IPFR Deep Dive Report

2025-2026

Chief Executive Sponsor	Abigail Harris	Swansea Bay University Health Board
Senior Responsible Officer	Iolo Doull	NHS Wales Joint Commissioning Committee
Delivery Leads	Oliver Harness Dr. Rachel Gemine Natalie Hall	NHS Wales Joint Commissioning Committee, Patient Care Team

Executive Summary

The NHS Wales Joint Commissioning Committee (NWJCC) undertook a deep dive review of Individual Patient Funding Requests (IPFR) and Prior Approvals (PA) to understand demand, expenditure, variation in practice and opportunities to improve value, efficiency and patient outcomes. The review was commissioned in response to increasing financial pressures, rising demand and the need to strengthen commissioning arrangements for specialist and highly specialised services.

The review found that current IPFR and PA processes are robust, well-governed and operating effectively. Independent audits provided substantial and reasonable assurance, confirming strong governance, financial controls, policy compliance and decision-making arrangements. However, significant opportunities exist to streamline processes, reduce duplication and improve consistency across Wales.

During 2024-25 and 2025-26, the Patient Care Team managed almost 4,000 funding requests, approving over £59 million of activity. Analysis identified a high volume of low-value IPFR applications, repeated requests for the same treatments, significant prior approval activity, variation in service utilisation and ongoing challenges relating to data quality, commissioning clarity and outcomes monitoring.

Ten recommendations are proposed to modernise and strengthen funding request arrangements.

- Minimum IPFR panel application value
- Automatic consideration of treatments repeatedly approved at IPFR.
- Improving access to care
- HPN prescribing practices
- Clarity on commissioning responsibilities
- Expansion of IPFR collaboration between UHB and NWJCC
- Digitalisation
- Patient reported outcomes
- MOD Fasttrack and war veteran applications
- Patient care team

Collectively, the recommendations are expected to reduce administrative burden, improve referral-to-treatment times, support more consistent and equitable decision-making, enhance patient and clinician experience, strengthen value-based commissioning, and provide better intelligence to inform future commissioning decisions.

Contents

1. Introduction pg.5
1.1 Strategic context pg.5
1.2 Drivers for the deep dive pg.6
1.2.1 Financial pg.6
1.2.2 Value and commissioning pg.6
2. Background pg.6
2.1 Funding application process pg.7
2.2 Funding mechanisms pg.8
2.2.1 Contracted pg.8
2.2.2 Prior approval pg.8
2.2.3 Individual patient funding requests pg.8
2.3 Role of the patient care team pg.9
2.4 Governance and assurance pg.10
2.5 External audits pg.10
2.5.1 Summary of external audit findings pg.10
2.5.2 Implications of audit findings pg.12
2.6 Deep dive aims and objectives pg.12
2.7 Methodology pg.13
2.7.1 Data caveats pg.13
3. Assessment pg.14
3.1 Overview pg.14
3.2 Individual patient funding request panel pg.15
3.3 Individual patient funding requests pg.15
3.3.1 IPFR by health board pg.16
3.4 Declined IPFR applications pg.22
3.4.1 Reasons for IPFR declined pg.22
3.5 Prior approval funding requests pg.24
3.6 HPN pg.28
3.7 Non-approved prior approval applications pg.29

3.8 Data quality pg.31
3.9 MOD Fast-track and war veterans pg.32
3.9.1 War veterans pg.32
3.9.2 MOD Fast-track pg.33
3.10 Treatment centre utilisation against NWJCC policies pg.34
3.11 Key risk / matters for consideration pg.35
4. Summary of Recommendations pg.36
4.1 Impact of recommendations pg.36
4.1.1 Improved productivity pg.36
4.1.2 Improved value for money pg.37
4.1.3 Improved patient outcomes pg.38
4.2 Activity undertaken so far pg.38
4.2.1 PET Policy update pg.38
4.2.2 Discussions with online PA system providers pg.38
4.2.3 Discussions with NHS England pg.38
4.2.4 Discussions with Centre for Healthcare Evaluation, Device Assessment, and Research (CEDAR) and NHS Performance and Improvement pg. 38
4.2.5 Deep dive socialising to wider stakeholders pg. 39
4.3 Implementation plan for recommendations pg. 39

Abbreviations pg.40
Appendix One – Full List of IPFR treatment requests and frequency pg.42
Appendix Two – Prior Approval AMV Approval Distribution pg.44
Appendix Three – Top 30 PA Treating Organisations by total AMV pg.45
Appendix Four – Top 30 PA Treatments by total AMV pg.46
Appendix Five – Top 30 PA Treatments by frequency of referrals pg.47

1. Introduction

The NHS Wales Joint Commissioning Committee (NWJCC) Annual plan 2026-27 identifies Individual Patient Funding Requests (IPFR) as one of three national "Deep Dive" programmes. The decision reflects the increasing financial, commissioning, quality and equity challenges associated with IPFRs and prior approvals and the need for a more strategic, evidence-based approach to managing demand and decision-making.

The aims of this deep dive were to gain a greater understanding of our current position and key challenges, identifying opportunities to mitigate the financial risk to the NWJCC and better inform future commissioning decisions focussing on current activity and spend and explore the opportunity to utilise a prior approval system, such as Blueteq which we current use for high-cost drug prior approval (Link). This deep dive will not include a full review of contracts, contract performance or provider mix, nor will it scrutinise IPFR panel decision making.

Specific deliverables included in the activity brief focus on:

- Variation analysis across Wales to understand equity and clinical variation in cases
- Clarifying finance streams and cost of requests
- Review of IPFR process considering minimum value threshold for cases to go to panel
- IPFR demand and alignment with policy or need for commissioning policies or pathway changes
- Provider analysis and understanding referral pathways and flows for prior approvals

1.1 Strategic context

The IPFR deep dive was specifically selected as one of eight strategic programmes aligned to the NWJCC's objectives to **Maximise Value** and **Ensure Quality**.

The Annual plan 2026-27 states that all deep dives are intended to:

- Identify population need.
- Review best practice.
- Examine areas of duplication and inefficiency.
- Inform future commissioning arrangements.
- Develop evidence-based recommendations for the Joint Committee.
- Ensure recommendations are assessed for both quality and equality impacts.

1.2 Drivers for the deep dive

1.2.1 Financial

The Annual plan 2026-27 highlights that IPFR contributed to a 2025/26 in-year cost pressure of £2.6m, with IPFR Enzyme Replacement Therapies generating a further £0.8m pressure. These costs form part of the NWJCC's recurrent underlying deficit and are described as demand-driven pressures within highly specialised pathways where commissioners have limited ability to influence demand.

Consequently, the deep dive provides an opportunity to better understand IPFR demand, expenditure trends, drivers of growth and opportunities for more sustainable commissioning approaches.

1.2.2 Value and commissioning

The Annual plan 2026-27 identified several value and commissioning priorities that are directly relevant to the IPFR review, including reducing unwarranted variation, strengthening prioritisation and investment decisions, improving cross-border commissioning controls, reviewing the use of non-designated providers, enhancing performance intelligence and commissioning assurance, and supporting a transition towards value-based commissioning.

The IPFR deep dive focused on variations in approval rates and decision-making across Wales, potential differences in access to treatments funded through IPFR, patterns of cross-border referrals and activity, and the use of non-designated providers. The review also considered whether certain IPFR activity could be more appropriately managed through routine commissioning arrangements, while identifying opportunities to reduce duplication and improve consistency across Wales.

As IPFR exists specifically to consider access to treatments outside routinely commissioned pathways, it is an area where consistency, fairness and transparency are critical. The deep dive therefore provided an opportunity to assess whether current arrangements support equitable decision-making for patients across Wales.

2. Background

The NWJCC operates IPFR and Prior Approval (PA) processes to manage access to highly specialist treatments that are not routinely commissioned, high cost, or require controlled use. These processes support lawful, transparent, and equitable decision making, ensuring alignment with Prudent Healthcare principles and responsible stewardship of public resources.

2.1 Funding application process

Before submitting an IPFR or PA application clinicians are required to review any relevant policies and guidelines to ascertain if the patient' s presentation, indications for treatment and specific treatment align with the policy or not. This will also include ascertaining if the commissioning responsibility sits with the NWJCC as a highly specialist treatment or is listed as specialist treatment on the individual trust's 'Interventions Not Normally Undertaken (INNU) list, demonstrated on figure 1.

Once established as NWJCC, and policy alignment confirmed, a PA will be submitted if the treatment or drug is not under contracted activity with a provider or Blueteq respectively. If outside of policy, national guidelines, or if regimen is outside of license, the clinician will be required to submit an IPFR application. Currently, over 200 published policy positions and service specifications exist on the NWJCC website.

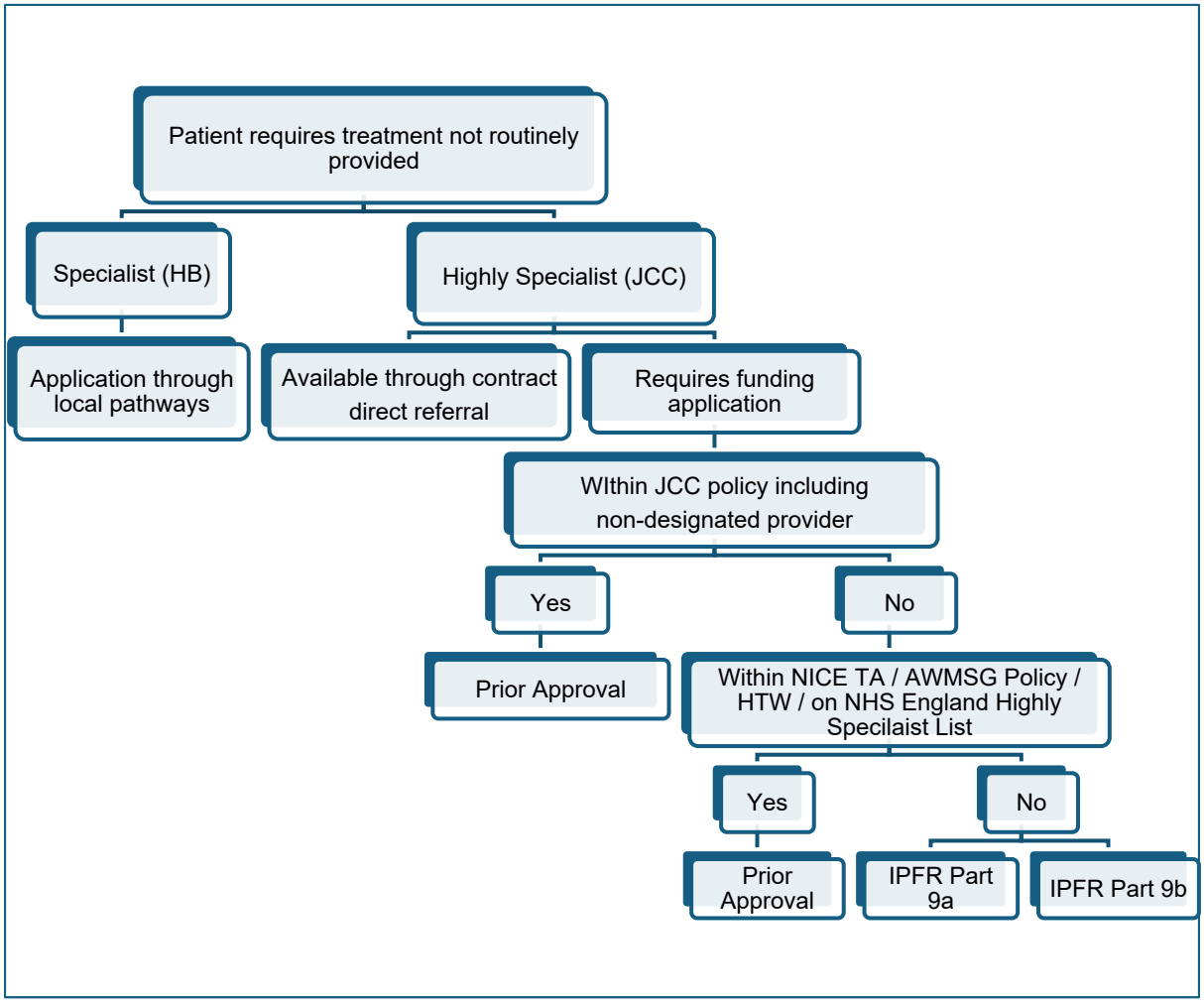


Figure 1. Patient funding pathway

2.2 Funding mechanisms

Once funding has been ascertained that of NWJCC commissioned, non-emergency patient care can be generally grouped into three main categories:

- Contracted
- Prior Approval (PA)
- Individual Patient Funding Requests (IPFR)

2.2.1 Contracted

Whereby a contract is in place between the JCC and a provider to provide a specific treatment(s) for patients from Wales or registered with a Welsh GP, that the NWJCC has been commissioned to provide. Clinicians will refer directly to the treating organisation without need to establish funding for the patient's treatment. University Health Boards (UHB's) often utilise contracts in place between the JCC and treatment providers as an alternative to having direct contracts in place for relatively small amounts of activity. Patients are directly referred from UHB to provider. These are services not commissioned by the NWJCC and financed by the annual risk contributions made by the UHB's to the NWJCC Governance of these referrals and services is the responsibility of the HBs.

2.2.2 Prior approval

In circumstances where a treatment or drug is commissioned by the NWJCC and no contract is in place between the provider and the NWJCC, a prior approval application is required. This ensures that the application is within NWJCC commissioning policy and costs are in line with those expected. Since 2021, the NWJCC has been utilising an automated prior approval online solution for high-cost drugs. This ensures governance and reduces the time patients have to wait to start treatment. PA applications can also be made in circumstances where a service is not available in Wales to aid treatment planning in Wales, a second opinion is required and not available in Wales, or for continuity of care having previously taken place with a provider outside of Wales.

2.2.3 Individual patient funding requests

The NWJCC currently has over 200 published policy positions and service specifications relating to some of the services and treatments it is commissioned to provide. These contain inclusion and exclusion criteria and often designated commissioned providers. If a patient has specific requirements or a presentation which sit outside of a policy relating to their condition or treatment then, with patient consent, their clinician will need to make an IPFR application. This will contain information of the patient, their treatment needs, and how the patient's presentation is significantly different to that of their comparator cohort and would derive a greater benefit then the comparator cohort. Urgent requests can be reviewed in 24-48 hours

by means of a chairs action, non-urgent cases are considered by a full IPFR panel. The minimum quorate consists of 4 of the 7 Health Boards representatives, 1 NWJCC Clinical Director or deputy and the Chair or Vice Chair. Please see IPFR policy for further details.

Once applications are approved the referring clinician is notified, and the patient can be referred to the treating provider to commence treatment. Invoices are then submitted to JCC for reimbursement up to an approved maximum value (AMV).

2.3 Role of the patient care team

Currently, the patient care team (PCT) reports to the senior leadership of the NWJCC Medical Director with immediate deputy leadership of the Associate Director for Evidence, Evaluation and Effectiveness. The PCT works closely with the medicines optimisation team and commissioning colleagues of the subspecialities of the specialised services. Both the Medical Director and Director of Specialist Services have authorisation to a maximum of £500k and signed delegation of authority to the those reporting to them for varied amounts. The group dealing with the 'day to day' processing of applications and majority of the approvals sits under the leadership of the senior IPFR manager, and consists of four colleagues in total, with limited resilience or current cross training of colleagues for the roles of senior IPFR manager and IPFR manager. This currently poses a risk regarding seamless IPFR panel activity and PA sign scrutiny and sign-off.

The PCT sits as an interface between the patient facing clinicians and the NWJCC, both formally processing IPFR and PA applications and offering support and advice to patients, clinicians, and administrative teams. Currently, the team complete the following functions:

- Patient, clinician and administrative funding queries
- Patient and clinician post panel support and advice
- Recording of full IPFR and PA applications and outcomes
- Support off framework mental health funding requests
- Support Gender Identity Disorder (GID) funding requests
- All aspects of IPFR panel administration and management
- Funding request approvals with support of medicine optimisation, medical director and commission colleague support for complex cases
- Finance and commissioning activity queries
- Support horizon scanning, prioritisation and policy development
- Lay member line management, and training including IT support

With robust data quality and platforms in place, the PCT is best placed to detect early trends and liaise with service users to gather the information required to build evidence pertaining to the value and effectiveness of the treatments commissioned by the JCC. The following recommendations are centred around the development of the PCT.

2.4 Governance and assurance

All requests are reviewed with oversight and clinical governance provided by the JCC Medical Director and supported by commissioning colleagues.

The All Wales Therapeutics and Toxicology Centre (AWTTC) monitors IPFR approved applications for demand trends with treatments forwarded to All Wales Medicine Scrutiny Group (AWMSG) or Health Technology Wales (HTW) for review. Currently, there is no coordinated all Wales PA system to monitor trends which could lead to All Wales block or 'demand mapped' contracts for specialist and highly specialist services with potential to increase economies of scale and lower treatment costs.

2.5 External audits

During the reporting timeframe of this deep dive two NWSSP audits took place; the Individual Patient Funding Request Process 25/26 and 'NWJCC High-Cost Drugs Audit 25/26', alongside these quarterly AWTTC individual IPFR individual application reviews

2.5.1 Summary of external audit findings

Individual Patient Funding Request Process - NWSSP - 2025/26

The Internal Audit review of the NWJCC's Individual Patient Funding Request (IPFR) process provided **substantial assurance**, with no reportable findings identified. The audit concluded that IPFR arrangements are well managed, with clear processes, comprehensive documentation, and strong audit trails supporting decisions.

Key findings included:

- IPFR decisions were made in line with the All-Wales IPFR Policy, with clear rationale recorded and applicants informed within required timescales.
- Urgent (Chair's Panel) cases were appropriately managed and complied with policy requirements.
- Clinical approvals were supported by appropriate financial authorisation, with all sampled cases approved in accordance with the NWJCC Scheme of Delegation.
- Robust monitoring arrangements were in place to ensure expenditure remained within approved funding limits and treatment timeframes.
- Quality assurance processes were operating effectively to promote consistency and adherence to policy across Wales.

The only improvement identified was the need for the remaining Health Board to formally approve the revised All-Wales IPFR Policy to enable its publication and implementation across Wales.

NWJCC High-Cost Drugs Audit - NWSSP - 2025/26

The Internal Audit review of the provided an overall **reasonable assurance** rating. The audit found that key controls around high-cost drugs and prior approval arrangements are operating effectively but identified several areas requiring improvement.

Key findings included:

- The Blueteq electronic prior approval system is supporting clinical and financial governance for high-cost drugs, with appropriate controls in place for setting up new drugs and prescribing criteria. However, the Blueteq Form Development Standard Operating Procedure (SOP) was still in draft form.
- For high-cost drugs not managed through Blueteq, the Patient Care Team operated an effective prior approval process. Testing confirmed requests were appropriately reviewed, approved by authorised officers, recorded accurately, and communicated to clinicians promptly. However, no formal SOP existed for this process.
- Strong financial controls were in place, with invoices reconciled against approved commitments and variances investigated.
- The audit identified a high-priority finding that detailed reporting on high-cost drug activity and expenditure was not routinely provided to Health Boards or reported internally within the NWJCC, limiting financial oversight and challenge.
- The Blueteq system contains data that could support additional monitoring, including identifying patients approaching eligibility changes and those who may be suitable for lower-cost biosimilar medicines, but these reports are not currently produced.

IPFR Quality Assurance Group Audit - AWTTC - (Apr-Jun 2026)

NWJCC IPFR Panel achieved full compliance, meeting all 9 quality assurance criteria. No actions or recommendations were identified for NWJCC following the audit. 47 applications were considered during the quarter, including 14 Positron Emission Tomography (PET) scan requests. 94% of urgent cases met required timescales, an improvement on previous quarters. The audit confirmed appropriate decision-making, clear documentation, and timely communication of outcomes. Overall, the report provides positive assurance that the NWJCC IPFR process is operating effectively and in line with policy requirements.

2.5.2 Implications of audit findings

The three audits provide strong overall assurance that NWJCC's key commissioning processes are operating effectively and in line with policy requirements.

Key strengths identified were:

- Robust governance, decision-making and financial controls.
- Clear documentation, audit trails and timely communication of decisions.
- Strong compliance with IPFR and prior approval processes.
- Effective quality assurance (QA) arrangements, with full compliance achieved in the latest IPFR QA review.
- Appropriate monitoring of expenditure and funding approvals.

The main opportunities for improvement related to:

- Finalising outstanding policies and standard operating procedures.
- Strengthening management reporting and oversight of high-cost drugs expenditure.
- Making greater use of available data to support monitoring and planning.

Overall, the audits found well-controlled and compliant arrangements, with only limited improvements required to further strengthen governance and reporting.

2.6 Deep dive aims and objectives

The deep dive was undertaken in order to provide understanding of the process, financial arrangements and make recommendations to improve the efficiencies and effectiveness of IPFR and prior approval. The following were key objectives of the deep dive:

- Understand equity and clinical variation in submitted and approved cases
- Understand financial mechanisms including contracting
- Understand impact of IPFR trends on commissioning intent
- Understanding of referral pathways and prior approval flows
- Development of recommendations to improve processes, efficiencies, financial mechanisms and patient experience.

2.7 Methodology

The deep dive was conducted through a review for the financial years of 2024-2025 and 2025-2026, this period will be referred to as the deep dive period (DDP). Data

was collated at a patient level to include individual details of patient requests such as condition, treatment and centre, in addition to finances relating to requests. This data was primarily sourced from a locally hosted Microsoft Access Database, supplemented with finance data pertaining to invoices paid. In addition, regional population data for Wales was sourced from StatsWales. Blueteq, contracted and emergency activity was not included in this analysis. Costs from applicants approved prior to 2024-2025 was also not included.

Once downloaded to excel, circa 1000 rows required validation and updating to ensure elements such as local health board (LHB) of residence, application status, and generic terms such as drugs were more specifically labelled. Those cases that did not include a clear indication in the database were manually reviewed and the data updated to ensure maximum completeness where possible. This was only undertaken for IPFR requests

Where appropriate policies and contracts were reviewed to support the making of recommendations. This deep dive does not include a review of activity completed within contracts between NWJCC and treating organisations, emergency care, nor the non-contracted activity of care commissioned by UHB's which was invoiced through NWJCC contracts.

2.7.1 Data caveats

The following assumptions were made when extracting and analysing data:

- Value of activity is based on AMV at point of approval sign off, subsequent higher invoice or supplementary funding requirements against initial approval amounts not included.
- To minimise cardinality, activity based on English cross border patients is based on treating organisations grouped with the geographical Integrated Care Boards (ICB) regions post April 2026.
- Treatment delivered close to home refers to care provided within the borders of the patient's local health board of residence. This can refer to an NHS provider or private provider offering patient care at home, such as Home Parenteral Nutrition (HPN). Dialysis away from home is excluded from the treatment delivered close to home as this activity is skewed due to changes in location being at patients request.
- Dialysis away from home is excluded from the treatment delivered close to home as this activity is skewed due to changes in location being at patients request.
- Care provided by Immunodeficiency Centre for Wales, Velindre UHB and PETIC Centre is classed as care received within the Cardiff and Vale UHB geographic region.

The data was used to generate summary tables and maps were created demonstrating location of patient care. This has been grouped into Welsh UHB's and English ICB's post April 2026 regions.

3. Assessment

3.1 Overview

During the two financial years of 2024-2025 and 2025-2026, the NWJCC PCT received a total of 3908 recorded requests for IPFRs and PAs. In addition, the PCT also receives on average 13 non-patient specific enquiries a week for advice regarding local health board versus NWJCC funding responsibilities.

During this period 117 different public and private health care providers cared for patients in Wales, England, Scotland, and Europe. Most of these patients reside in Wales though a small number of cross border patients also reside within the borders of Cheshire, Shropshire, Herefordshire, and Gloucestershire and are registered with a Welsh GP. Over half (52%) of all approvals were to nine key providers with Cardiff and Vale UHB the top provider of highly specialist care for the patients referred to and approved by the NWJCC, providing 492 (15%) of all care in terms of requests approved. Calea COMM are the largest private provider in terms of requests with 160 (5%) offering home parenteral nutrition for patients suffering intestinal failure.

In the period analysed the PCT approved 3361 (86%) requests, including both IPFR and PA. Of these 932 (28%) courses of treatment were provided within Wales, by both NHS and private providers, and 483 (17%) of patients received their care within the borders of their LHB not including dialysis away from home (DAFH). The total AMV of all requests received stood at £65,215,327 of which £59,294,554 (91%) were approved. Individual AMV values ranged from £50 to £414,250, £12,882,503 (22%) of the total AMV was signed off to NHS Wales health boards.

A comparison was made of the 2024-2025 combined PA and IPFR applications against invoices paid to date. Not including service level agreements (SLA) or development treatments 75% of AMV funds were utilised. Due to the longevity of some courses of treatment, this evaluation was not conducted for financial year 2025-2026. Reasons for the difference between total AMV and actual invoices paid to date may include differences in outpatient appointment actual cost versus AMV, changes to patient treatment plans, courses of In Vitro Fertilisation (IVF) are typically signed off to include three rounds though only one course maybe required to complete intended outcomes.

Applications for funding are typically categorised into 'one off' costs or annual meaning that the treatment required is need for a long period of time and potentially lifelong care. All approvals should be for 12 months duration and only extended or renewed with evidence that the treatment has been effective or reasons for delayed provided. Of all the annual approvals still alive in 25-26 and carried forward into 26-27, 137 of these were approved over 12 months before the review, of which 73 were

expected to generate costs to the JCC in 26-27. The date range for initial sign off of these cases ranged from 2011 to 2024.

3.2 Individual patient funding request panel

In accordance with the NHS Wales Policy - 'Making decisions on individual patient funding requests (IPFR) - 2025' the NWJCC is required to hold a minimum of one panel per month. However, due to demand the NWJCC aims to hold two panels per month.

In 2024-2025, 20 of the 24 planned panels took place, with an average of six cases per panel (3-10) and maximum approved value range of £390-£187k, 60% of cases were under £5k in maximum approved value. Similarly, in 2025-2026 18 of the planned 24 panels took place, with an average of six cases per panel (3-10) and maximum approved value range of £300-£180k, though with fewer cases under £5k (46%). Of the 10 panels cancelled over the two-year period, 8 were cancelled due to below quorate attendance and one due to IT issues, with the final meeting being cancelled as it fell on a bank holiday.

3.3 Individual patient funding requests

Over the course of the DDP, the NWJCC PCT received 304 IPFRs of which 243 (79.9%) were approved to a total AMV of £4,028,234. Approved AMV's ranged from £300 to £187,268 (Median £4,320, IQR £850 - £21,817). Figure 2 demonstrates the distribution of IPFR AMV range collated into bins of £25k. Of those received requests discussed at panel, 54% were below £5k in value.

The NWJCC IPFR approved rate was in line with the All-Wales average of 83% for 24-25 and 82% for 25-26 reported by the AWTTC. The average individual funding requests (IFR) approval rate in England is lower than Wales, with only approximately 10% being approved. Discussions with NHS England indicate this is largely due to the introduction of pre-panel screening process leading to non-approval as no significant difference to comparator cohort could be ascertained, although they also have a greater number of specialised policies than Wales so potentially offsetting some IPFR submissions. NHS Scotland do not include this as a criterion in their decision-making process.

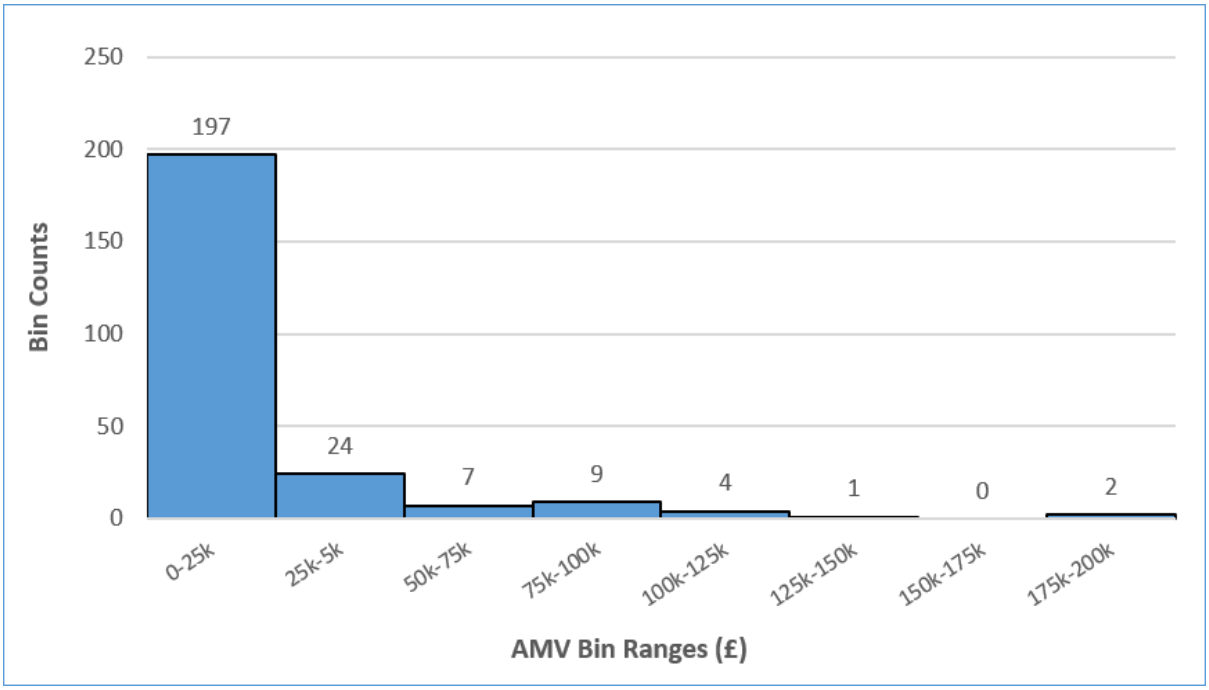


Figure 2 – Distribution of IPFR AMV Values for JCC IPFR panel decisions

Recommendation 1 - Minimum IPFR panel application value

54% of IPFR are under £5k in value, given the time taken to prepare these for and discuss at panel it is recommended that in line with UHB based IPFR panels, JCC implement a minimum IPFR panel amount of the total funding required for duration of the treatment applied for. Currently, minimum IPFR panel amounts vary across individual Welsh UHB's from £3.5k to £7k. To ensure clinical governance and equity across Wales a standardised approach would be preferrable.

This will reduce referral to treatment time (RTT), simplify pathways, improve patient experience and outcomes and reduced IPFR administrative burden.

Recommendation: Review minimum value for cases to go to panel on an all Wales basis and update IPFR policy to reflect this.

3.3.1 IPFR by health board

Illustrated in Table 1 and Figure 3, the number of approved IPFR applications ranged within Wales from 59 for Cardiff and Vale UHB (86.76% approval rate, total AMV £1,040,720, AMV per head population £2.00) to 5 for Powys Teaching HB (62.5%

approval rate, total AMV £114,418, £0.85 AMV per head population). Further statistical analysis would be required to show if this difference is statistically significant or potentially skewed by the proportion of cross border care with Powys patients registered with English GP's being referred along English treatment pathways. This information was outside that available for this deep dive.

LHB of Residence	Number Approved	% Approved	UHB Total AMV	AMV per head population
Cardiff & Vale UHB	59	86.76%	£1,040,720	£2.00
Aneurin Bevan UHB	49	84.48%	£994,923	£1.65
Cwm Taf Morgannwg UHB	37	72.55%	£322,139	£0.72
Hywel Dda UHB	29	85.29%	£613,236	£1.58
Betsi Cadwaladr UHB	28	77.78%	£494,034	£0.71
Powys Teaching HB	5	62.50%	£114,418	£0.85
Swansea Bay UHB	34	77.27%	£456,242	£1.16
NHS England	3	60.00%	£4,912	n/a

Table 1. IPFR AMV and population distribution

Treatment received by patients within their LHB of residence for all Wales was achieved for 36% of patients though there was large regional variation, with 91.53% of those patients living within the boundaries of Cardiff and Vale UHB receiving their care within these boundaries. Circa 50% of patients from Betsi Cadwaladr and Swansea Bay UHB's within the boundaries of their LHB of residence. Almost all other patients needed to travel outside the boundaries of their LHB of residence to receive their care (Table 2). This reflects the commissioner provider split of Welsh Health Boards.

LHB of Residence	Number Approved	Same LHB Region %	% Tt Wales
Cardiff & Vale UHB	59	91.53%	91.53%
Aneurin Bevan UHB	49	0.00%	85.71%
Cwm Taf Morgannwg UHB	37	2.70%	78.38%
Hywel Dda UHB	29	3.45%	89.66%
Betsi Cadwaladr UHB	28	46.43%	46.43%
Powys Teaching HB	5	0.00%	80.00%
Swansea Bay UHB	34	52.94%	91.18%
NHS England	3	0.00%	100.00%

Table 2. IPFR Treatment within same LHB boundaries and Wales

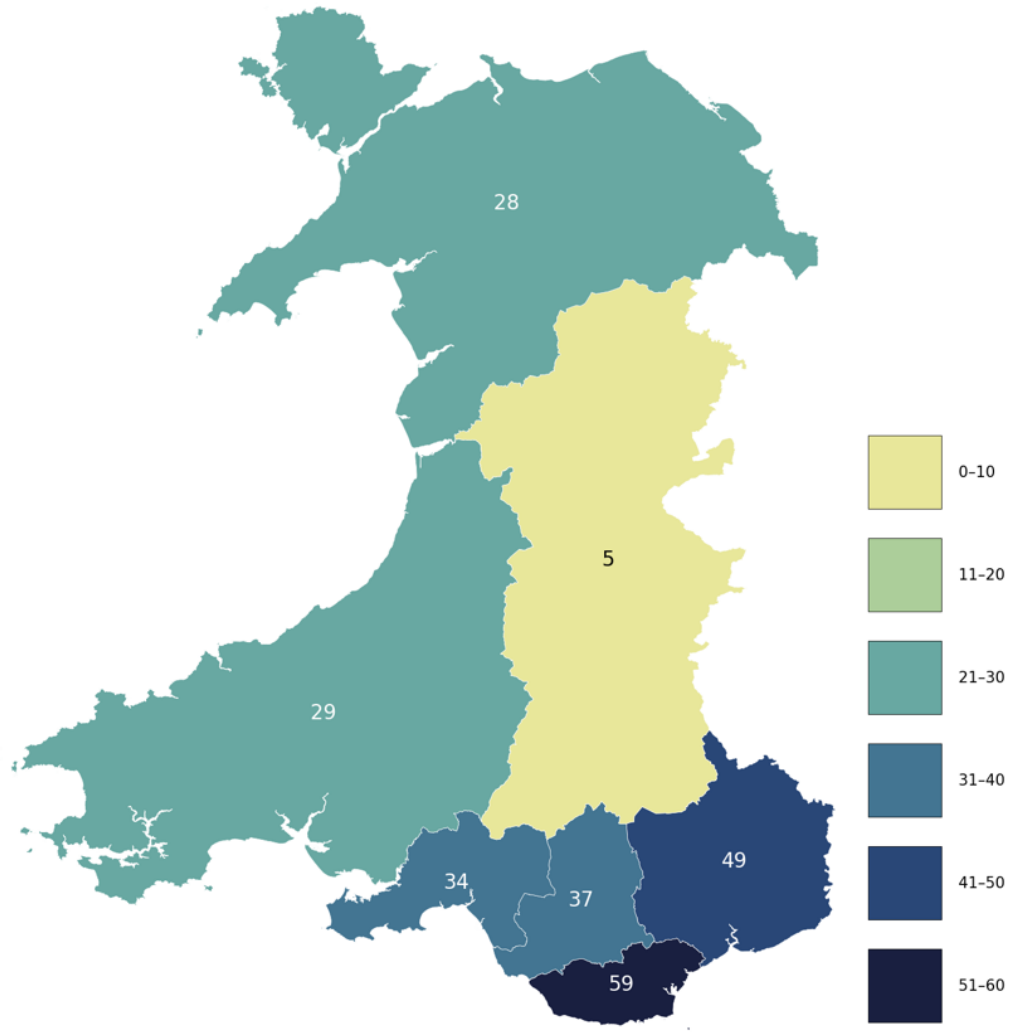


Figure 3. Number of IPFR approvals per UHB

When evaluating levels of care received within Wales overall 83% of approved patients received their care within Wales, though of patients residing in Betsi Cadwaladr UHB 46.43% accessed their care within Wales. This distribution of regions patients receive their care is shown in Figure 4.

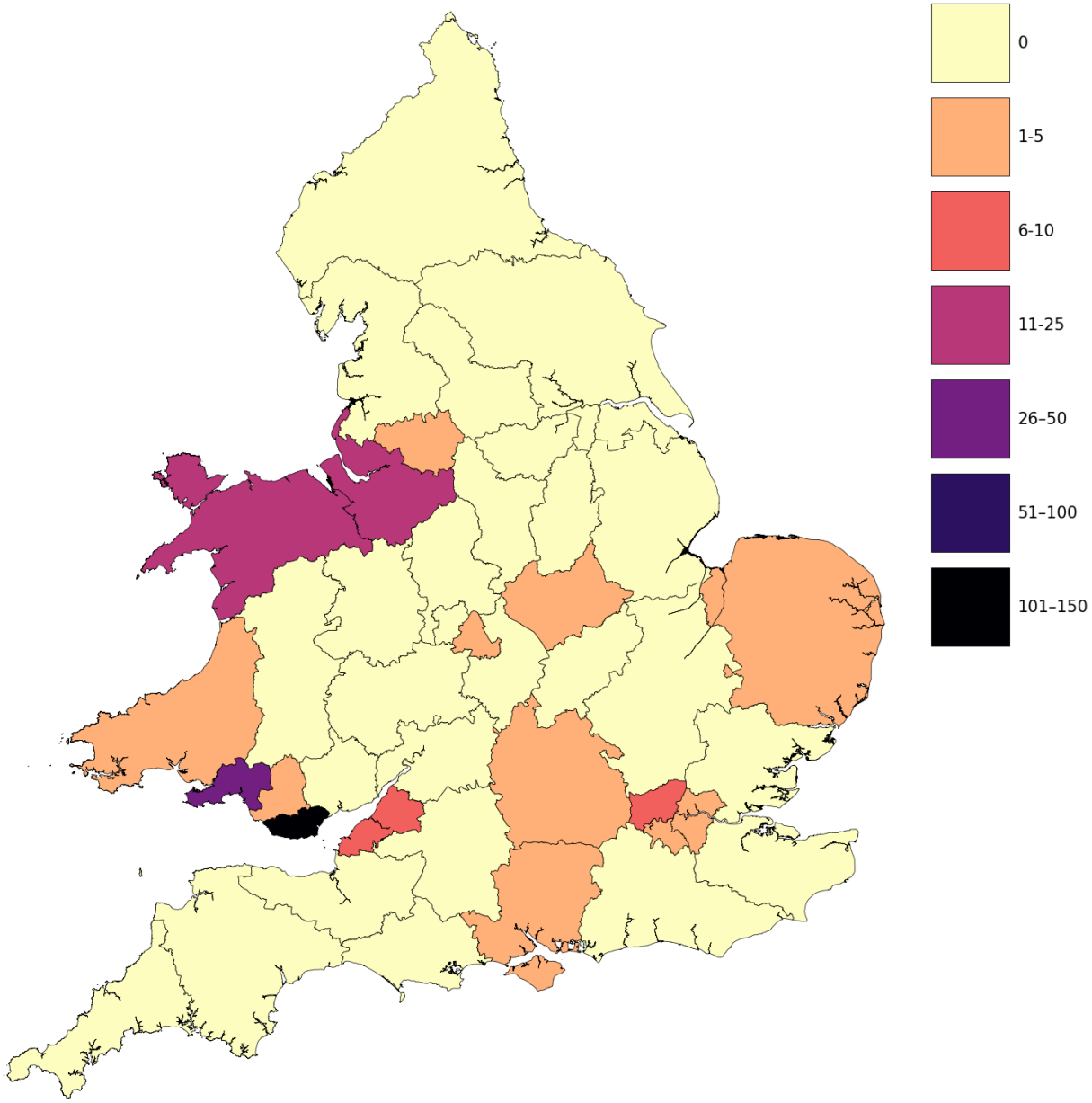


Figure 4. IPFR Total number treatments provided per Welsh UHB / NHS England ICB

Cardiff and Vale UHB are the leading provider of IPFR patient care with 118 cases spanning across Immunodeficiency, Paediatric, Haematology, Artificial Limbs and Appliances Service (ALAS), and Immunology specialities (Table 3).

Treating Organisation	Number	Sum AMV
Cardiff & Vale UHB	118	£2,333,588.10
Swansea Bay UHB	35	£262,975.52
PETIC Centre, Cardiff	26	£25,750.00
Betsi Cadwaladr UHB	16	£174,236.12
Liverpool Heart and Chest Hospital NHS FT	8	£108,000.00
University Hospitals Bristol NHS FT	5	£223,606.00
Velindre University NHS Trust	5	£65,726.00
Royal Free NHS FT	4	£115,074.00
St. Barts. NHS FT	3	£120,717.00
The Christie NHS FT	2	£109,272.00
Oxford University Hospitals NHS FT	2	£56,320.00
Alder Hey Children's NHS FT	2	£25,757.16
Liverpool Women's NHS FT	2	£17,393.69
Royal Brompton & Harefield NHS FT	1	£86,082.00
Hampshire Hospitals NHS FT	1	£75,000.00
Liverpool University Hospitals NHS FT	1	£71,500.00
Manchester University NHS FT	1	£42,000.00
James Paget University Hospitals NHS FT	1	£27,000.00
The Royal Marsden NHS FT	1	£25,000.00
The Walton Centre NHS FT	1	£23,000.00
University Hospitals of Leicester NHS FT	1	£15,000.00
Imperial College Healthcare NHS FT	1	£10,000.00
The Hillingdon Hospitals NHS FT	1	£7,846.00
Various - please select	1	£5,000.00
Hywel Dda UHB	1	£850.00
University Hospitals Birmingham NHS FT	1	£850.00
Guy's and St. Thomas' NHS FT	1	£390.00
King's College Hospital NHS FT	1	£300.00

Table 3. IPFR Treatment location (trust) count and AMV totals per trust.

A full list of the treatments approved can be found in Appendix one. Historically, once the NWJCC had received three applications for a treatment with common indications these would then be considered for prioritisation and those that scored highly were recommended for funding consideration. If approved by Joint Committee (JC) then a policy would be developed and the service commissioned, if not IPFR applications would continue and typically approved unless the JC agreed the commissioning was the responsibility of the health boards.

Table 4 highlights all approved treatments with three or more approvals within the DDP. On further review of the indications highlighted by the referrer for the treatments six of the referrals for Blinatumomab were to treat Acute Lymphoblastic Leukaemia, three Anakinra cases were to treat Autoinflammatory syndrome, and four of the referrals for Emicizumab were for the treatment of moderate Haemophilia A.

IPFR Treatment Approved > 3 Approved requests	#	Sum AMV
PET Scan (various indications)	100	£107,200
Prosthesis / Equipment	24	£368,874
LAAO	8	£108,000
Blinatumomab	6	£473,274
PRRT	6	£244,574
Anakinra	6	£50,668
Emicizumab	5	£222,247
Dupilumab	4	£97,637
Ruxolitinib	4	£84,068
Tocilizumab	4	£66,061
IVF	4	£24,594
Percutaneous Transcatheter Tricuspid Valve	3	£94,037
Mitral & Pulmonary Valve Replacement	3	£75,000
Baricitinib	3	£26,292
Etanercept	3	£17,931

Table 4. IPFR Treatment description

In the DDP, 100 referrals were received for PET scans that fell outside the commissioning policy. All Wales PET Advisory Group annually review those with 3 or

more indications received to determine if these should be recommended for inclusion in the commissioning policy (CP50). In 2025, cancer of unknown primary and IgG4 disease were included following 8 and 6 requests respectively with 100% approved. Since policy update, no requests for these indications are needed, reducing burden on clinician and PCT and enabling faster scanning times for patients.

Recommendation 2 - Automatic consideration of treatments repeatedly approved at IPFR.

Individual Patient Funding Requests (IPFR) where requests for the same intervention/indication have been submitted for three or more individuals. These often provide early indications of clinical demand for new treatments. IPFR requests where over three requests have been submitted in a 12-month period, should precipitate a formal evidence review and a decision on whether commissioned or for a decision to not commission.

This will reduce RTT, simplify pathways, improved patient experience and outcomes, reduce burden for clinical teams completing requests and reduced IPFR administrative burden

Recommendation: Develop Standard Operating Procedure (SoP) for the process of automatic evidence reviews of treatments repeatedly approved at IPFR.

3.4 Declined IPFR applications

Over the course of the DDP, the JCC IPFR panel declined 61 applications, with declined distributed across all heath boards (Table 5). 48% (29) of these applications were for plastic surgery, specifically various breast surgeries, abdominoplasty, and gynaecomastia (Table 6). In addition, 15% (9) of the declined applications were for various types of PET scan.

3.4.1 Reasons for IPFR declined

70% (41) cases the panel were not satisfied that the clinical presentation of the patient's condition was significantly different in characteristics to the comparator group. 11% (7) cases the panel were not satisfied that the patient would derive a greater clinical benefit from the proposed intervention than that of the next best alternative. 10% (6) cases the panel were not satisfied the patient would derive a greater clinic benefit from the intervention than other patients with the same condition at the same stage. Finally declined requests were centred around insufficient evidence for a proposed change to treatment centre or derived benefit from intervention than if patient were not to receive the proposed treatment. See table 5 for breakdown by applicant HB.

On review of the declined case mix a large proportion of those (48%) had requested some form of plastic surgery including breast surgery, abdominoplasty or apronectomy (see table 6 for categories of declined requests). Most patients were signposted to IPFR panel and not approved through prior approval due to their body mass index (BMI) being outside of policy range. Of the applications not approved many cited the adverse physical and mental health effects caused by large or asymmetric breasts, or excess skin following significant weight loss. Unfortunately, and despite guidelines given to the applicant clinicians, evidence of physical or mental health assessments to confirm the adverse effects was either not included in the application or not carried out. This resulted in the panel being unable to determine if the patient's presentation was significantly different to that of a comparator group or that they would derive a greater clinical benefit to that of those within a comparator group. It is also clear that in the early application process that should referring clinicians highlight adverse physical or mental health effects of the patient's presentation that needs to have been assessed and attempts to resolve before the IPFR application. Also of note was a difference in patient pathways; patients from North Wales are typically referred to the IPFR panel by a plastic surgeon, whereas patients from South Wales are typically referred by a GP to panel. The South Wales referrals are then sent for review by the SB UHB plastics team and screened against administrative criteria without any clinical involvement potentially creating a geographical inequity of access.

Declined IPFR applications per HB	Count
Cardiff & Vale UHB	9
Swansea Bay UHB	11
Cwm Taf Morgannwg UHB	14
Aneurin Bevan UHB	10
Hywel Dda UHB	6
Powys Teaching HB	3
Betsi Cadwaladr UHB	7
NHS Gloucestershire NHS FT	1

Table 5. Declined IPFR Distribution

Declined IPFR applications per Commissioning Treatment Group	Count
Plastic Surgery	29

Cancers & Tumours	9
Artificial Limbs and Appliances (ALAS)	7
Women & Children	7
Cardiology And Cardiac Surgery	4
Paediatrics	2
Immunology	1
Respiratory	1
Haematology	1

Table 6. Declined IPFR Categories

3.5 Prior approval funding requests

During the DDP, the JCC PCT received 3588 recorded prior approval requests of which 3118 (86.9%) were approved to a total AMV of £55,278,981. The total received figure does not include the circa. 10 – 15 additional non-patient specific enquiries which are time intensive for the PCT to manage. Approved AMV's ranged from £50 to £414,250 (Median £1,400, IQR £300 - £14,000), Figure 5 demonstrates the distribution of IPFR AMV range collated into bins of £25k.

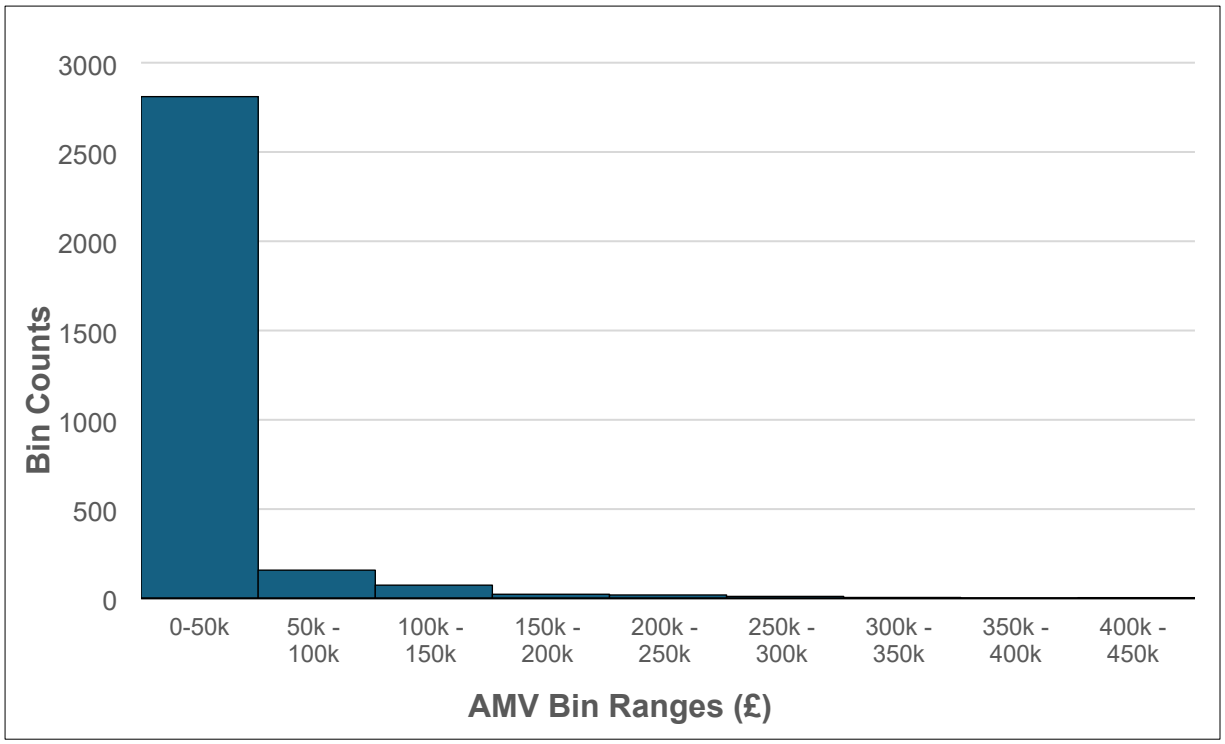


Figure 5. Prior Approval AMV Distribution

The number of approved prior approval applications ranged within Wales from 609 for Aneurin Bevan UHB (609) to 198 for Powys Teaching HB. Approval rates were

consistent for all UHB's ranging from 81.4% to 89.4%. Total AMV for all applications was £55,251,189, with Cardiff and Vale UHB the highest individual AMV proportion of 20%. When considering prior approval spend per head of population this showed a large variation, with Hywel Dda UHB average approval per head of population at £10.82 compared to Cardiff and Vale UHB at £22.36 (Figure 6). See Appendix 2 for full breakdown.

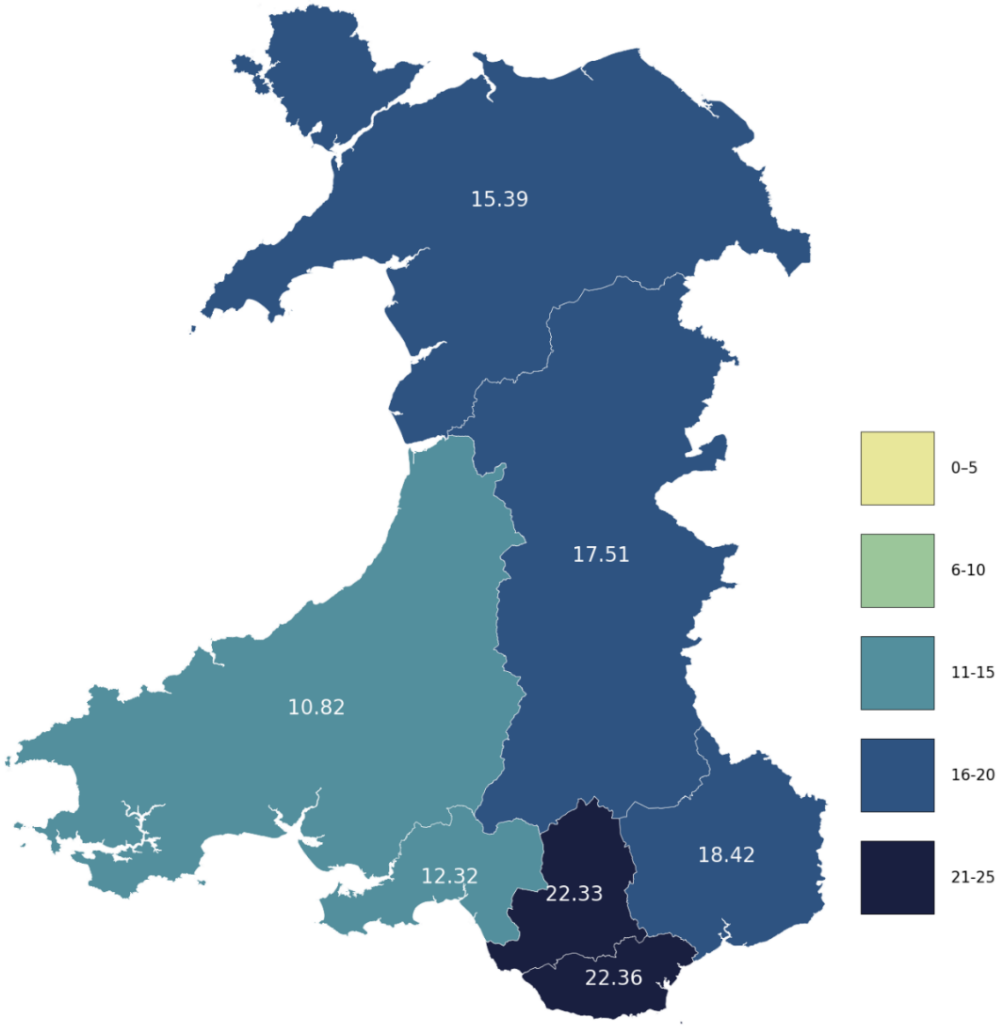


Figure 6. PA (£) AMV average spend per head of UHB population.

Prior Approval treatment received by patients within their LHB of residence for all Wales was achieved for 396 (15%) of patients though large regional variation, with 28.4% for patients living within the boundaries of Cardiff and Vale UHB receiving their care within these boundaries, only 9 (4.7%) of patients living within the boundaries of Powys Teaching HB received their care within these boundaries.

When evaluating levels of care received within Wales overall 731 (27.2%) of approved patients received their care within Wales, ranging from Powys Teaching HB 19.4% to Hywel Dda UHB 33.3% (Table 9).

LHB of Residence	Number Approved	Same LHB Region %	% Tt Wales
Cardiff & Vale UHB	604	28.41%	32.34%
Aneurin Bevan UHB	609	9.40%	25.38%
Cem Taf Morgannwg UHB	399	10.53%	31.58%
Hywel Dda UHB	328	7.02%	33.33%
Betsi Cadwaladr UHB	602	18.22%	18.59%
Powys Teaching HB	198	4.71%	19.37%
Swansea Bay UHB	310	12.16%	31.37%
NHS England	67	0.00%	4.48%

Table 9. Prior Approval Treatment within same LHB boundaries and Wales

When considering the distances patients need to travel for care not available in Wales, Figure 7 shows clear hotspots of referral activity. With holiday dialysis removed due to patient choice in location, Cardiff & Vale UHB and Royal National Orthopaedic Hospital are the highest locations followed by the regions of Sheffield, Bristol, Manchester and Liverpool, and Oxfordshire which includes the high number of cardiac catheterisations in Bath. Home Parenteral Nutrition (HPN) gives the highest single provider spend with £15.8m to Calea, and highest spend of £19.1m for spend on single type of treatment. Full details of AMV per centre and cost of request by indication can be found in Appendix 3,4,5.

Contracts are in place with some but not all PA treatment centres, inclusion of these cases within existing contracts or establishment of new ones would reduce burden for clinicians and JCC.

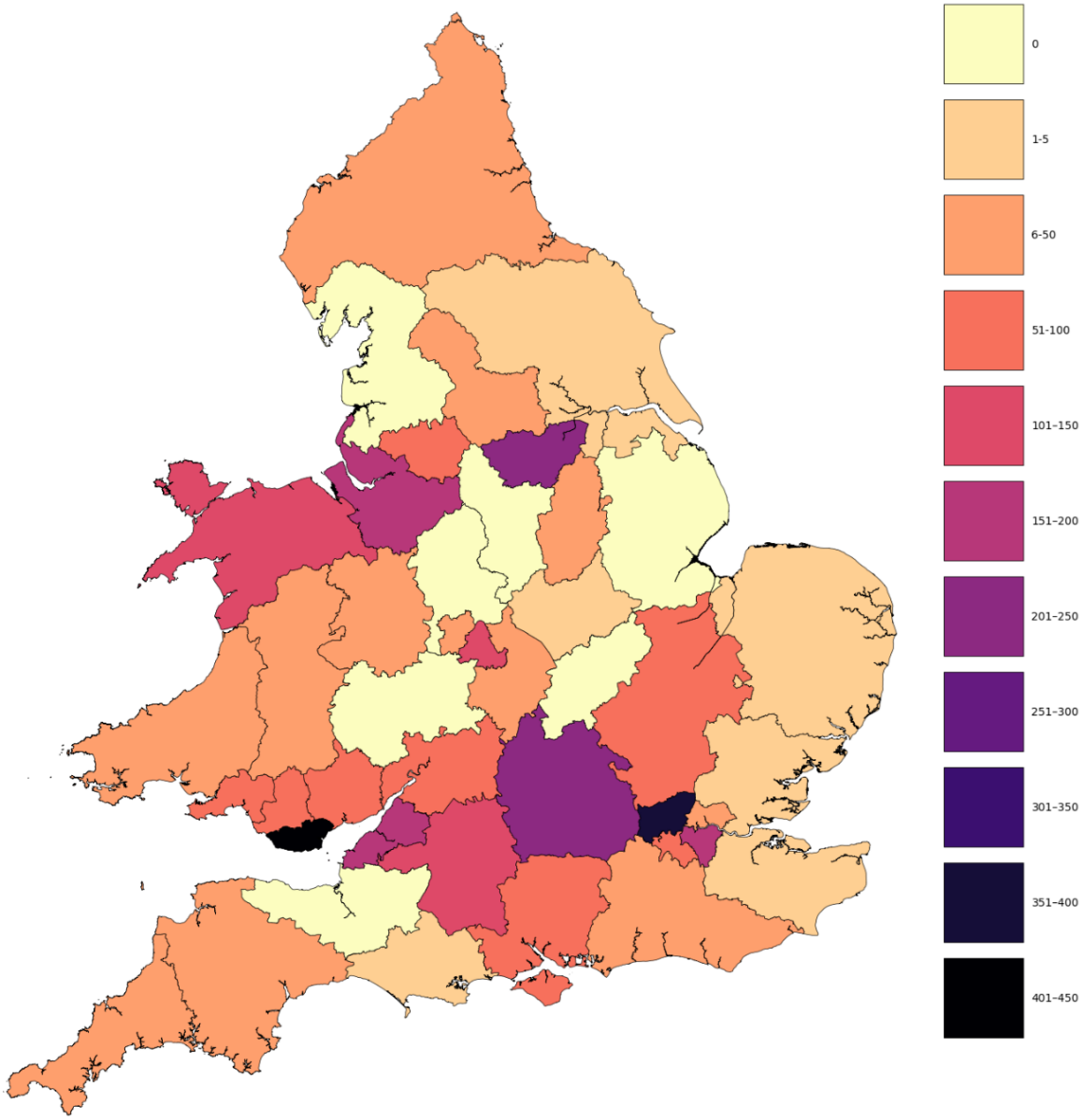


Figure 7. PA Total number treatments provided per Welsh UHB / NHS England ICB

Recommendation 3 – Improving access to care

Over the deep dive period, 3,588 prior approval requests were received across 177 providers, each requiring assessment against more than 200 policy positions. Clear contractual treatment pathways and designation of approved providers within updated policies would reduce administrative burden by enabling direct clinical referrals. Agreed activity thresholds and performance indicators should trigger evaluation of service repatriation to Wales. Where repatriation is not viable, alternative contracting models, including block contracts, should be explored to secure efficiency gains and potential cost savings while maintaining access to specialist services.

This will improve patient experience and outcomes, potential cost saving, increased value and reduced IPFR administrative burden

Recommendation: A review of contracts and policies relating to top requests and development of process for ongoing review.

3.6 HPN

On further review of HPN applications over the DDP, significant regional variation would appear to exist in terms of utilisation per head capita and median AMV. Aneurin Bevan UHB received the highest number of approvals (49) however, Betsi Cadwaladr UHB total AMV was within £95k with nine less approved applications. On further review BCU UHB median and IQR ranges tended to be higher than other UHB's (£103, 733 median, IQR £89,204 - £129,474). Typically, cost variation between applications centres around the nursing element of the application (Table 10, Figure 8).

LHB of Residence	Count	Sum AMV	AMV per head population	Mean AMV	Median AMV
Cardiff & Vale UHB	36	£3,421,559	£6.58	£95,043	£90,843
Aneurin Bevan UHB	49	£4,536,189	£7.54	£92,575	£86,346
Cwm Taf Morgannwg UHB	33	£3,624,073	£8.07	£109,820	£103,773
Betsi Cadwaladr UHB	40	£4,441,193	£11.41	£111,030	£110,255
Hywel Dda UHB	18	£1,386,599	£1.99	£77,033	£70,186
Powys HB	9	£735,158	£5.44	£81,684	£98,082
Swansea Bay UHB	14	£997,849	£2.53	£71,275	£65,805

Table 10. Top 30 PA Treatments by frequency of referrals

Recommendation 4 - HPN prescribing practices

The deep dive has shown large regional variation of median HPN costs across Wales. Further analysis of the prescribing and associated community nursing support approaches within HPN services to ensure equity across Wales.

This will improve patient experience and outcomes, lead to potential cost saving, increase value and reduce IPFR administrative burden.

Recommendation: Review of HPN prescribing practices to ensure equity of care across Wales and explore options to decrease the financial costs of nursing time.

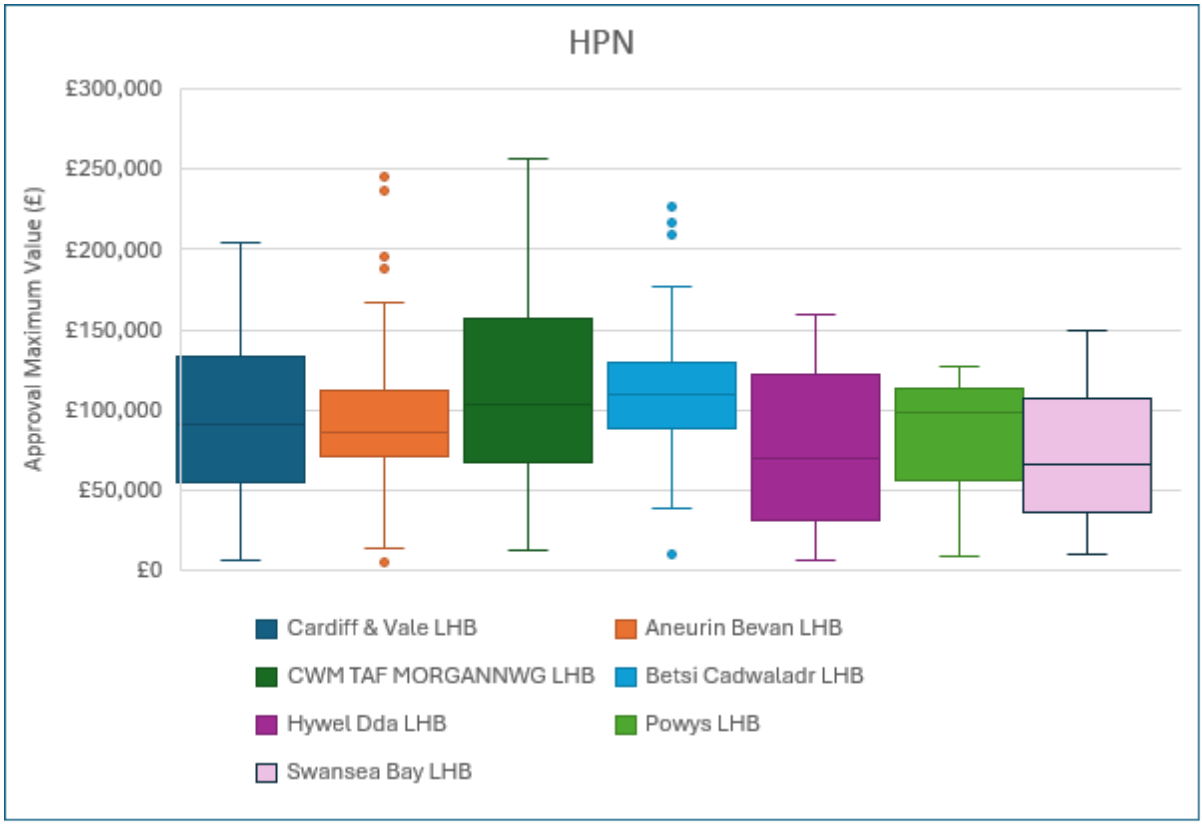


Figure 8. HPN Box plot of Mean/Median costs (£) per UHB

3.7 Non-approved prior approval applications

During the DDP, the NWJCC PCT received 3588 recorded prior approval requests of which 3118 (86.9%). Of the applications not approved:

- 192 (40%) were due to the commissioning responsibility of the requested treatment or drug sitting with the local health board of the patient
- 151 (32%) of the prior approval requests cancelled before the application was fully considered and decision made

- 90 applications (19%) were not approved following suitability concerns after medical director review or primary care requests for English tertiary care without seeking local Multidisciplinary Team (MDT) opinion.

Following a review of a selection of cancelled applications the main reasons for cancellations were due to:

- Change to patient requirements or care plans
- No reply to PCT following queries made regarding application
- Patient moved to England for follow up care

During the DDP the NWJCC patient care team did not receive any concerns from patients or clinicians regarding delays or patient harm specifically due to delays to IPFR or PA decision making.

Recommendation 5 – Clarity on commissioning responsibilities

40% of declined prior approvals are outside the remit of JCC. In addition, 10-15 queries per week are received to determine commissioning responsibility**.** Clearly defined lists of commissioned services from UHB's and NWJCC would reduce the current ambiguity of patient signposting. Some patients with complex or multiple needs are likely to still require discussion between the NWJCC and UHB to establish the current funding pathway.

This will reduce RTT, simplify pathway, improve patient experience and outcomes and reduced IPFR administrative burden.

Recommendation: Clarity on NWJCC commissioning responsibilities and published list of JCC and UHB commissioning responsibilities.

Recommendation 6 – Expansion of IPFR collaboration between UHB and NWJCC

The potential endorsement of the recommendations within this deep dive, of which a number involve the operational activity of both UHB and NWJCC, would require early dialogue and implementation planning between all stakeholders. This would be required to ensure seamless integration ensuring all stakeholders involved whilst minimising any potential impact on 'day to day' activity. In addition, where operational changes have been made within the NWJCC, increased dialogue would provide a platform to demonstrate potential benefits to local adoption and reduce inequity.

This will reduce RTT, simplify pathways, improve patient experience and outcomes and reduced administrative burden.

Recommendation: Explore opportunities for greater collaboration across IPFR panels in Wales.

3.8 Data quality

The review highlighted a lack of data completeness within the requests received. This led to complexities of data extraction and data quality. A process for consistent data entry and coding is needed to ensure source data is complete. In addition, despite outcome data provision being mandatory following an approved request, this is rarely received and only provided if extensions are requested. No patient reported outcome measures (PROM) or patient reported experience measures (PREM) feedback on treatments approved by the NWJCC is routinely collected.

Recommendation 7 – Digitalisation

For all NWJCC PA and IPFR applications to be received via single online platform. NHS England currently utilises such a platform for IFR requests. An all-Wales approach to standardised libraries for treatments, drugs, and indications would improve data quality and reduce manual inputting.

This will reduce RTT, improve data quality, improve all Wales evaluation of value and effectiveness and reduce IPFR administrative burden

Recommendation: Online IPFR and prior approval application system

Recommendation 8 - Patient reported outcomes

PROM and PREM questionnaires can be integrated into an online referral system, with demonstrations given by Blueteq as an example. Following initial discussions with CEDAR and NHS P&I further feedback on treatment success is potentially also available via National Registers already in place such as the National Pulmonary Hypertension Audit, though not all national programmes are mandatory or exist for rare conditions.

This will reduce RTT, simplify pathway, improve patient experience and outcomes and reduce IPFR administrative burden.

Recommendation: Implementation of process for PREM and PROM collection along with process for ensuring clinically reported outcomes.

3.9 MOD Fast-track and war veterans

3.9.1 War veterans

Currently, the NWJCC received all war veteran and MOD fast-track applications from the Artificial Limb and Appliances (ALAS) service and various MOD direct referrers respectively. For War veterans a NWJCC policy exists (CP49) for enhanced provision, though no formal agreement or policy exists for MOD fast-track. The MOD fast-track pathway receives no additional funding and is funded through the UHB risk pool.

During the DDP the JCC received 28 referrals typically from local physiotherapists into ALAS, or from ALAS requesting further equipment for existing patients. All applications were approved. Geographical distribution and cost illustrated in table 11.

War Veteran UHB of Residence	# Approved	Sum AMV (£)
Cardiff & Vale UHB	0	£0
Aneurin Bevan UHB	0	£0
Cwm Taf Morgannwg UHB	2	£28,727
Hywel Dda UHB	10	£84,631
Betsi Cadwaladr UHB	9	£112,564
Powys Teaching HB	3	£81,793
Swansea Bay UHB	5	£30,275

Table 11. Summary of War Veteran referrals and AMV

3.9.2 MOD Fast-track

During the DDP the NWJCC received 80 referrals from MOD medical centres requesting the fast-tracking of care for serving frontline military personnel who were unable to be deployed during to treatment requirements. Treatment requirements included Orthopaedics, Hernia repair, Gynaecological, Gastrointestinal (GI), and Urology. No requests were for highly specialist services commissioned by the NWJCC. All applications were approved without scrutiny, with multiple applications citing standard waiting times as the reason for making the fast-track referrals. Geographical distribution of patient UHB of residence and value illustrated in table 12.

LHB of Residence	# Submitted	Sum AMV (£)
Cardiff & Vale UHB	26	£52,400
Aneurin Bevan UHB	0	£0
Cwm Taf Morgannwg UHB	1	£2,000
Hywel Dda UHB	26	£49,000
Betsi Cadwaladr UHB	12	£20,400
Powys Teaching HB	13	£26,100
Swansea Bay UHB	0	£0
NHS Gloucestershire CCG	2	£6,000

Table 12. Summary of MOD Fast-track referrals and AMV

During the deep dive process, it was found that implementation of MOD fast track varied across UHB's with some not accepting fast track referrals for serving non-deployable service personal, and the armed services covenant interpretated as for war veterans only. In some cases, this led to patients being referred to alternative UHB's further away from base or waiting for prolonged period unable to be deployed potentially affecting promotion and employment.

Recommendation 9 - MOD Fasttrack and war veteran applications

Given the number of requests and time it is recommended to remove the requirement for MOD Fasttrack referrals to be sent to the NWJCC, referrals sent directly from referral to required service ensuring proportionate costs to UHB's based on patient residence and demand. Also ensuring pan UHB interpretation and implementation of the Armed Forces Covenant and treatment where possible close to home.

This will reduce RTT, simplify pathways, improved patient experience and outcomes and reduce IPFR administrative burden. There would need to be certainty over pathways and waiting lists, and options should be discussed with NHS Wales P+I.

Recommendation: Full responsibility of MOD Fasttrack and war veteran applications to be transferred back to HBs

3.10 Treatment centre utilisation against NWJCC policies

An aim of this deep dive was to establish adherence to NWJCC policies in respect of designated treatment centres. Several examples of IPFR panel requests exist for treatment to be undertaken in centres not listed as designated providers. In attempting to evaluate the use of designated providers for PA treatments this became more difficult. During approval of a PA the PCT will often utilise both historic cases as references and also a published list available on the NWJCC website (March 2026 NWJCC Extraordinary meeting – Appendix 1 – Commissioned Services Directory). In addition, where highly specialist services are not available in Wales and a patient requires a revie for treatment planning it may be necessary to referral to a UK national centre of excellence. Due to differences in libraries for conditions, treatments, and drugs between the PCT access database and the spreadsheets used by finance colleagues, together with changes to the names of NHS England trusts not implemented in JCC policies and PCT Access Database direct comparisons to identify examples of non-designated treatment centres.

The deep dive did identify examples of historic lifelong approved PA's whereby patients were under the care of centres now not included in published policies. This included the care of 15 patients who received Cochlear implants under the care of Nottingham University Hospital NHS FT, a service which is now available in Wales. In addition, cases whereby sub-speciality treatments are required at different providers to the initial agreed treatment centre occur. For example, Ocular cancer is commissioned by the NWJCC with Liverpool University Hospital NHS FT as designated provider however, if the patient needs low density proton beam therapy they will then be referred on to The Clatterbridge Centre. Historically, patients with Ocular cancer have also been referred to Sheffield Teaching Hospital NHS FT from across Wales. Narratives of the approval highlight Sheffield Teaching Hospital NHS

FT as a designated commissioned provider though this centre does not appear on published policies or provider list.

3.11 Key risk / matters for consideration

The following risks need to be considered in the completion and implementation of the recommendations outlined within this report:

- Data quality and availability to assess all deep dive aims
- IPFR team capacity alongside daily activity
- Future of Blueteq uncertain as NHS England undergoing tender process
- Lack of support from referrers on implementing recommendations on changes to IPFR / PA form submission, and PROM / PREM submission
- Welsh UHB IPFR team buy-in to national approach
- Implementation and maintenance costs of online IPFR / PA platform

Recommendation 10 – Implementation plan and resource requirements

To maximise the benefits of the recommendations made a full implementation plan is required, including identification of the resources needed, to maximise benefits for patients accessing care via both NHS Wales Joint Commissioning Committee and university health boards.

This will lead to improved team capacity and efficiency, value, increased financial savings and optimised patient care.

Recommendation: Development of implementation plan and required resources to deliver recommendations of deep dive together with routine activity.

4. Summary of Recommendations

Recommendation	Faster Access	Simpler Process	Better Outcomes	Less Admin	Better Value
R1. Minimum IPFR Panel Threshold	✓	✓	✓	✓	
R2. Automatic Review of Repeated IPFR Approvals	✓	✓	✓	✓	
R3. Improve Access to Care			✓	✓	✓
R4. HPN Prescribing Review			✓	✓	✓
R5. Clarify Commissioning Responsibilities	✓	✓	✓	✓	
R6. Expansion of IPFR collaboration between UHB and NWJCC	✓	✓	✓	✓	
R7. Digitalisation of Applications	✓	✓	✓	✓	
R8. PROMs & PREMs Collection			✓	✓	
R9. MOD Fast Track & Veterans Pathway Review	✓	✓	✓	✓	
R10. Implementation plan and resource requirements		✓	✓		✓

Table 13. Summary of recommendations and associated potential benefits

4.1 Impact of recommendations

4.1.1 Improved productivity

The recommendations are designed to reduce administrative burden, eliminate duplication and streamline decision-making processes across Wales. Introducing a minimum threshold for IPFR panel consideration and moving low-value requests out of panel processes will reduce preparation, administration and panel time, allowing clinical and commissioning resources to focus on more complex, high-value cases.

Processes to trigger evidence reviews of treatments repeatedly approved through IPFR ready for Joint Committee consideration could reduce recurring applications, enabling common requests to move into routine commissioning pathways. Clarifying commissioning responsibilities between Health Boards and the NWJCC will reduce

the significant volume of inappropriate referrals and funding queries currently received, while increased collaboration across UHB and NWJCC for IPFR and PA has the potential to reduce duplication across organisations and improve resilience.

Digitalisation of funding applications, supported by standardised coding and online workflows, will further reduce manual processing, improve data quality and shorten referral-to-decision times.

4.1.2 Improved value for money

The review identifies opportunities to strengthen value-based commissioning and ensure funding decisions are supported by robust intelligence and evidence. Regular review of high-volume treatments and services could allow consideration of routine commissioning, block contracting and alternative procurement approaches that may reduce costs and secure economies of scale.

Improved monitoring of demand, outcomes and expenditure will support earlier identification of emerging cost pressures and commissioning opportunities. Reviewing variation in HPN costs and prescribing practices may identify opportunities to reduce unwarranted variation and achieve greater consistency across Wales.

Enhanced data collection, PROMs, PREMs and outcomes monitoring will provide stronger evidence of treatment effectiveness, enabling resources to be directed towards interventions delivering the greatest patient benefit and value from public expenditure.

4.1.3 Improved patient outcomes

The recommendations support faster, more consistent and equitable access to care across Wales. Reducing unnecessary administrative processes and moving appropriate activity into commissioned pathways will shorten referral-to-treatment times and improve patient experience.

Earlier identification of treatments suitable for routine commissioning will reduce the need for repeated exceptional funding applications, providing more predictable access to effective interventions. Greater clarity regarding commissioning responsibilities and referral pathways will ensure patients are directed to the right service first time.

The introduction of digital platforms, routine collection of PROMs and PREMs, and stronger outcomes monitoring will enable the NWJCC to better understand treatment effectiveness, learn from patient experience, and continuously improve services. Collectively, the recommendations support more equitable access, improved patient

experience, and better health outcomes through evidence-based commissioning decisions.

4.2 Activity undertaken so far

4.2.1 PET Policy update

The All-Wales PET Advisory Group (AWPET) review the PET commissioning policy and indication list annually following a call for indications. As part of this review, indications with repeat IPFR applications for PET are discussed and where an evidence base exists are recommended for inclusion in the policy. In August 2026, Systemic IgG4 related disease (IgG4-RD) and Carcinoma of Unknown Primary (CUP) were included. Guidance was also updated on patients discussed in UK national MDTs, where PET imaging is suggested. Since publication of the updated guidance (CP50) there have been significantly less IPFR applications for PET scans.

4.2.2 Discussions with online PA system providers

An initial meeting has taken place with Blueteq to ascertain if functionality exists within the system to expand from high-cost drugs only to all IPFR and PA applications. This process has been adopted recently by ICB's in NHS England successfully with implementation by Blueteq which also enables single sign in for clinicians.

4.2.3 Discussions with NHS England

Two meetings have taken place with peers from the NHS England Individual Funding Request (IFR) team as an opportunity to learn of the processes and technologies adopted by NHS England for the management of IFR's. Representatives from NHS England highlighted that whilst initially difficult the transition to full digitalised application process was the correct move. NHS England also give insight into Apollo, a bespoke system designed for NHS England by Arden and Gem, and the back-office management of applications. This advice will be utilised together with that from Blueteq when considering online platform suitability and functionality required.

4.2.4 Discussions with Centre for Healthcare Evaluation, Device Assessment, and Research (CEDAR) and NHS Performance and Improvement (P&I)

Discussions have taken place with both CEDAR and NHS P&I for advice on the implementation of PROMs and PREMs. NHS P&I highlighted that there is potential support available to the implementation of these measures though further work is required to overcome the challenges of implementing existing methods for highly

specialist treatments and those for one off surgical interventions versus long term treatments. In addition, NHS P&I also advised engagement with treatment providers to explore options to access information submitted to nationally reported audits such as the National Pulmonary Hypertension Audit.

4.2.5 Deep dive socialising to wider stakeholders

Owing to time constraints caused by initial data quality, there has been no opportunities to socialise the draft deep dive before the 9th November submission deadline. However, before joint committee discussion in late November 2026 the draft deep dive will have been socialised with all Wales IPFR 'Policy implementation group', current NWJCC IPFR panel chair, Wales chief pharmaceutical officer, and UHB Medical directors. A summary of comments can be discussed

4.3 Implementation plan for recommendations

Following approval from the JC, we will develop an implementation plan for each of the approved recommendations in their final form, including partner organisations where needed.

Abbreviations

Abbreviation	Definition
ALAS	Artificial Limbs and Appliances Service
AMV	Approved Maximum Value
AWMSG	All Wales Medicines Strategy Group
AWTTC	All Wales Therapeutics and Toxicology Centre
BCU	Betsi Cadwaladr University Health Board
BMI	Body Mass Index
CAR-T	Chimeric Antigen Receptor T-cell Therapy
CEDAR	Centre for Healthcare Evaluation, Device Assessment and Research*
CRS	Cytoreductive Surgery
DAFH	Dialysis away from home
DDP	Deep Dive Period
FT	Foundation Trust
GI	Gastrointestinal
GID	Gender Identity Disorder / Gender Identity-related funding requests
GP	General Practitioner
HB	Health Board
HIPEC	Hyperthermic Intraperitoneal Chemotherapy
HPN	Home Parenteral Nutrition
HTW	Health Technology Wales
ICB	Integrated Care Board
ICSI	Intracytoplasmic Sperm Injection
IFR	Individual Funding Request
IMTP	Integrated Medium Term Plan
IPFR	Individual Patient Funding Request
IQR	Interquartile Range
IT	Information Technology
IVF	In Vitro Fertilisation

JC	Joint Committee
JCC	Joint Commissioning Committee
LAAO	Left Atrial Appendage Occlusion
LHB	Local Health Board
MDT	Multidisciplinary Team
MOD	Ministry of Defence
NHS	National Health Service
NW SSP	NHS Wales Shared Services Partnership
NICE	National Institute for Health and Care Excellence
NWJCC	NHS Wales Joint Commissioning Committee
PA	Prior Approval
PAH	Pulmonary Arterial Hypertension
PET	Positron Emission Tomography
PETIC	PET Imaging Centre
PGD	Pre-implantation Genetic Diagnosis
PGT	Preimplantation Genetic Testing
P&I	Performance and Improvement
PO	Purchase Order
PREM	Patient Reported Experience Measure
PROM	Patient Reported Outcome Measure
PRRT	Peptide Receptor Radionuclide Therapy
QA	Quality Assurance
RTT	Referral to Treatment Time
SABR	Stereotactic Ablative Radiotherapy
SLA	Service Level Agreement
SOP / SoP	Standard Operating Procedure
TA	Technology Appraisal
TBC UHB	To Be Confirmed University Health Board

Appendix One – Full List of IPFR treatment requests and frequency

IPFR Treatment Approved	#	Sum AMV
PET Scan	100	£107,200
Prosthesis / Equipment	24	£368,874
LAAO	8	£108,000
Blinatumomab	6	£473,274
PRRT	6	£244,574
Anakinra	6	£50,668
Emicizumab	5	£222,247
Dupilumab	4	£97,637
Ruxolitinib	4	£84,068
Tocilizumab	4	£66,061
IVF	4	£24,594
Percutaneous Transcatheter Tricuspid Valve	3	£94,037
Mitral & Pulmonary Valve Replacement	3	£75,000
Baricitinib	3	£26,292
Etanercept	3	£17,931
Dinutuximab	2	£229,765
CRS and HIPEC	2	£150,000
Kaftrio	2	£127,318
Cochlear Implant	2	£70,942
Pembrolizumab	2	£47,686
Brachytherapy	2	£31,249
Eculizamab	2	£29,088
SIRT	2	£25,300
Mepolizumab	2	£21,492
Cannabidiol	2	£17,255
ICSI	2	£13,500
Upadacitinib	2	£9,269
Trametinib	2	£7,200

Ravulizumab	1	£187,268
Stem cell transplant	1	£180,000
Canakinumab	1	£119,113
Cholic Acid	1	£95,472
Treprostinil	1	£86,082
Selumetinib	1	£80,928
Mitral Valve Replacement	1	£53,000
Bilateral Cochlear Implant	1	£42,000
Daratumumab	1	£38,776
Nitazoxanide	1	£35,000
Ryplazim	1	£30,000
Hyperbaric Oxygen Treatment	1	£27,000
Vedolizumab	1	£25,200
Isolated Limb Perfusion	1	£25,000
Autologous Stem Cell Transplant	1	£24,000
Deep Brain Stimulation	1	£23,000
Quinidine	1	£18,000
Belatacept	1	£17,868
Plerixafor	1	£11,720
Leadless pacemaker	1	£10,710
Body contouring	1	£10,000
Aortic Root & Ascending Aortic Replacement	1	£7,000
Hyftor Sirolimus	1	£6,240
Pazopanib	1	£5,045
Sperm Preservation	1	£5,000
Tofacitinib	1	£4,410
Breast Reduction	1	£3,500
Omalizumab	1	£3,074
SABR	1	£3,013
Stereotactic Radiosurgery	1	£3,013

Sirolimus	1	£2,371
Clonidine	1	£2,300
Efanesoctocog Alfa	1	£2,220
PGT	1	£390

Appendix Two – Prior Approval AMV Approval Distribution

LHB of Residence	# Approved	# Total	% Approved	UHB Sum AMV	AMV per head population
Cardiff & Vale UHB	604	693	87.16%	£11,619,287	£22.36
Aneurin Bevan UHB	609	681	89.43%	£11,081,538	£18.42
Cem Taf Morgannwg UHB	399	453	88.08%	£10,035,298	£22.33
Hywel Dda UHB	328	376	87.23%	£4,212,374	£10.82
Betsi Cadwaladr UHB	602	685	87.88%	£10,727,678	£15.39
Powys Teaching HB	198	239	82.85%	£2,364,358	£17.51
Swansea Bay UHB	310	381	81.36%	£4,859,366	£12.32
NHS England	67	80	83.75%	£351,290	n/a

Appendix Three – Top 30 PA Treating Organisations by total AMV

Top 30 (Value) Prior Approval Treating Organisations	#	Sum AMV
Calea	160	£15,818,673
Cardiff & Vale UHB	375	£8,690,979
The Newcastle Upon Tyne Hospitals NHS FT	34	£5,013,411
Hampshire Hospitals NHS FT	27	£1,935,687
Manchester University NHS FT	38	£1,876,421
Guy's and St. Thomas' NHS FT	148	£1,792,091
Oxford University Hospitals NHS FT	192	£1,748,962
Various - please select	95	£1,659,783
Lloyds Pharmacy Clinical Homecare Ltd	22	£1,610,755
University Hospitals Bristol NHS FT	110	£1,312,898
Sheffield Teaching Hospitals NHS FT	195	£1,250,775
Royal Free London NHS FT	56	£1,080,766
The Clatterbridge Cancer Centre NHS FT	53	£948,513
Sheffield Children's NHS FT	26	£845,588
Royal United Hospitals Bath NHS FT	110	£735,631
Salford Royal NHS FT	6	£661,585
The Walton Centre NHS FT	32	£650,156
Birmingham Women's and Children's NHS FT	9	£600,620
Betsi Cadwaladr UHB	61	£556,557
Swansea Bay UHB	50	£539,830
Great Ormond Street Hospital for Children NHS FT	62	£536,597
The Christie NHS FT	13	£512,253
Bristol Hospitals NHS FT	50	£486,298
NHS Blood & Transplant	11	£432,482
St. Barts. NHS FT	23	£371,934
Leeds Teaching Hospitals NHS Trust	31	£351,371
University Hospitals Birmingham NHS FT	89	£347,641
B. BRAUN	4	£303,341

Royal Liverpool and Broadgreen University NHS FT	19	£257,988
Royal National Orthopaedic Hospital NHS Trust	197	£218,793

Appendix Four – Top 30 PA Treatments by total AMV

Top 30 (£) Prior Approval Treatments	#	Sum AMV
Home Parenteral Nutrition	199	£19,142,618
Drug Therapy	144	£4,480,128
Stem Cell Transplant	25	£3,908,006
BMT	21	£3,647,162
Cytoreductive Surgery and HIPEC	30	£2,160,000
Enzyme Replacement Therapy	7	£1,684,686
PGD	53	£1,654,388
Immunoglobulin Drug Therapy	41	£1,488,464
Deep Brain Stimulation	35	£884,240
Peptide Receptor Radionuclide Therapy (PRRT)	28	£876,904
Immunology	15	£534,168
Extra Corporeal Phototherapy	12	£523,929
Cardiac Catheter	65	£472,398
Intestinal	2	£468,680
Transplant	5	£465,873
Proton Therapy	30	£460,130
Pompes Disease	1	£414,250
Gamma Knife Treatment	30	£405,300
War Veteran	28	£337,990
Stereotactic Radiosurgery	51	£315,672
Ventricular Assist Device	1	£311,469
Eculizamab	8	£295,554
Mifamurtide	3	£293,520
Macitentan	13	£266,704
Defibrotide	7	£264,951

Alkaptonuria	17	£255,000
Cardiac Surgery	9	£241,575
Cardiac Catheterisation	33	£241,259
CAR-T (Chimeric Antigen Receptor T-cells)	2	£237,042
Cardiac	22	£235,340

Appendix Five – Top 30 PA Treatments by frequency of referrals

Top 30 (Applications) Prior Approval Treatments	#	Sum AMV
Holiday Dialysis	373	£203,597
Home Parenteral Nutrition	199	£19,142,618
Outpatient Appointment	161	£122,570
PET Scan	160	£163,845
Drug Therapy	144	£4,480,128
Follow Up Appointment	82	£35,367
MOD Fast Track	80	£158,900
Living Donor Expenses	68	£203,383
PGD Assessment	67	£98,140
Stickler's Syndrome	67	£25,196
Cardiac Catheter	65	£472,398
Follow up	57	£17,393
Pulmonary Arterial Hypertension	55	£24,327
PGD	53	£1,654,388
Stereotactic Radiosurgery	51	£315,672
Second Opinion	45	£139,651
Cryopreservation	44	£181,200
Mitochondrial Disease	44	£26,965
Immunoglobulin Drug Therapy	41	£1,488,464
Pulmonary Hypertension	40	£12,000
Deep Brain Stimulation	35	£884,240
Cardiac Catheterisation	33	£241,259

Neurofibromatosis	31	£157,714
Cytoreductive Surgery And HIPEC	30	£2,160,000
Proton Therapy	30	£460,130
Gamma Knife Treatment	30	£405,300
Sarcoma	30	£64,791
Sildenafil	29	£68,919
Peptide Receptor Radionuclide Therapy (PRRT)	28	£876,904
War Veteran	28	£337,990