from functional tests/ investigations, such as gait analysis, physiotherapy/ OT assessment;
- History of the pain/ impairment and the response to/ impact/ effect of conventional therapies available.

Significant functional impairment is defined as:

- Symptoms that result in a physical/ functional inability to sustain employment/ education despite reasonable occupational adjustment, or act as a barrier to employment or undertaking educational responsibilities;
- Symptoms preventing the patient carrying out routine domestic or carer activities;
- Symptoms preventing the patient carrying out self-care or maintaining independent living.

Cosmetic Procedures

Treatments or surgery are not eligible for NHS funding. A significant degree of exceptionality must be demonstrated before funding can be considered outside of these policies.

Specifically, psychological factors are not routinely taken into consideration in determining NHS funding.

Whilst some degree of distress is usual among people who consider aspects of their physical appearance as undesirable, the degree of this will not routinely be taken into account in any funding decision. Further, it is expected clinicians consider the possibility of psychological problems including Body Dysmorphic Syndrome NICE Guidance CG31 assess for these and ensure appropriate management before considering any referral for plastic surgery.

This guidance applies to many of the following policies, in particular:

Abdominoplasty or Apronectomy Breast asymmetry Breast augmentation (Breast enlargement) Breast prosthesis removal or replacement Breast reduction Bunion surgery Ganglion removal Gynecomastia Inverted nipple correction Mastopexy Revision mammoplasty Blepharoplasty Pinnaplasty Repair of lobe of external ear Septorhinoplasty Vaginoplasty, Labial Vulvoplasty and Vulvar Lioplasty	Circumcision Hirsutism Removal of tattoos Resurfacing procedures Face lift or brow lift Liposuction Removal of benign skin lesions Thigh lift, buttock lift and arm lift Surgical Treatment for Hair Loss Oculoplastic Eye Problems Surgical Fillers Varicose veins
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Commissioning Responsibility

The procedures contained within this policy document are the commissioning responsibility of Integrated Care Boards (ICB's). There are a number of procedures/treatments that fall within the commissioning responsibility of NHS England (NHSE), and as such, providers should satisfy themselves that they are following the relevant policy prior to undertaking any interventions. Examples of such procedures that are NHSE commissioning responsibility include:

- Autologous Cartilage Transplantation
- Bone Morphogenetic Protein
- Cervical disc prosthesis

1. Process

BlueTeq holds two differing modules to apply for NHS funding for the procedures listed within the VBCC Policy

PAT module enables primary and secondary care clinicians to obtain instant funding approval where the patient meets the clinical criteria for the procedure. A patient does not need to follow the Individual Funding Request (IFR) process in these circumstances.

IFR module manages IFR submissions.

The PAT module within BlueTeq should be used in the first instance for any patients being referred or treated for any procedures documented within the policy.

3. Implementation

The VBCC policy is available to use by both primary and secondary care using the BlueTeq online system. If the procedure required is known at the point of referral it is expected that the prior approval ticket (PAT) will be generated by the GP. If the GP refers for an opinion and secondary care clinicians advise that a specific procedure is needed, then the PAT should be generated by secondary care.

All directors and managers are responsible for ensuring that relevant staff within their own directorates and departments have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

It may be necessary to develop specific implementation plans.

4. Training Implications

It has been determined that there are no specific training requirements associated with this policy/procedure.

5. Documentation

5.1 Other related policy documents.

- NENC ICB IFR Policy
- NENC VBC Policy Terms Of Reference and SOP

6. Monitoring, Review and Archiving

6.1 Monitoring

The VBCC Policy will be accessible to all ICB staff, published on the ICB website and incorporated into the BlueTeq system.

All updates to the VBCC Policy will be communicated directly to primary and secondary care referrers via email from the IFR & VBC admin team.

6.2 Review

Commissioners will review policies upon receipt of new national or local guidance from organisations such as NICE, in addition to any changes to service/pathways.

The policy will be reviewed in its entirety twice a year.

Where there are any minor amendments that do not impact the application of the policy criteria, these can be reviewed and approved by the Value Based Commissioning Steering Group. Any changes that impact the application of the criteria will need to be brought through the governance process for approval in line with the Scheme of Delegation.

6.3 Archiving

The Board will ensure that archived copies of superseded policy documents are retained in accordance with Records Management: NHS Code of Practice.