HOUSE OF COMMONS

Welsh Affairs Committee

Oral evidence: Cross-border healthcare arrangements between England and Wales, HC 65

Tuesday 23 June 2026

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Watch the meeting

Members present: Ruth Jones (Chair); David Chadwick; Ann Davies; Gerald Jones; Ben Lake; Andrew Ranger; Henry Tufnell.

Questions 50-132

Witnesses

I: Dr Clara Day, Executive Medical Director, Betsi Cadwaladr University Health Board; Nicola Prygodzicz, Chief Executive, Aneurin Bevan University Health Board; Pete Hopgood, Deputy Chief Executive and Executive Director of Finance, Capital and Support Services, Powys Teaching Health Board.

II: Suzanne Rankin, Chief Executive, Cardiff and Vale University Health Board; Paul Mears, Chief Executive, Cwm Taf Morgannwg Health Board; Abigail Harris, Chief Executive, Swansea Bay University Health Board; Professor Philip Kloer, Chief Executive, Hywel Dda University Health Board.

Examination of witnesses

Witnesses: Dr Clara Day, Nicola Prygodzicz and Pete Hopgood.

Chair: Good afternoon, everyone, and welcome to this oral evidence session of the Welsh Affairs Committee. My name is Ruth Jones and I am the Chair. Today is the Committee's second session in its inquiry into cross-border healthcare arrangements between England and Wales. We are hearing from executives from all seven Welsh health boards, starting with the three that are on the border. Thank you for appearing before us in person; we really appreciate you coming today.

Given the heat, we are relaxing the dress code, so if people need to remove their jackets, they are very welcome. There is water around, and if you need more water, please indicate and the Clerks will sort that out for you. Similarly, if you feel that you need a break because of the heat, please indicate to us and we can do that.

The other complication is that we have votes coming this afternoon. When the bell goes, please do not be alarmed. We will disappear, but we will come back.

We know that it is very rare to have all seven health boards at a session of the Welsh Affairs Committee, so we are grateful to have the opportunity to speak to you all. We hope that it will not be the last time that we get all seven of you together, because it is really useful for us to have all seven, to give a true picture of what is going on in Wales.

This is also the first oral evidence session since the Committee's report on prisons, probation and rehabilitation in Wales was published. It included a chapter on the provision of healthcare where we talked about the jagged edge of healthcare in prisons. We recommended that the MOJ and the Welsh Government should review, "the effectiveness of the current health board model and should consider the potential merits and demerits of moving to a national oversight model overseen by NHS Cymru", perhaps. We said, "In the meantime, we suggest that health boards in Wales commit to making prisoner healthcare a standing item in their governance agendas and to publishing regular data releases on individual healthcare provision in prisons", compared with your other populations.

Today, we are focusing on cross-border healthcare. Do any Committee members have any interests to declare? No; that is fine. In that case, can the panel introduce themselves and say which health board and which position they are in?

Pete Hopgood: Good afternoon, everyone. My name is Pete Hopgood. I am the deputy chief exec and director of finance, capital and support services for Powys teaching health board.

Dr Day: I am Clara Day. I am the executive medical director at Betsi Cadwaladr.

Nicola Prygodzicz: Prynhawn da, I am Nicola Prygodzicz. I am the chief executive of Aneurin Bevan University health board. It is nice to see you.

Q50 **Chair:** I declare that I know Nicola, because she is the chief exec of my health board.

We are looking at cross-border healthcare between England and Wales. How well do the arrangements currently operate? I am thinking specifically of your health board, not the overall generic picture.

Pete Hopgood: I will start by saying that there have been improvements on the back of the common values and understanding statement that was brought in following previous Committee action. Clearly, cross-border healthcare is an important part of services provided for the Powys population. Given our geography and rurality, and given that we do not have a district general hospital, we rely on cross-border arrangements for the care of our patients and population.

Dr Day: There are two aspects for us. There are the aspects about going backwards and forwards for people who live near the border, which will be the same for everyone. Then particularly for us in north Wales, we have very important cross-border health pathways for advanced secondary and tertiary care from the health board into the north-west of England in particular. Although we are a very large health board, for the best treatment and patient outcomes, people often have to go outside of the health board into those specialist areas. Our main focus is on those pathways back into the north-west of England.

Nicola Prygodzicz: The majority of our flows into England are primarily for the specialist tertiary care that is commissioned by the Joint Commissioning Committee, which I know is going to be a separate session. In terms of our borders, our main issues are where we have English residents who are registered with a Welsh GP—there are about 10,000 of those. That is where we have most of our flows. We have quite robust long-term agreements in place with Gloucestershire, Bristol and Wye Valley NHS trusts so that we can support the flow of patients into secondary care through the referral assessment service that has been put in place, again following the work of the previous Committee. There are no major concerns or problems about that particular flow across the borders around Bristol and Gloucestershire.

Q51 **Chair:** Over the last 10 years or so, the Welsh Affairs Committee has investigated cross-border healthcare a number of times, and the same issues keep arising. Why are these issues so persistent?

Nicola Prygodzicz: When we look back at some of the improvements that have been put in place since the work of the previous Welsh Affairs Committee, the statement of shared values and principles has been really helpful. On the referral assessment service, there is a difference in Wales with the patient choice option, so those patients who are registered in Wales are not disadvantaged in the patient choice scheme. That has worked relatively well.

Digital systems and accessing information are a key challenge, ensuring you have all the information relevant to that patient in the different parts of the system. We have those issues in Wales between sectors within the NHS, so I am not saying we have a perfect system in Wales, but it is more complex when you are crossing borders. We have tried to mitigate some of that, because there are about seven GPs in the Aneurin Bevan area that have those 10,000 patients. Arrangements have been made so that they have access to the electronic system for some of those English providers in particular, where the majority of those flows are, which has helped.

Having slightly different policies on a number of areas between Wales and England causes some challenges. Local authority responsibility is another area where we get particular challenges. The other area is the NHS app. We have been developing the apps in parallel, but they are slightly different. Those are the challenges we continue to face.

The robust relationships that we build with the ICBs and the health board help us navigate those specific individual cases, because there are not huge amounts of more complex cases. We have managed to mitigate many of the issues that are common to all around access to information, but that is the area where we need to continue to try to improve.

Q52 **Chair:** Dr Day, is there anything you want to add to that?

Dr Day: From a patient-safety perspective, the digital stuff is key. Equally, unless everybody is on the same electronic health record, one would have the same problems anyway. The communication with general practices, which are often on the same systems, feels fundamental to basic safety around patient allergies and medication, for example, if you are coming from an English hospital into a Welsh one as an emergency. The thing is, we know that, so we put in place things to make sure that we call and get that information from patients and use it. But the ability to look at that directly would make it much easier and safer, particularly in emergencies.

For the wider pathways of inter-secondary and tertiary care, whether commissioned by us or the JCC, there are really good relationships between the clinicians on both sides. There are established pathways that will often have shared multidisciplinary meetings held locally, with secondary and tertiary clinicians joining in. They are very well set up and flowing reasonably backwards and forwards, based on relationships between clinicians and basic networked pathways.

It works to that effect because those relationships work. The key is to ensure that the patient is equally caught in that relationship, ensuring that they are safely transferred backwards and forwards, and that they know who to contact for which element. When the pathways are relatively well set up like that, it is easier, because it is common practice.

Chair: I am sure we will come back to communication in a minute.

Pete Hopgood: I echo colleagues' comments around the digital system. Often the solutions to make it work are found by clinicians' workarounds. The most significant issue is that patients individually see healthcare as

one system, but across the border we have different policies and approaches. That is very confusing for them to understand why there may be a different approach and procedure for the same condition in Wales or England.

Q53 **David Chadwick:** Dr Day, you mentioned the importance of having people manage those pathways and the relationships on both sides. Could you spell out what that means, with some examples of how it benefits patients to have those well-established relationships managed by people who presumably know each other?

Dr Day: Certainly. For instance, one of our pathways for pre-term birth would be through to Wirral. For babies under 26 weeks, we would go across to Wirral with that communication, so all the maternity units will know that that is the pathway to use for a mother in that situation. That is because you have relationships associated with that backwards and forwards.

There are also the cancer pathways. Though we have had a north Wales cancer centre for 25 years, there are pathways into Clatterbridge or the Christie. The MDT will discuss if we cannot give the treatment locally, and we will have input from the specialists into our local discussions. Then there will be a joined-up discussion about whether the patient can be managed locally or needs to go across to one of our partners, be that into Clatterbridge, into Liverpool for hepatobiliary surgery, or into the Walton, where we have lots of links across for neurology. There are those links into joined-up working. We will always try to keep the patient as local as we can, but I accept that on some occasions, for the patient to get the best outcome, they will need to travel to see other people. That has been standard in north Wales for many years.

Q54 **Ann Davies:** Your comments on how things are different digitally between England and Wales were interesting, and that came up in the prison report that we worked on. It seems incredible to me that, here we are in 2026, and we have not sorted this out yet. This should have been sorted out 25 years ago. Wherever you are from, whether you live in England or Wales, that digital information should flow seamlessly across the UK, but we will park that for now.

Pete Hophood, can you describe the process of referring someone across the border for healthcare? Powys has the longest border between England and Wales. Can you describe how it works for you, apart from cancer care? There are different pathways for cancer care.

Pete Hopgood: In terms of the referral from primary care into secondary care and how that then is triaged?

Q55 **Ann Davies:** Yes. Say I went to the GP in Llandrindod Wells, and I needed to go to hospital in Hereford, Oswestry or wherever, how does it work?

Pete Hopgood: The relevant individual's GP would make a referral to the relevant hospital. That will depend on the pathway. In Powys, as you rightly say, we have a challenging geographical arrangement. The

pathway you follow will depend on where you live, whether that be in the north or south of Powys. That may mean that you are referred to a Welsh provider or an English provider. That will depend on the relevant pathway. That referral is made, accepted by the relevant provider, triaged, assessed and then placed on to the relevant list to be seen.

Q56 **Ann Davies:** Moving on from that—perhaps Llandrindod Wells was not the best example—if I lived in one of the villages closer to England and my nearest hospital was in England, how would you decide? Do I go to the nearest hospital, or do I go to the nearest specialist hospital? The nearest hospital might not be the best place to send me.

Pete Hopgood: We have myriad contracting arrangements with our relevant providers. Each of those will have a recognised pathway for each part of Powys, and that pathway will dictate where that patient goes. That will be to receive the best service. Clearly, in Powys, travel distance is a challenge that matters and is important to individuals. The distance travelled can be significant, depending on where they live. I think that is the point you are referring to.

Q57 **Ann Davies:** Which hospitals in England would you normally refer to? When would you refer, say, down to Cardiff? Where is your cut-off within the whole of Powys, which is huge? Where is the cut-off for taking people across the border or down south, or even up to Glan Clwyd, for example, which is in Betsi?

Pete Hopgood: You are quite right. If you look around Powys, our main English providers are Shrewsbury and Telford, and Wye Valley. We also have a significant contract with Robert Jones and Agnes Hunt for orthopaedics, so some of the smaller provision is made along the English border.

We then have commissioning and provider arrangements with our Welsh providers, including Hywel Dda, Aneurin Bevan, Cwm Taf Morgannwg and, to a lesser extent, Cardiff and Vale. It may be helpful if I provide to the Committee what we call a spaghetti hoops diagram, which shows you the relationships we have in Powys. That may be a very simple, visual way of explaining it, if that is acceptable. We affectionately refer to it as spaghetti hoops, because you can see those various dynamics. I think that would give you a very helpful visual representation of what you are asking.

Q58 **Ann Davies:** That would be helpful for us so we can understand the vastness of Powys and where people go or are referred to.

Roughly how many patients from your health boards are automatically referred over the border if they have illnesses that cannot be treated within your health board? How many patients would you refer to England?

Nicola Prygodzicz: There are two methods: the majority of our residents who access care in England because we cannot provide it locally will be those who go through the specialist tertiary services through the JCC, because they may need heart transplantation or other very specialist care that we do not provide. Most of the patients will be commissioned via the

JCC and go through the established route. There are established, long contracts with English providers on that basis, with criteria for the patients to meet.

What we sometimes have locally—it is a much smaller issue, and the data last year showed it was about 70 patients—is those who can apply through the individual patient request form, the IPFR. You need to meet certain criteria, and we do not provide the care locally—it might be a novel treatment or a special case. There are three special criteria, and we will consider those on an individual, case-by-case basis. We will fund treatment in England if it meets those criteria, following a clinical panel that considers the cases. As I say, that is about 70 patients a year.

Dr Day: I would have to get exact numbers, but for those commissioned by us, as opposed to by the JCC, I can tell you that the spend is £91 million a year, but about £40 million of that is associated with secondary care for those who go back and forth between the Countess of Chester. So that is about £50 million of activity, the majority of which goes to Robert Jones and Agnes Hunt, and Liverpool University hospital foundation trust, in standardised pathways for secondary care, although those who go through the JCC pathways into other areas will be in addition.

Q59 **Ann Davies:** Is that Robert Jones in Gobowen? And it is all orthopaedics?

Dr Day: Yes. Robert Jones and Agnes Hunt is orthopaedics.

Q60 **Chair:** If you have figures—

Dr Day: We can get you figures.

Chair: That would be really helpful, because while you are talking in finance, we are talking in people.

Dr Day: I apologise for that, because as doctors we are always talking in people. I will get those numbers to you.

Pete Hopgood: To give you the absolute detail on the numbers, whether in-patient, emergency, out-patient and so on, I would have to do that after the Committee. Our spend is between £40 million and £50 million with our NHSE providers.

Q61 **Ann Davies:** It would be good to have the people numbers too.

Chair: The spaghetti diagram would be really helpful too.

Pete Hopgood: Sure, and with that we can give an indication of numbers in the relevant parts of our diagram, which would be helpful.

Q62 **Ann Davies:** My last question is whether these figures are reported in your waiting list statistics to the Welsh Government. Even though they are treated in England, are they included or are they parked as being treated across the border?

Nicola Prygodzicz: We generally report waiting lists as a provider, so those people we are planning to treat in our organisation are what we

have to report on as a health board. Obviously the relevant provider trust in England would report on the Welsh patients they have, although we monitor through our contract arrangements what patients are waiting. We would have oversight, but they would not be in our numbers.

Ann Davies: That is really interesting, because Welsh Government waiting list figures are therefore not really accurate.

Dr Day: I am relatively new to Wales, so I am just working that through. I think that some of ours are reported, but separated out. For the very long waits, you might say that might be English waiters, but we can get you more information specifically. The very long waiters are less likely to be going across, but we will get the numbers for you and exactly how that is measured, if that is helpful.

Pete Hopgood: As mainly a commissioner, we report our provider performance in terms of waiting lists, and as a commissioner we report our waiting lists against our providers. We do report both.

Q63 **Ann Davies:** Thank you. Having the extra information in writing would be fantastic.

Nicola Prygodzicz: When the Welsh Government report their waiting lists, they probably have each health board and then add in waiting lists with other providers. I think those will be included in the numbers, but as a provider we will report on our current waiting lists. The overall Welsh numbers will be correct, but sometimes there will be a separate line of patients waiting in other organisations. We can clarify that separately.

Q64 **David Chadwick:** I want to follow up something that you mentioned, Pete. You talked about Powys's reliance on commissioning services in England. One of the things that must have made this more difficult last year was when the then Welsh Government said that the extra money they were providing for commissioning services could not be spent on services provided in English hospitals. Can you spell out how that shaped your decision making on who to send where?

Pete Hopgood: In simple terms, we commission our care to Welsh policy and the Welsh budget, including the Welsh performance targets. That is the approach that we have taken with our NHSE providers on a last year and this year basis.

Q65 **Henry Tufnell:** You started by referring to the statement of values and principles that you said had been helpful in improving the patient experience. I am going to read out two of those principles now. The first is, "Both countries will act in the best interest of patients at all times, and there will be no delay in accessing healthcare services whilst commissioning responsibilities are clarified." The second is, "The overriding principle of this statement is that no treatment will be refused or delayed due to uncertainty or ambiguity as to which body is responsible for funding an individual's healthcare provision."

Having got a bit more clarity about what we are actually referring to, do you think you are meeting the needs of your patients in the context of the two principles that I have just read out?

Nicola Prygodzicz: We absolutely stand by those principles, which are particularly relevant in complex cases where things are not as clear—perhaps original residents have moved and been in different residential places at different times. When a placement is made, there is sometimes a lack of clarity about who is responsible for funding a placement, then one of us will take a position or we will do something together and we will work it out later.

Sometimes we go into dispute later about who was responsible for paying, but none of that would have delayed the placement or treatment of the individual. We are absolutely making sure that patients are at the heart of this and are not knowingly delayed while we decide who is responsible for their care or funding.

On a day-to-day basis, the issue is fairly clear; I don't think there is any ambiguity. But things can become ambiguous in specific complex cases, which need a lot more time as well as legal advice and other things. At that point, we will take a position and one of us will be responsible or we will share it between us.

Recently we had a case—not necessarily a cross-border one—where we have split the cost until we have bottomed out the exact legal position. But we have made sure that the patient is not delayed in any way and that their care is as appropriate and quick as is needed.

Q66 **Henry Tufnell:** Do you think those values and principles should be legally binding?

Nicola Prygodzicz: Yes, they could be, but we operate them anyway. We accept them. As a chief executive, I will take a risk on funding if it means making sure that the patient is not delayed.

As I said, I have a recent case fresh in my mind, between two health boards in Wales. We took a position together. We sorted it later, but the priority was the placement of the individual, to make sure that they got the right care. Whether that was legally binding or not would not have changed the position that we took as organisations.

Dr Day: I would completely uphold those values. As a registrant with the GMC, I obviously have professional responsibilities to make sure that people are treated in their best interests. As Nicola says, most of this is going down very standardised pathways. There are occasions—I have not seen this in our own health board, but I have seen it previously—where there are some complexities, particularly regarding patients in the mental health arena, as to where they live, where their GP is and where they have presented. That can be tricky, but I have seen, again and again, people just working together to make sure that the patient is kept at the centre of it, and then working out those elements around the edges.

Pete Hopgood: I echo colleagues' comments. It is absolutely about values and principles, and there will be that collaborative and co-operative approach to working around the issue in any situation. But I think there may be a case for more formalised, clearer arrangements in those sorts of situations; that may be helpful going forward.

Q67 **Henry Tufnell:** We have talked about how there is clarity in situations where that relationship already exists, particularly within a specialty, but when you go down the individual patient funding request route, presumably that becomes an issue in terms of upholding that statement of values and principles—although I appreciate that you are not the NHS Wales Joint Commissioning Committee.

The reason I bring that up is that we have had evidence to this Committee saying that those funding requests, "take hours and hours…to do," and, "where IPFRs have had to come into play…there are then difficulties with trying to access services."

Dr Day: With IPFRs, there are elements around whether we go down a standardised route or whether there is an exceptionality associated with going down a route that is not standardly commissioned. There is a separation between those two sometimes.

You may have a standardised route through which patient A may go from your hospital to a hospital over the border, because that is the relationship that you have. If that patient, for some reason, does not go down that standardised commissioned route, but, clinically, it might be better for them to go somewhere else, or there may be an issue of the patient or others feeling that they might want to go down somewhere different, then that becomes that IPFR route.

Certainly for us in north Wales, you would not standardly be using an IPFR just to access healthcare across the border; it would be associated with exceptionality. And yes, there is then paperwork associated with that to make sure that you are proving exceptionality as well.

Q68 **Henry Tufnell:** Are you suggesting that those established relationships are around 90% or 95% of the cases that you handle, and that, outside the things you referenced—I think we had reference to cancer pathways and pre-term birth in the Wirral, for example—IPFRs are a very small percentage of the total caseload that you deal with?

Dr Day: For us in north Wales, the percentage that go down the IPFR route is very small, because you have established routes for the commissioning of services in that direction. It is certainly not something that would be done on every occasion in any way—only on rare occasions.

Henry Tufnell: Is that the same experience for you both?

Pete Hopgood: Yes.

Nicola Prygodzicz: Yes, absolutely.

Henry Tufnell: Are you able to put a figure on it?

Nicola Prygodzicz: As I mentioned with the IPFRs, I think the maximum number of requests that go through our own local panel is 1,000 a year, many of which are not accepted because we offer the service locally—sometimes people will put requests through because they want to be treated more quickly somewhere else. But generally, none of those delays in the IPFR is because we are not accepting commissioning responsibility or there is a funding issue; they are often around complexities, efficacy, exceptionality, and making sure we are not setting a precedent for other patients.

The cases that generally go through an IPFR are because of exceptionality, and that is why they sometimes take time. As the shared values say, it is not that we are delaying because we are debating commissioning responsibilities or funding; it is often about whether it is appropriate to support the treatment being done, rather than the funding of it, so it is different.

Sometimes we see a theme, and this is particularly relevant in the JCC. In the context of all our work as a health board, there is a very small team that looks at these because there are not many cases. But, through the JCC, if you see a theme of a particular treatment coming through that we consistently approve, you would recognise that it is a more common treatment and you now need to make it an established pathway. We will often put a contractual arrangement in place, say, with Bristol, if that is where the treatment is offered, and then set up a contractual arrangement to say, "We think that there are 50 patients a year that meet the requirements for this treatment," and put it through an established pathway so that you do not have to go through an IPFR any more. Where we see something like that developing, we will try to make that core business.

Q69 **Henry Tufnell:** On the relationship with the JCC, how do you find that? From what you are saying, it sounds like you try your level best to avoid them. You create those established pathways, and that works better than going through—

Nicola Prygodzicz: I am a member of the JCC, which is a committee that allows for collective accountability of all the chief executives in Wales. Obviously, there is a team and resource there that runs the commissioning of this on a day-to-day basis, and we get the IPFR data shared with us. It is generally a growing area. It is particularly through the specialist services that you will start picking up more of those thematics and need established pathways.

Overall, there is a robust process. We are looking to strengthen health board representation on those IPFR panels to make sure that we have good clinical representation from all the health boards on the panel. I know that that has been strengthened recently with a medical director there. Again, they are the exceptional cases rather than the core treatments.

Q70 **Chair:** Thinking about IPFRs in particular, it would be really helpful to

have the actual figures for the percentages each year that are going down that route.

As Henry Tufnell has already said regarding the NHS statement of values and principles, are you confident that there is not a single patient on the IPFR pathway who has a delay in accessing healthcare services? We can all talk to you about people who have written to us in desperation.

Pete Hopgood: I couldn't say that no one is waiting. Normally, the delays come from getting approval co-ordination across organisations, but that is about as much as I can add.

Dr Day: Having contacted the chair of my IPFR committee last night about this, I cannot tell you specifically whether anyone is waiting, but he tells me that it is extremely rare for the services we commission. Obviously, the JCC-commissioned ones are separate, but there is not a large number. I cannot be absolutely sure that we do not have one or two from the transfer of that care into the commissioned pathways we have, because we are commissioning those pathways.

As we say, the balance and the difficulty come where a treatment request may be within that exceptionality element—new treatments come along all the time—and where it is outwith standard guidance as to where that treatment is provided. That is of course standard across the whole of healthcare, because it would be the same if we were trying to access healthcare associated with that exceptionality in our own health boards. I cannot tell you the exact numbers, but, from when I spoke to them last night, they are certainly not a major barrier.

Nicola Prygodzicz: I am sure that there may be patients who are delayed going through an IPFR process, often because of the need to gather the right information and get the right clinical expertise and evidence into the relevant meetings. That is one of the reasons that the medical director was keen to strengthen the membership and attendance of those panels so that they are not delaying someone's treatment.

I am not aware of cases that were delayed because we were debating commissioning responsibility and funding. That was my point, which goes back to the core message of the shared values. I am aware that sometimes I will get a case where there is an expedite letter because of concern about a delay, but it is generally a process issue involving getting the right evidence and expertise around the table. That is where more of the delays come from, from my insight. Obviously, the JCC will have much greater insight into the IPFR issues it is facing, because its volumes are greater than we would see at a local health board level.

Chair: Be assured that we will be questioning the JCC tomorrow, so that is fine. You are talking about small numbers of patients, but for one patient and their family, a delay is a big issue, and that is where we get involved.

Q71 **Ben Lake:** Just taking two steps back, on the commissioning pathways that might exist with particular trusts in England, materially speaking or in practice, is it any different trying to establish those commissioning

pathways with a hospital in England compared with a hospital in Wales that is outside your health board area?

Nicola Prygodzicz: We have standard long-term agreements, as we call them, with Cardiff and Vale University health board, Cwm Taf University health board and Bristol trust. Those are all run through a similar mechanism. Once you have that established contract, we run it through a kind of monthly monitoring to see how we are doing. Where contracts are in place, things run much more smoothly than when you are dealing by exception.

Ben Lake: Do either of you have anything to add, or is it similar?

Dr Day: Most of our contracts will be back up into the north-west of England as opposed to the rest of Wales anyway.

Q72 **Chair:** I am sure we will return to this at some point. Moving on, we have talked about patients that might be on a long waiting list for whatever reason, but what support do you offer those cross-border patients and their families who are waiting to receive treatment across the border?

Pete Hopgood: We have care co-ordinators—people who can liaise with those individuals, check in on how they are, and let them know where they are on the pathway, so there is that regular dialogue. Of course, if an individual's situation deteriorates, that would lead to their place on the waiting list for treatment being reassessed.

Dr Day: Again, because we have established what I suppose would be called network pathways elsewhere—our network reaches across the border—you would tend to stay under the care of the local team until the intervention associated with that element was needed. If it were a cancer pathway, for example, the local cancer team would make sure that the patient was referred on and then brought back. The other element we need to ensure is that, when someone comes out, we know when they can come back. They would be within that continuing care that we offer through those wider multi-professional teams.

Q73 **Chair:** I am thinking about people who are travelling daily or on a regular basis for treatment across to England. For instance, Young Lives vs Cancer told us that, on average, families from Wales are spending £280 a month on travel. Is there any support being offered by the health boards for that?

Nicola Prygodzicz: Transport is an ongoing issue. Obviously, we have the standard eligibility criteria for patients who can access free patient transport, but that does not apply to everyone, as you said, who must then travel. We offer some community transport options for different parts of local authorities in Wales. We have a number of options there for people and, in some cases, by exception, we will consider reimbursement if they meet certain criteria. We recognise that issue.

When it comes to specialist commissioning, people sometimes have to get closer accommodation. We appreciate that that is a huge challenge for some patients and their families. Community transport, in particular, is our

best offer for how we can try to supplement what is available through the normal non-emergency patient transport service.

Q74 **Chair:** If one of your patients is going across the border for this complex treatment and they need transport and accommodation, is that funding part of the IPFR?

Nicola Prygodzicz: It would probably be considered on a case-by-case basis in terms of what the issue is, but I assume it would need to be considered as part of the application—I am obviously not close to the detail to be able to give a level of confidence on that.

Chair: I am sure we can clarify that.

Q75 **David Chadwick:** This is a question for Pete. This Committee has heard a lot of evidence from people in Powys who are suffering greatly as a result of the decision to extend waiting times for people who are awaiting operations. I have met those people in my constituency, and I have seen plenty of pensioners who are finding that they cannot live the life that they should be living because they are waiting one, two, three, four or even five years for an operation that they ought to be having on the other side of the border. That frustration is really peaking, because they know that if they live just 1 mile on the other side of the border sometimes, they would be eligible for that treatment or that operation. Clearly, pensioners in their 60s or 70s waiting for a hip operation, hip replacement or knee operation will not just get better by themselves. The question is: has this policy actually saved any money? Has it significantly reduced expenditure for Powys teaching health board?

Pete Hopgood: First, in terms of your comment about individuals, clearly it is hugely frustrating for the individuals who live on the border and may see a neighbour who has access to healthcare under a different policy and different timescale. I fully recognise that.

As a reminder of my point before, we abide by the values and principles in terms of Welsh residents being treated within Welsh policy and Welsh performance targets. Clearly, we have a limited resource envelope, and we need to protect all our services, including our primary community services and so on, which provide care and regular contact for all our population. It is about us living within our means and then commissioning appropriately based on the Welsh policy. That is not to say that it is not frustrating for the individual—I totally recognise that. What I will say is that there are safety mitigations in place so that there are exclusions to our commissioning intentions for cancer, under-18s and emergency treatment.

Q76 **David Chadwick:** Has it actually saved any money? How much money is Powys teaching health board saving as a result of this decision? These people will eventually need their operations anyway; they are not just going to run it off, and they will not get better by themselves.

Pete Hopgood: It means that we have not spent an additional amount of resources in those areas to the detriment of other services within our responsibility.

Q77 **David Chadwick:** You have sort of alluded to this being a financial decision, and one that comes from the fact that you have a very large budget deficit—as do many health boards, if not all the health boards in Wales—but how long do you intend to keep this extended waiting list policy going? What would help you to stop it?

Pete Hopgood: There is a financial element to this decision, but it is not the total factor within it. As I said, we are adhering to Welsh policy, which means that there is equity of access to services across Wales for our Powys population. There is a disparity when you compare it with the English system, and that comes back to the earlier comment around the fact that it is two different policies and the approach, although people see it as one system. Our intention is to continue to work within that Welsh policy and to commission at that level. Sorry, I may have missed another point to your question.

Q78 **David Chadwick:** How long do you think that this policy will go on for? What would help you to send these people off for the treatment that they need?

Pete Hopgood: In terms of the Welsh policy and changing performance targets, that would be a national decision that we would adhere to. We are constantly focused on our overall performance, including our financial position, and improving that as far as possible, year on year. It is a bit of a general response, but our intention is to provide the services that the population need and to commission those within the resource we have available.

Q79 **David Chadwick:** This is obviously a question I have asked to Welsh Ministers here and in Cardiff, and one of the responses that always comes back is that people should not be allowed to go for their treatment in Herefordshire or anywhere else in England because everybody in Wales should have the same waiting times. However, does that not undermine the point of actually having health boards, which is to manage these care pathways independently? This is a question for all of you: should there be one general waiting time across all the health boards in Wales, or should different health boards be able to manage their own patients quicker if they have the facilities available to do so?

Nicola Prygodzicz: The Welsh Government set ministerial targets and priorities for some of the waiting times. That is what we work to achieve. Usually it is a maximum waiting time; it does not say, "Make sure everyone's waiting 52 weeks in out-patient." You try to go as low as possible.

We already have a level of disparity between us based on our local positions. In the south-east, we work with Cwm Taf Morgannwg and Cardiff and Vale. Obviously, Powys patients will be attending that. One of the things we have been trying to do on the regional planning is make sure that we balance out any inequity between us.

We recently did a huge piece of work on regional cataracts. All of us had a challenge with cataract patients waiting more than two years, but some

were in a slightly better position than others. The number of people on the waiting list in Cardiff, say, was lower than in Cwm Taf Morgannwg. As a region, we secured some additional funding and commissioned additional activity to try to get every health board in Wales to the same place.

Naturally, when you have your own organisation and your own capacity, you will have workforce challenges, whether that is sickness or estate constraints. There will always be a level of variation. What we are ultimately trying to get to is for everyone in Wales to get an equal service offered to them in terms of the waiting list.

Q80 **David Chadwick:** That sounds a bit contradictory. You say that people will be getting the same treatment, but you also said that different health boards can deliver things at different paces because of the various capabilities.

Nicola Prygodzicz: That is just the nature of the work that we do.

Q81 **David Chadwick:** So you agree that there should be differences between waiting times?

Nicola Prygodzicz: I think there will inevitably be some variation, but we need to close the gap of that level of variation as we progress forward. If you look at all the health boards now, some specialties are a bigger challenge for some than others. That is often related to particular challenges, maybe around the workforce. We are working together to try to minimise the variation that exists between us by working together more effectively.

Dr Day: In north Wales, we are a region by ourselves. As we say, those targets are maximum targets, not ones to hit. They are a balance of the fact that the same clinician will have to do on-call for emergencies, plus perhaps deal with urgent suspected cancers, plus deal with routine work. You are always having to manage their capacity and the department's capacity among all those elements so that you are balancing the capacity you need for on-the-day emergencies with the capacity you need for cancer work and the capacity you need for more routine.

Depending on the workforce models you have, or indeed the specialties of the individual clinicians, that will vary. Some of our services already pan across, but what we are doing now across the whole of north Wales is trying to equalise, as Nicola has said. If your waiting time in one of our hospitals is much shorter than in another, we are trying to equalise that. However, that is associated with the fact that the patient may need to travel further for their treatment. Those are discussions that you need to have with associated individuals: "Would you prefer to wait longer to be seen here or to be seen quicker if you travelled across that distance?"

Again, that will be different for different people and depends on how people's conditions are affecting them and what their personal choice would be. For some people, it might be very important to wait two or three months longer but be treated much more locally. It is that balance that is important with all of this. It is important to recognise that you have

a clinician who has to do several different waiting list priorities that you then have to balance your workforce across.

Pete Hopgood: I agree with both colleagues. The No. 1 thing in that situation, as described, is the frustration for patients, and I totally recognise that. One thing that could be helpful is having a clear framework for understanding the treatment of waiting times, cross border, so that individuals and the population fully understand it and the position is not confusing for them. I go back to my comment about it being one system for them; the difference in policy and approach between NHS England and NHS Wales is not on their minds or their concern. That is one area that could be helpful.

Q82 **Andrew Ranger:** Good afternoon, all. I am sorry I missed the start of the session. On a similar vein, I will concentrate on the cancer treatment waiting times in Betsi Cadwaladr. Clara, Betsi is obviously facing some of the most challenging circumstances around cancer waiting times. Are cross-border healthcare solutions being explored to support patients to receive treatment more quickly?

Dr Day: You will have to forgive me if I as the medical director, as opposed to anyone else, do not have the direct elements on this, but we already have cross-border elements. For instance, for prostate, local work-up will be done, then surgery will be across the border. Some patients were travelling to London for that, and we recently changed that so that they go to the Wirral, which is much closer for that group of patients.

Breast and skin we do locally, and those are our areas of longest wait. We are working through the capacity to be able to do that locally; I am not sure that the cross-border element would particularly aid that. Some of this is around waiting times for people in diagnosis pathways, the vast majority of whom do not have cancer, as opposed to the treatment waiting time for those who do have cancer. Most of your urgent suspected cancers—probably 90%—will not have it, and therefore the wait is associated not particularly with the treatment and delivering the care, but with making sure you have the diagnostic capacity to diagnose the absence of cancer, which is, of course, just as important for the people on those lists.

Q83 **Andrew Ranger:** Do we have that diagnostic capacity in Betsi Cadwaladr, or do we need to use cross-border capacity for that as well?

Dr Day: Most of our diagnostic capacity—for prostate, certainly—is within that. For skin, we have significantly increased our capacity to do that; we do the urgent suspected cancers at Connah's Quay, to be able to do those biopsies. That was opened recently and is associated with that. Challenges around endoscopy provision, for upper GI and particularly lower GI cancer pathways, remain, but again, we have had insourcing help with that.

We are in the process of large-scale work on demand and capacity, and we have external support to help us make sure that we are clear around our pathways. We have had national support on making sure that really good,

clear referral vetting is going in; for instance, we now have nurses who are doing the vetting, and people who are going straight to test.

We are making the most of those pathways in that efficient way, while working out exactly what long-term, sustainable capacity we will require, and we are using insourcing in the meantime to balance that. Endoscopy is probably the biggest one, but we continue to provide that internally. I do not think that going cross border would help at this stage.

Q84 **Andrew Ranger:** As the MP for Wrexham, I spoke to members of the well-organised prostate group in my area, who told me about their trips down to London and the sheer cost of them—for instance, someone who had treatment came back from London in a taxi on their own—so it is really good to hear the news about the Wirral, Clatterbridge and places like that being used. I know it is hard to predict, but given what you have just spoken about, how fast will those cancer waiting times drop?

Dr Day: I could get you more information on that. They all have individual trajectories associated with reducing them; if those would be helpful, we could get them to you. Those are generally reported up and through—certainly, to public committees—so we should be able to get them to you without difficulty.

One thing that we are trying to work through is, as my colleagues would say, what we make and what we buy. There are some things within our health board that we will never be able to deliver—renal transplantation, for instance; we have very good partnerships associated with that. One of the reasons for bringing cancer back from London up to the Wirral, besides the obvious reason—the enormous travel—is to make strategic partnerships with local providers up in the north-west so that they can support us to develop and bring back our services. With robotic surgery, particularly in the prostate field, being able to develop that strategically with a partner and then bring it back into the health board is particularly important.

One of the areas that we are trying to work through on cross-border healthcare is how to employ people in both England and Wales, such that the doctor can, to some extent, go with the patient and back again. That is complex, because it means employing someone in NHS Wales and NHS England, but the ability to do that means that we are more likely to be able to continue to treat people within the Welsh system. That is one of the things that we are trying to work through, and we are training to that effect. We are training in north Wales, then across to the north-west and back, so that everyone is able to work through those partnerships.

Q85 **Andrew Ranger:** That sounds really interesting. I would be grateful if you could send the trajectory figures. That would be really useful.

Dr Day: Yes, of course.

Andrew Ranger: Thank you very much.

Q86 **Gerald Jones:** I would like to ask some questions about delayed transfers

and discharge. We know that that is an issue in most places, without the added complexity of going cross border, but the process for discharging patients differs between England and Wales. For a Welsh patient receiving treatment in England, extra steps are required before they can be discharged. There are things like care packages and accommodation. Could you outline what steps are being taken to prevent delays in hospital discharges due to complexities around the cross-border element?

Nicola Prygodzicz: I will come in briefly, but it is not something that we spend a huge amount of time on because our numbers are relatively small. The majority of our local issues are where English residents are with Welsh GPs. They often receive secondary care in their hospitals. If there are examples where they are in our hospitals and we are looking for discharge, there are slightly different rules in England around the social care charge, so they often have more of an incentive to get the patient home. It is not an issue that we have had a major challenge with. When we do on an individual case, we have worked really closely with the ICBs, which have helped us to navigate our way through that.

Pete Hopgood: Yes, it is a very real challenge. The difference in policies, procedures and approach can lead to delays and frustration. One of the things that helps is that we have discharge liaison people based in the NHSE providers in Shrewsbury and Telford, and Wye Valley. They are there to support the individuals, help them to make the necessary arrangements, and enable them to get access to the care packages they require.

It is a challenge for us. Again, it comes down to collaborative working with our local authority colleagues—the relevant English provider—to work through that and make sure it is on as timely a basis as possible. It remains a challenging area for us.

Dr Day: Similarly for us, it is most likely to be around the Chester-Wrexham interface. The border not being a brick wall means that people flow backwards and forwards, associated with the natural flows in that area. We know that we have a problem in hospitals on the Welsh side with people being in hospital longer than they need to be medically and needing to be discharged into social care, be that through placements or going home with support. Equally, that is likely to be the case for our patients coming out of Chester.

If appropriate, we will always try to repatriate them into the community elements to at least have them with us within the local authority boundaries. There is very close working across the border to facilitate that, because that is one of the standards of the backwards and forwards flow associated with that. For those who go across to the north-west, that tends to be less of a problem. Certainly, on occasion, we are contacted directly, either by the providers or the ICBs associated with those elements, to be able to bring people back closer in that regard.

Q87 **Gerald Jones:** Obviously, there are delays in discharge across the board; is anybody specifically looking at the added cross-border complications, or

are they all dealt with the same, whether the patients are receiving their treatment in Wales or in England?

Dr Day: I cannot tell you specifically, but I can get you information on whether we have anybody specifically looking at patients in the Countess of Chester, for instance. I can certainly get you more information associated with that.

Q88 **Gerald Jones:** That would be helpful, thanks. The Committee has heard about patients experiencing delays in cross-border tests or treatments due to uncertainty from health boards about responsibility for funding. Could you give us some information about the specific barriers that exist between the Welsh local health boards and the English NHS bodies around those delays?

Dr Day: If it is part of a standard pathway of care, we have said that that would fall into standard commissioning; if it does not, it goes through the escalated route that we have discussed. It would be a secondary or tertiary care pathway that would include certain elements along the way. If it falls within that pathway, we would not feel we have to discuss who is responsible for that. It is when there is exceptionality associated with those that that becomes slightly more tricky.

Q89 **Gerald Jones:** Is it more like the point you were making earlier about making the payment and then discussing the issues later to work out if there is any discussion around where and how it is funded?

Nicola Prygodzicz: You mentioned diagnostics; they should be fairly standard pathways, and I would like to think that we are not having debates about who is paying for those because, going back to the shared principles, we have clear rules around contracts and where responsibility lies for patients who might be resident with a different GP. It is only if it is an exceptional diagnostic outside of a normal pathway that you would expect them to go through an IPFR process. If there are examples where people are getting caught up in a debate about who is paying for diagnostics, it would be useful to escalate those for us to work them through.

There is the NHS shared cross-border network, where people come together to talk about common issues that we are experiencing between borders, and that is really useful, particularly around delayed transfers and local authority issues, as you have mentioned. One of the themes that has come back, which we have picked up with Gloucestershire ICB, is that, especially if you have turnover of staff, a Welsh patient who is registered with an English GP can go to the local hospital and some of the staff say, "Oh no, you're not entitled to the treatment," because they do not understand the rules.

Sometimes, there can be a slight delay that has come through, if there is a lack of clarity on the rules. There may be examples of those type of situations, and we just need to continue to communicate with staff in all the relevant departments to make sure that everyone is really clear on what the rules are. That has come up as a theme, and sometimes there is

a delay because we have had to then clarify that people are absolutely entitled to have that treatment.

Q90 **Gerald Jones:** It is about raising awareness.

Nicola Prygodzicz: Yes. I would imagine that something like diagnostics falls under that category, rather than needing to go through an IPFR.

Q91 **Gerald Jones:** Finally, in terms of Welsh patients and their pathways, and when they are receiving care in England, how do you work across the border to make sure that people do not fall through the cracks between providers? How is that managed?

Nicola Prygodzicz: Can you give an example?

Gerald Jones: For example, people are falling through the cracks where they are receiving care in England and the pathway is managed by a Welsh local health board. How do you work together with English providers to make sure that the cross-border issue is not the reason people are falling through the cracks?

Nicola Prygodzicz: That is just part of the regular contractual relationship and work with the ICBs, because it is more complex where, for example, staff are accessing community services or they need the district nursing team. The palliative care team comes up again as another area where it is not quite as straightforward as when you just have a referral to go and have an orthopaedic operation, for example.

Where you have that wider continuity of care, that is where the risk seems to come around patient pathways. It is just about regular communication and making sure that the established relationships are there with the key clinical operational teams, so that if any problems are experienced by patients, we can respond to them really quickly and sort them out.

Q92 **Gerald Jones:** So it is about constant communication.

Nicola Prygodzicz: Yes, constant communication is key.

Dr Day: That is where the digital element, if you were able to do that, would be much easier, because then everybody would be able to see where their next appointment was, whereas we are still reliant on transfer of correspondence backwards and forwards to make sure that everybody knows where they are within the pathway and that both the general practitioner and the patient are aware, but it is more complicated in that the digital element does not follow the patient. That would be incredibly helpful.

Q93 **Ben Lake:** Dr Day, I would like to follow up on that point about the lack of a unified digital platform to share patient records. All three witnesses mentioned the difficulties that the lack of interoperability between the systems causes. I have two questions. The first you have probably heard a million times, so forgive me for asking it, but why is it so difficult to establish this unified pathway? Following on from that, do we have any hope of creating one in the not-too-distant future?

Dr Day: It is a fundamental thing. Equally, I would challenge the idea that we are able to do that in England. Nobody has the same electronic health record. Obviously, with the upcoming changes in the NHS Bill in England, there is a discussion about unifying a single patient record. That is going to take some time, as we all know, because we have been talking about this for many years. There are also plans for Wales to have a unified electronic patient record that would then mean communication in and out of Wales could be done in one way.

Of course, general practice is its own data controller. That is not unreasonable. If you talk to the public about data sharing, there is always that balance between being able to share data and not being able to share data because of patient privacy issues. That balance between who the data controller is, patient privacy and the fact that we do not have one unified digital infrastructure, either in Wales or in England, makes this complicated.

What you then have to do is try to communicate—this is the point where, technically, I cannot speak in any more detail. There are ways that you can communicate, but when you have to communicate individually between lots of different systems, that of course becomes complicated and not ideal. As a doctor, the ability to transfer patient information backwards and forwards seamlessly feels vital from a patient safety perspective. The obvious way to start to do this is through the NHS app, so that at least patients can share their information with the healthcare profession. That is one way to do it, but I am not entirely sure that the NHS app is going to be the same in both countries either. Why it cannot happen is a very good question.

Q94 **Ben Lake:** That is very useful. I have a quick follow-up question. Do we have a rough idea of the number of duplicated tests, or delays to prescriptions, caused by the lack of a unified framework or digital system? I know that is a very difficult question, but I have to ask. Do you have any feeling about how many problems that is causing?

Dr Day: It is very difficult to be specific about that. If, for instance, you were doing basic blood tests, you would try to transfer those tests across to people, but you are likely to repeat them so you all have them on your system. Imaging can be transferred backwards and forwards through PAC systems. The sharing of images is much more straightforward, and it is something that we would do routinely with our major trauma centre—in Stoke, we would send images across to the Walton.

Image sharing is much more straightforward. The rest of it would require asking for those tests to come across—a lot of the time, that is down a standard pathway, if you have done them. Again, if you have local multidisciplinary processes, what had been done would be reviewed, and that package would go across with the patient.

I come from Birmingham. If I was working there and had patients down in Hereford, I would not be able to see what Hereford hospital had done. The

whole of the NHS is like that; the cross-border situation is not that different in that regard.

Q95 **Ben Lake:** It is across health board areas as well.

Dr Day: Yes, it is across health areas as a whole.

Nicola Prygodzicz: We have a lot of work to do in Wales to get a more consistent digital offer. That is where data sharing, and seeing the whole picture, is a challenge for us locally in Wales. I know that a shared summary record has been considered—a read-only shared summary record for cross-border patients would be really helpful.

We are starting to increase the use of the NHS app in Wales. NHS England has got further ahead—people have access to their own records. Trying to get that aligned better will be a key priority in helping cross-border issues in the meantime, while we tackle the wider digital challenges in health.

Q96 **Chair:** It is interesting. You have outlined the difficulties, but we have had evidence from Estonia, which is probably the size of Wales. It has had patient records with 100% of activity and compliance with patients across the whole country for the past 10 years. We have a long way to go on this.

On north Wales, Carol Shillabeer appeared before the Committee in January 2025, when she said that she was absolutely determined to ensure that there would be a drive forward on electronic health record collaboration, working with colleagues in the north-west. What has happened there?

Dr Day: I have only been on the health board about eight months at this point, but locally we have an agreed business case to put an electronic health record in our health board. That agreement is now back through to be procured as a Welsh health record for everybody. I do not know the exact history of that, but until we have an electronic health record, it is difficult for us to share anything electronically with England.

Q97 **Chair:** So there does not seem to have been any progress at all on that.

Dr Day: Nicola will know more than me, but I think the electronic health record for Wales is a central policy. Is that correct?

Nicola Prygodzicz: In all fairness, I think Betsi Cadwaladr progressed the case for an electronic health record. The conversation is still happening on whether we should all have exactly the same system, or whether we need foundations and fundamentals in place so that we have the flexibility to work at slightly different paces depending on our starting point. That dialogue about our digital priorities is happening right now, and there is currently a review of what the digital priorities investment fund prioritises and over what period of time. The electronic health record is part of that.

Chair: Conversation is great, but action is better.

Q98 **Andrew Ranger:** I want to turn to the impact of the changes on the structure of NHS England. How do you anticipate the changes to ICBs in

England impacting on cross-border healthcare? Is there a risk that ICBs with bigger geographic scopes will lose sight of the needs of patients across the border? There is an increasing focus in England on moving to community healthcare. Are you concerned that, again, cross-border patients may be overlooked or unable to access services due to the reforms in England?

Nicola Prygodzicz: That is an area of concern identified through the feedback to the inquiry: we must not lose that continuity. We have established those relationships between people who have a lot of experience and history of working together, and it is concerning that we could lose some of that. We need to make sure that the pathways are well established and written down so that if there is turnover we do not lose the policies that we have worked hard on and the protocols that we have established to put in place locally.

I would like to think that the focus on community and neighbourhoods should not stand in the way. In fact, it could help us because we are trying to do similar things in Wales in focusing on neighbourhood-based care. Hopefully it could strengthen us, but we need to make sure that we have the necessary infrastructure and relationship with the ICBs—what does that look like in the new arrangements? That is where the focus needs to be to make sure that we do not lose anything, and to make sure that people do not get delayed in the process while the change is happening, more than at the final point.

Dr Day: I have a slight conflict here because I was chief medical officer of Birmingham and Solihull ICB, which is now in a cluster with the Black Country ICB and so part of a much larger organisation. I do not have any discriminating principles associated with that but there was a turnover of staff that was not associated with the formation of the larger ICBs but with the requirement to reduce staffing. That turnover means that a lot of corporate memory associated with the commissioning pathways has gone.

Moreover, when people are very concerned about jobs and things that does not help to progress discussions. The job of each of us is to make sure that the changes do not have an effect on patient care and to make sure that those relationships remain. At this point, those of us in Wales are likely to be the ones with continuity of corporate memory if there are changes within the ICBs during that period of time.

Pete Hopgood: I do not want to repeat too much, but there is obviously uncertainty. I totally agree that we need to maintain focus on the cross-border issues and maintain those relationships. The No. 1 concern is that ICBs may move away from that if there is another focus.

Q99 **Andrew Ranger:** Is work happening to make sure that focus is maintained while ICBs go through their reforms? That is probably work from their side, but are you aware of it happening? Is that a key thing that they are doing during their reforms and their thinking?

Dr Day: A lot of our relationships are directly with providers. You work through the ICB with commissioning groups but relationships are often

direct—provider to provider—certainly in my neck of the woods, so there is probably less of an issue associated with that. I cannot speak for the ICBs.

Chair: Thank you for appearing before us in person; it is much appreciated. There are a couple of issues to flag. There appears to be a great disconnect between what you are telling us—that things are going along okay—and the evidence that we have heard from individual patients and their families. I am not having a go at you on the panel, but there is a lack of urgency in addressing long-standing health issues across Wales. That is an issue. We look forward to receiving the information that you were not able to provide us today.

I think the patient voice is critical in all this discussion because, as MPs, we hear a lot from patients about how they feel. You have explained the opacity of cross-border healthcare and its issues and I am amazed at your calmness with it, because I would be climbing the walls by now, but I understand that you are working with it day in, day out.

Pete Hopgood, Dr Clara Day and Nicola Prygodzicz, thank you for appearing before us.

Examination of witnesses

Witnesses: Suzanne Rankin, Paul Mears, Abigail Harris and Professor Philip Kloer.

Chair: Good afternoon, and welcome to our second panel of witnesses for this Welsh Affairs Committee session on cross-border healthcare arrangements between Wales and England. For the second half, we have four witnesses who are appearing virtually. Thanks to the IT systems, we now have them—hopefully they can hear us properly. Can I begin by asking you to briefly introduce yourselves? Please say who are, what position you hold and where your health board is. Suzanne Rankin first, please.

Suzanne Rankin: Good afternoon. My name is Suzanne Rankin, and I am the chief executive at Cardiff and Vale University health board.

Paul Mears: Good afternoon, I am Paul Mears, the chief executive of Cwm Taf Morgannwg health board, covering Bridgend, RCT and Merthyr local authority areas.

Abigail Harris: Good afternoon, everybody. I am Abigail Harris, the chief executive of Swansea Bay University health board, covering Neath Port Talbot and Swansea local authority areas as our host patch.

Professor Kloer: Good afternoon, everyone. I am chief executive of Hywel Dda University health board, and we cover the counties of Ceredigion, Pembrokeshire and Carmarthenshire, but we also provide services for mid-Wales.

Chair: My name is Ruth Jones. I am the Chair of the Committee, which is why I am speaking to you now. I will move straight over to Ann Davies.

Q100 **Ann Davies:** As health boards with less proximity to the border—the first three were on the border; you are a little bit further away—what are the main challenges in planning and delivering cross-border healthcare?

Suzanne Rankin: I am happy to answer that question. The first thing I would say is that cross-border healthcare is really important for delivering a full range of services to the patients who we serve, whether they are in Wales or from over the border. It is important and not exceptional, I would say, and in relation to specialist care, it is even more so. I am sure my colleagues from the more proximally located health boards on the border have described how important it is that, in order to deliver specialist services—though not exclusively—you need particular comprehensive skills, critical mass and infrastructure and so on. That has not always been possible to generate in Wales.

Sometimes the scale of population required to provide that service is not available in Wales, so we do use a lot of cross-border care. In my organisation, we both deliver care to patients from across the border and send patients across the border. For me, there are roughly equal proportions of care incoming to my health board compared with care that is outgoing for patients from my health board.

The main issues are in relation to many of the things that I am sure you have already discussed. We do not yet have full digital interoperability of patient care records, which of course includes imaging and other important pieces of information that are needed to provide effective and safe care. We often operate on paper, which is not an entirely Welsh problem by any means. Indeed, until now, many healthcare systems have not worked in such a way that meant the interoperability of the systems was clearly a requirement, but we are clear in Wales that that is a future requirement. Ensuring that interoperability happens right across the United Kingdom, indeed, is important and something that we should all work towards.

Managing patient pathways can be very challenging, particularly where that patient pathway crosses multiple providers, or the providers are delivering a mixture of what might be considered more universal and/or secondary care, and specialist services. That adds complexity for patients. We have to think about developing integrated pathways of care, which we must work together on as health boards in Wales, as well as with colleagues in England, in order to ensure that whether a patient requires a particular intervention as part of a pathway, or their entire pathway of care, either in Wales or in England, we have a means of doing that collaborative work.

Where clinicians have pathways of care that are well established, and where clinicians and clinical teams know each other, the pathways are often managed more effectively and more seamlessly. That may not always be completely apparent to the patient, so patient and family communication is really important. If it is an unusual pathway, however, or the patient is an emergency or unplanned admission to one of our units, that can be very challenging for patients. I have an example of a poor patient who has been with me since the beginning of May. I have been

looking to get the patient back to the north of England, but struggling to establish a route for the pathway of transport, and two ambulance services are necessarily being involved, which is not good for patients.

Q101 **Ann Davies:** Sorry, Suzanne, but I will move on to someone else, or no one else will have a chance to say anything, with all due respect. Paul, will you answer?

Paul Mears: To add to Suzanne's point, as I described, the geography of my patch is not coterminous with the English border, so we do not have as many of the issues as the colleagues you would have spoken to earlier on today. As with other colleagues, however, there will always be cases where we have patients—whether on holiday or visiting relatives in the area—who may come in from England and need to receive treatment in one of our facilities. We also have some established pathways for patients from our patch going into England for certain treatments, particularly for specialist services provision. For example, if a patient from my patch needed a thrombectomy, there is a chance that they would go to Bristol for the treatment. That means the patient would be treated in Bristol and then need to be repatriated back.

To confirm what Suzanne said, this is a challenge wherever you work in the NHS, whether in England or in Wales, because people who come from outside your area, whether in England or in Wales, often have to be transferred back to services that are not familiar to the people who are trying to discharge them. You have to liaise with local authorities where you do not have the necessary relationships that you would do on a day-to-day basis for someone from your own patch. It can prove logistically challenging, but it is something we manage. It is one of those areas that our operational patient flow teams in particular, who deal with this on a daily basis, are well experienced in, trying to navigate through and get people back home as quickly as possible to their place of residence.

Q102 **Ann Davies:** Thank you, Paul. Abigail, would you like to add something?

Abigail Harris: From the Swansea Bay perspective and in the way that Suzanne described, we will have patients who flow from our patch into England for three reasons. They are accessing specialist services that are commissioned from the Joint Commissioning Committee, or accessing services that we commission directly, generally from Bristol.

We have some pathways where we need additional capacity. We have in the past commissioned ophthalmology and orthopaedics where we have needed some extra capacity. Often, it can be in an emergency situation, such as a student living in Bristol in term time or somebody visiting Bristol who becomes unwell and needs to access services. There are slightly different mechanisms in place for each of those scenarios.

We are also a net provider. Swansea Bay provides the burns centre for south-west Wales and south-west England for adults and the burns unit for paediatrics. As Suzanne described, there are very clear pathways for that, where the multidisciplinary teams from one patch to another would talk if a patient is coming to us for specialist burns activity. We would only want

to keep a patient in our provision for the minimum amount of time. Those conversations are about making sure that patients can be discharged back to their local hospital, if they still need in-patient care, or back into the care of the local community.

Again, we have really good mechanisms for providing outreach support through an out-patient arrangement, often using technology like video calling to keep in touch, and through multidisciplinary teams. We can continue to provide a bit of specialist overview, but the majority of the care has been handed over to local individuals. The challenges are the ones that Suzanne and Paul have talked about. We have similar things between some of our health boards in making sure patients get back to local services. It is not just a cross-border issue.

Similarly, we are all struggling with the same issues of not having a single complete electronic record. If you are a patient from Swansea Bay and you need emergency treatment in Bristol because you are visiting family, Bristol will not be able to access the records that we have in our hospital system here or our GP system to see the totality of the clinical record. Clearly it is advantageous if you can do that, rather than relying on phone calls to find out medical history or particular issues. That is one of the challenges.

Clearly one of the things is making sure that patients can get the transport they need. We have had a lot of discussions in our health board about the impact of poverty, and I am aware of that. For those communities living with the experience of poverty, we need to make sure they can access the funding or transport provision, if they meet the eligibility criteria. Our feedback is that for some patients, that is trickier to navigate than it should be. That is something that we need to be strengthening in our support for patients who are travelling on those pathways.

Q103 **Ann Davies:** Thank you, Abigail. Phil is my local chief exec. It is lovely to see you here. Is there something that you would like to add?

Professor Kloer: I will try to be brief. The vast majority of care is provided within our health board area. If it needs to be provided outside, it is normally provided within the long-term agreements we have with all our Welsh providers, or with the two main providers in England where we have a long-term agreement. That is Agnes Hunt hospital and Bristol. The rest of it is through the Joint Commissioning Committee. There are very few other patients—it was 631 last year—who went to England through our referral management process. Most of it happens locally.

I suppose the other thing to say is that we are in a holiday zone. We have hundreds of thousands of people who come to our beautiful area every year. We provide services for them, but our population does go elsewhere into England. There is that cross-border flow as well, for which there are established arrangements.

I agree about the digital point for our population; that is an issue. Travel and transport are one of the biggest issues for our population, as we have

discussed many times with a number of members of the Committee, given our rural geography.

Q104 **Chair:** Today we are specifically interested in Welsh patients and their movement across the border. If we are looking at individual patient funding requests, or IPFRs, do you know how many you have within your health board each year, for example? What are they typically referred for?

Professor Kloer: We had 37 requests specifically in our organisation last year. It is normally for high-cost drugs, or access to high high-cost medication, I should say. There needs to be a demonstration of exceptionality, so we have a process in place that examines that. I know that you are meeting the JCC tomorrow, and there is also a much larger number, I think, that are considered through the JCC.

Chair: When you talk about the 37, are they IPFRs or are they separate to that?

Professor Kloer: No, the 37 were the IPFRs last year.

Abigail Harris: Apologies, I do not have the number of IPFR referrals, but I can get that for the Committee. We will supply that to you as quickly as we can.

Chair: That would be great; thank you very much.

Paul Mears: Similarly to Abigail, I can provide that information to you in written form. Just to be clear, is it IPFRs for going for treatment in England that you particularly want information about?

Chair: Yes.

Paul Mears: Okay. We can get that supplied to you.

Suzanne Rankin: We are absolutely the same. I will need to provide that information. The JCC brief does contain detailed numbers for each of the health boards, so I was just looking for that, but the vast majority will have been put through the JCC. But as you are clearly aware, there are one or two—or a smaller number—that come through the individual health boards. We are happy to provide that.

Q105 **Chair:** Thank you very much. It would be good to have that. Philip, you have your hand up.

Professor Kloer: The 37 are IPFRs. There were 631 patients last year from Hywel Dda who went across to England outside the JCC process and outside our long-term agreements with Agnes Hunt hospital and Bristol. That is quite a lot of people, but the population we serve is nearly 400,000.

Q106 **Chair:** Can I probe a bit more deeply? How and why are those 600-plus people going across to England?

Professor Kloer: In our health board, we have a referral management process for when clinicians think that there is a patient who needs

something outside the normal pathways that we have in place. We do not use the referral management process where we have long-term agreements, as we do with all of our Welsh health boards or with the Bristol trust or Agnes Hunt, because those are all in place. We do not use them, of course, for the JCC because that is specialist commissioning and we have a process through the JCC for that.

These are patients where clinicians identify a need that they believe could be met at a provider in England. We have a process that we run internally to oversee where those patients go to make sure the referral makes sense—that it could not be provided locally or within one of our providers that we have a long-term agreement with, and that the care is going to be of high quality and meet the standards. It is run by the same people who run our IPFR process, but it is a different process because the IPFR is demonstrating a specific exceptionality criterion, whereas our prior approval process is demonstrating that it could not be provided within our current agreements or through the JCC.

Q107 **Chair:** That is an added strand, so effectively you have three strands. You have your long-term pathways, your IPFRs and your others. That is interesting because I am not sure that I was aware of that. How well do you think that the referral processes are working in terms of making sure that patients get to where they need as quickly as possible without any delays?

Paul Mears: Obviously, when a clinician in one of our organisations determines that somebody needs to go to a specialist service elsewhere, or be referred on to a treatment in a different provider in England, the most important thing for the patient is that we get them there as quickly as possible. Having said that, there is also the need to make sure that that treatment is appropriately funded and that our teams are aware of that.

As Phil has just described, similarly, we would make sure that where those sorts of things happen, there is a process for an internal sign-off for that to happen. There are, as Phil described, a number of patients who go for planned arrangements, which would be under something like an IPFR, where there is very specialist requirement, but there will be a small number of patients for whom a clinician working in one of our facilities may well know or be connected to a clinician in a specialist centre in England and will say, "I've been in contact with a specialist in England, and they have a particularly novel treatment or a different procedure that they may be able to use to treat your particular condition." There will be cases like that.

The priority is getting the patient treated. It is our job then to work out how the mechanics and the funding work for that particular patient. Where that is happening a lot, the question is, "Does that need to be formalised by a contractual arrangement with that particular provider?" That is where the JCC would then come into play, in terms of setting up a contractual arrangement with that particular provider and being clear about the number of patients we would expect to send, and how much we would expect to pay the English provider for that treatment.

Q108 **Chair:** Suzanne, does this referral process work? Is it timely?

Suzanne Rankin: If the patient requires urgent treatment, I would be confident that the patient will get transferred and will get referrals, providing that the receiving hospital has capacity—that is the challenge right across our system. By that, I mean here and in England. I do not think there would ever be any contractual reason for that to be a problem. Indeed, among ourselves, we have what Professor Kloer referred to as the prior approval mechanism, which can involve escalation to a medical director or a chief executive, which has happened. We would make that call if the patient needed urgent care.

In planned care scenarios, it can be more challenging. There is sometimes a debate—a healthy debate, but it does not always feel comfortable for patients and clinicians—where we might test the rationale of a recommendation to refer to do a potentially expensive treatment. Sometimes, those treatments are expensive, but do they provide value? Are they going to make a big difference to the patient's life? For example, if they have been NICE-approved, that would be a good rationale for making that referral. If we did not have capacity and there was capability in England, that would be easier to see that that is a straightforwardly good scenario for the patient. In some circumstances, particularly unique circumstances and/or very rare diseases, or where the novel treatment is less familiar to clinicians, that sometimes brings more of a debate. That can take longer.

I would agree with Paul. Where we monitor the data, we would see if there was an increasing frequency, and then we would need to establish a proper pathway. Ideally, that is the work of the Joint Commissioning Committee. Taking the example of adolescent cancer and children's cancer—there are other examples—we have identified a need for that to be established into a mechanism for Wales, so that it is commissioned once on behalf of Wales, but we are struggling to generate the necessary funding to support that. That does not stop those children and young people accessing treatment, because we will operate it on an individual basis, but it is likely that we would be able to increase the efficiency and effectiveness, and improve the pathways, if we were able to work together to agree a contracted pathway. There are examples where there is still work to do.

Q109 **Chair:** Let me bring in Abigail Harris. Do you have anything else to add? Is it timely and effective in your area?

Abigail Harris: Let me give you a sense of the activity. Excuse me—I am looking at another screen that has the detail on it. I am able to confirm that we had 80 IPFRs and 102 prior approvals last year, all non-JCC. Someone has provided me with that information while we have been talking. In 2025-26, we had 700 episodes of care—that was the contracted activity—and primarily that related to three specialties: additional ophthalmology, gastroenterology and some oncology activity.

The kind of patient pathways that we would expect to see there are oncology treatments that we do not have available in our locality or in the south-east Wales cancer centre delivered in Velindre. It will be a clinician-to-clinician referral where they might want a second opinion through an out-patient appointment to seek advice about the most appropriate care pathway for patients. We would see examples like that.

As Suzanne said, in those situations, those pathways and referrals are often very timely because somebody is looking for an opinion very quickly to determine the right patient pathway and care plan for that individual—whether that is to transfer treatment and care to an English provider or just to get secondary advice around the patient being on the right care pathway.

In relation to non-contracted activity, which includes emergency care, the non-elective or non-planned activity accounts for between 65% and 75% of the activity that we undertake. There will then be some other specialist areas where we do not have provision in south Wales and we will be accessing services. That will follow the normal referral route with the normal waiting list management. We keep an eye on that as part of our oversight of waiting times and access to those referrals that have been made. I will pause there, but I am happy to take any further questions.

Chair: I am conscious that other people want to come in here. Philip, is there anything else you want to add to that?

Professor Kloer: The referral management process itself is pretty rapid. They will sometimes need to gather together quite a lot of complicated information and, particularly in urgent situations, it will happen quickly. However, I suspect that patients will at times feel delays in getting to the point of the referral management process. I am thinking about the concerns that I hear from members of the public: getting all the diagnostics done, seeing the relevant people and co-ordinating the care up to the point of that decision. Our challenge is making sure that it is as streamlined as possible at the start and then trying to work out the travel arrangements. Logistically, that is difficult, particularly from our rural area.

Q110 **Henry Tufnell:** Could you clarify some of the numbers that you put forward? You said you have 631 for outside the JCC and your relationships with Agnes Hunt and Bristol, but then you had 37 through the IPFR. The evidence from the previous session differentiated two lines, one through the established relationships—through Agnes Hunt and Bristol, where you have that contractual arrangement—and the other through the IPFR commissioned through the JCC. I do not quite understand how you are setting that out.

Professor Kloer: We have long-term agreements where there is a clear patient pathway where clinicians refer in through that pathway, for example, to Swansea, Cardiff and sometimes Cwm Taf, Bristol or Agnes Hunt. There is activity flowing through that pathway. There are some processes that we put in place even for that. However, that is through a contractual route and there is an LTA in place.

There will be specialist services that we commission through the JCC where, again, there is a rigorous process in place. Separately, there is a process for IPFR, which is where patients are demonstrating specific exceptionality against criteria for a treatment. Normally, or often, that is high-cost drugs or medications. Separately, there are times when a patient does not fit with the JCC or the contractual arrangements we have in the long-term agreements. My point is that, in our health board, we have the prior approval process for that, and it equated to 631 patients last year where our patients would have gone to another provider in England that could meet their need. *[Interruption.]*

Chair: I will stop you there because I am afraid that we have votes in the House and the Committee is going to have to suspend for half an hour or so. My apologies to the witnesses for that.

Sitting suspended for Divisions in the House.

On resuming—

Chair: Thank you for your patience, witnesses, especially given the truncated session. Unfortunately, organising votes is not in our gift, so thanks to all four of you.

Q111 **Ben Lake:** Thank you all for joining us this afternoon. I have one question regarding the process for a patient who might be referred for treatment in England via the JCC process, in the unfortunate event that they have a complaint to make. I want to understand who is responsible for the treatment that they receive, and whether that is something that they take up with the relevant English board, or something that the home or original board looks after.

Professor Kloer: The service is commissioned on behalf of us. In fact, we are all members of the JCC, so when I say, "on behalf of", we have a team working for us on our behalf, but we, the seven health boards, make up the JCC. My understanding of the process—others may correct me on this—is that the initial concern would be raised with the provider, because it might be something that can be resolved quite quickly, locally, with the provider. That would be the expectation initially. Clearly, if that is not possible, then of course the JCC has a process for dealing with complaints. Having said that, there is a third party in this, in the sense that we have the responsibility for the population—we would have a role in that, but others might give further representation on that.

Q112 **Ben Lake:** Thank you, Phil. Does anyone have any differing experience or representation in the system? I see heads being shaken, so to follow up: how confident are you that that process is clear to the patient who has been referred? Would the steps outlined be detailed in any referral letter they receive, so that in the unfortunate event that they have a reason to raise a concern or to make a complaint, they would know what to do? That is, they should go to the provider initially, but should that fail or if for whatever reason it needs to be escalated further, they can come back to the commissioning authority. I see a few nodding heads—so it is

something that would be shared with the patient as part of their referral documents.

Suzanne Rankin: I am not sure it would be as explicit as that. There is always room for improvement on how we communicate with patients, but the vast majority of patients will take up a complaint directly with the provider of healthcare, if it is related to the experience of the delivery of that healthcare. There are certainly examples—Abigail and I have worked together on one or two of these—where patients have escalated their concerns. If they feel that they are not getting a response, or not getting the answers they want, certainly we have worked together on that, particularly where patients have come out of a shared care scenario between Abigail and I, which is quite common. I can think of one in particular, Abigail—I am sure you can—where the real complaint was about a provider in London. Absolutely, we then sought to support that patient and navigate a way through to resolve their issues. We did that together, and then with the provider in London.

The JCC's real role in all this is contractual assurance. When it is contracting a service on our behalf, there are specifications, quality standards and assurances that we would absolutely expect from it in terms of the provision of that service and the decision to commission a service. Then, through the JCC, there is an oversight procedure, which would include monitoring of complaints, both for volume but for thematic reviews. That is a more systematic approach, not necessarily on a patient-by-patient basis. Within the oversight of the JCC, there is also a quality and safety committee, as one would expect, and I am pretty sure that Phil is the chief executive representative on that sub-committee to ensure chief executive engagement with the process, and with the oversight and quality assurance of the standing contracts. That is a bit of additional assurance that we take.

Q113 **Andrew Ranger:** Good afternoon, all. This is a question for Suzanne and Abigail. Your health boards both provide specialist care to patients from England, as was mentioned earlier. How do the processes for receiving patients from England, and discharging them, differ from the processes for Welsh patients?

Suzanne Rankin: I am interested in Abigail's view, but I am not sure that the processes are very different at all. I previously worked in England and now I work in Cardiff, and the processes seem pretty familiar to me. As previously described, most of those are clinician-to-clinician referral, which is a pretty standard process across medicine. If the patient requires urgent transfer for urgent treatment, generally the patient comes, and there may be a prior approval process, as Phil described, but I cannot think of an example where it would be different.

Abigail Harris: The burns centre specifically forms part of the south-west UK burns referral pathway, because we provide services not just to the south Wales population, but to the south-west UK. Being part of that network means that referrals are governed by a clear process, which is the same process for south Wales patients as for southern England patients

who come into our service. We are governed by clear referral pathways and guidance, and the multidisciplinary team has conversations about the care needs of the individual—when they need to arrive, when they need to be transferred. That is similar for discharge, because many of the patients we see in the burns centre, as you can imagine, may be with us for an intensive period, and may need to come back for periods, particularly as an out-patient or for follow-up surgery, although they might have ongoing care in their local health system. The referral pathways are the same, whether that member of the public came from the Aneurin Bevan health board or from somewhere in the south-west England region.

Q114 **Andrew Ranger:** To be clear, there is no difference in patient experience or from an admin or bureaucracy point of view.

Suzanne Rankin: I do not believe so, because the arrangement is contractual. Now, one of the key issues with all this is the variability in patient experience, and that is something that we need to continue to address collectively, because I think there is variability. Where pathways are very well established, the experience for patients will be better, smoother, more seamless; if the pathway is new or we are having to adapt, because of an innovative treatment or approach that we seek for a patient, that can be more challenging. But fundamentally, administratively, no.

Q115 **Andrew Ranger:** How do you manage the waiting list for cross-border patients from England?

Abigail Harris: Burns and plastics is generally not a waiting list specialty, for the obvious reason that it is urgent treatment being sought at the time of an event in someone's life that requires them to come into that service. From our point of view, the referral pathway that is set out by the south-west UK network facilitates the timely transfer of a patient, to make sure they get to us at the right time.

I guess if there are constraints in terms of our capacity—if we were full at a time that a patient needed to come to us—that is where the network would engage with other providers and other burns centres across the UK to provide timely treatment for those individuals. For us, it is less of a waiting list issue; it is about capacity at a time that a patient may need to be treated. If there was a major event where there were multiple burns casualties that needed treatment, for example, the network would kick in to ensure distribution of those patients where the capacity was and what we would need to do in terms of creating capacity to treat patients in an emergency and urgent timeframe.

Q116 **Andrew Ranger:** Are the patients recorded in your waiting time statistics in exactly the same way as a Welsh patient, or is there a difference?

Suzanne Rankin: I am happy to check, but I believe there is no differential and no discernment. A patient is a patient, and they are applied to the waiting list in the same way, wherever they come from. They are prioritised in terms of clinical need if the referral has been

accepted and there is an existing contractual arrangement. That would be my belief, but I am happy to check for the Committee.

Andrew Ranger: If you could, that would be useful. Thank you.

Q117 **David Chadwick:** I have a question for Abigail and Philip about cross-border accountability for GPs and doctors. As you will be more than aware, the devolved settlement says that the Welsh Government are responsible for delivering healthcare. However, the registration and certification of GPs and doctors is supervised by the GMC, which is obviously a Westminster competency. My constituents have told me many times that when they have complaints about a GP's conduct or performance, they are not quite sure who to go to. Sometimes online it says they should talk to, for example, Swansea Bay University health board. Other times it says they should make their complaint directly to the GP surgery, and other times it says they should go directly to the GMC. How does that process work? Do you think it works, and do you talk regularly to the GMC about complaints that are being made about doctors?

Professor Kloer: I was formerly the medical director of Hywel Dda, so I am a doctor and I am GMC registered. Where there are complaints about a practice, generally the first port of call is that the complaint goes straight to the practice, and in the vast majority of cases, that complaint is dealt with within the practice. When that process is exhausted, the complaint would come to the health board, and we have processes in place for investigating that complaint at a health board level. If someone happened to go to a health board that was not responsible for managing that complaint—if it was between Swansea Bay and Hywel Dda work, between Abigail and myself—the complaint would be passed to the other health board. That often happens.

The GMC point is a slightly separate but, I can understand, linked one. If there are issues with the professionalism of a doctor, again, the complaint could easily go through those processes, but the general public, staff in the NHS or anyone has the right to refer their concerns to the regulator, which is the GMC.

Q118 **David Chadwick:** That obviously requires constituents and citizens to do a lot of the heavy lifting themselves. Is there an automatic process by which, if somebody makes a complaint about a doctor from your health board to the GMC, the GMC alerts you that that complaint has been made?

Professor Kloer: The medical director in Wales is also the responsible officer to the GMC, so they are the link with the GMC. Where concerns are raised with the GMC, presuming it is not a concern they feel they cannot share with the health board, which happens rarely, that would immediately be discussed with the medical director. There is an employment liaison adviser in Wales working for the GMC who maintains the connection with each of the responsible officers—in other words, the medical directors—across Wales.

Abigail Harris: The only thing I would add is that I am very aware that there are situations where we have practices that span the border or may

have a branch surgery in a neighbouring health board—Phil, we have some of those on our boundaries. In those instances, where concerns were raised, there would be a host health board leading where the main surgery is based. There are examples where we have worked very closely together across the health board boundary in respect of concerns raised by a practice that might span and have a population base that does not fit neatly into a health board boundary.

Q119 **Gerald Jones:** My question is about patient transport, which is obviously logistically difficult for some, depending on the distance from the border. Can you describe in each of your health board areas how patient transport is supported for cross-border care?

Suzanne Rankin: I will go first, because I am afraid that I have to leave at 5 o'clock to chair a meeting. Is that all right, Chair?

Chair: Yes, that is fine.

Suzanne Rankin: It depends on what the transport is required for. If it is emergency transfer, that would be straightforward and standard; the Welsh ambulance service provides all emergency transport from the originating organisation's request. We operate that from here on a fairly frequent basis to Bristol—that would probably be our most frequent destination from Cardiff. The same applies if I want to send a patient to Abigail in Swansea for urgent care burns—that is the example she used—or if any of the organisations want to transfer a patient to me in Cardiff. I guess the reality there is much the same as other ambulance transfers: there is pressure on the system, so the patient will be accorded a level of priority, and we have to work with that.

For non-elective transport, there is the non-emergency patient transfer service, which is co-ordinated by our ambulance service and provided for us, as I think has previously been described. That is available on an eligibility basis; if eligible, the transport would be booked, and the patient would be supported. The reality is that that can feel very frustrating. If you are having to travel a very long way and do not meet the eligibility criteria, as we know, some of this transport can get very expensive.

I can certainly think of examples in my health board where we have chosen to pay for the transfer of a patient, not in a profligate way, but because we can see that in those circumstances, exceptionally, support is required and/or patients will need to be referred to third-party organisations and patient support organisations, which can sometimes support and offer grants and assistance where there is not eligibility for the non-elective transport service. Coming back to Wales can then equally be very challenging—the longer the distance, the harder that can be.

There are particularly unique challenges for the sickest patients, who may have auto-immune conditions or be immune-suppressed as part of their treatment. We have to think very carefully about supporting those patients, particularly young, vulnerable and elderly patients. There are sets of circumstances that often require quite careful consideration. I am

pretty confident that my clinical teams will do that careful consideration, but obviously we are having to balance access to limited resources and funding, and, sadly, that also has to be taken into consideration.

Gerald Jones: Thank you very much. I guess that would be a similar situation for patients in Wales. The system for cross-border would obviously be replicated. Obviously, it is a bit trickier when the distance is quite far.

Chair: Sorry, but Suzanne has to go now. Thank you very much for your time and efforts this afternoon. We wish you well in your new job in Hampshire and the Isle of Wight.

Suzanne Rankin: You are very welcome. I have my data, which I will just send to Lauren now.

Chair: Gerald, do carry on.

Q120 **Gerald Jones:** Paul, is there anything you would like to add to what Suzanne said?

Paul Mears: To add to Suzanne's point, there will also be very specific transport arrangements for certain groups of patients. If you take neonatal transfers, we sometimes have to transfer babies to facilities in England when there are no neonatal cots available in Wales. There are very specific neonatal transport arrangements for those patients.

There are similar arrangements for critically unwell patients to be transported as well. As Suzanne described, there are general emergency ambulance and non-emergency ambulance arrangements, but there are also, as you would expect, very specific transport arrangements for some of those more difficult and clinically vulnerable populations where we have to have very specialist teams that will come. Often with neonatal, they will bring in a team who will come and do what they call "retrieving" the baby from the host neonatal unit, to take it to the specialist centre. The baby will be supported by specialist paediatricians, intensive care consultants and others who will make sure that that it is safely transported. There are well established routes for that to happen.

Of course, that relates to the patient themselves. The other bit, which I think is important to note, is that the transport is often a challenge for the patients' families. Whether it is a baby or an adult, we get the patient to the place using our own transport, but then there is the question of how the other family members get there. That brings the additional pressure and challenge of accommodation, when somebody is being cared for in a facility that is not near their own home.

Q121 **Gerald Jones:** I guess that is going to vary depending on where the family are from and, obviously, where the hospital is.

Paul Mears: Yes.

Q122 **Gerald Jones:** Thank you, Paul. Abigail, do you want to add anything?

Abigail Harris: I support what Suzanne said about the arrangements that she described. I just reiterate that, while the main route is through eligibility criteria for the non-emergency patient transport, we also have a safety net and an ability to make exceptional circumstances if travel costs would prevent a patient from getting timely access to care.

There is another cohort of patients I want to refer to. On occasions, we have mental health patients who travel into England for treatment, either because they need assessment and our capacity for mental health assessment at a critical time is not available locally, or because we have a lack of capacity in a specialist area. For example, eating disorder provision may be an area where we are looking for support. Again, ensuring that we have appropriate transport to compassionately transfer and transport those patients is something we put in place as well.

Q123 **Gerald Jones:** Thank you. Do you have anything to add, Philip?

Professor Kloer: Not much. Only to say that I think that the emergency medical retrieval service for our population has been a big reassurance—both the helicopter service and the land-based service. The introduction of that has really opened the scope for getting people to Cardiff if they have had a major trauma, for example, or to Bristol for a thrombectomy if it is out-of-hours or not operating in Cardiff. That has been particularly important, but all the other comments that colleagues have made about non-emergency patient transport, travel and distance are definitely relevant to the population and communities I serve.

Q124 **Henry Tufnell:** I want to quickly follow up on Gerald's question with you, Phil. Ben and Ann have left, but you presumably face additional challenges in your area given the level of distance—you have to cover Carmarthen all the way up to Borth. The geographical area is greater than what some of your colleagues on the call cover. Do you have any additional plans or resources in place to deal with the rurality you are facing in your particular area?

Professor Kloer: In all our conversations with the public, this is pretty much up there in the top two issues. There are a couple of things that we are already trying to improve on. One is improving access to non-emergency patient transport to reduce cancellations. There is some evidence that there might be more cancellations in our area, so we are working really hard with WAST on that issue. Swansea is only halfway across Wales, so it is not just the cross-border issue for our population; travel even within our health board becomes a challenge—let alone going to other health boards or cross-border.

The other area we are trying to push more and more is virtual consultation so that people do not have to travel. We have had some real success in some of the most emotional situations. We can give a lung cancer diagnosis to people without the need for them to travel, and they have the lung cancer specialist remotely but have a specialist nurse with them in the room supporting them. That has been really effective. We are trying to

increase the opportunities around virtual clinics, and some of that is with Abigail and the Swansea clinicians.

Another element of this that we find quite hard because of our systems is trying to adjust the timings of appointments. For people who live a long way from the appointment, we are trying not to give them appointments in the morning—that is another piece of work. We are discussing at board if there are other things we can go further on, given that this is a particularly live issue locally, as we know from our recent consultations about clinical services.

Q125 **Henry Tufnell:** How does that work? You have these established relationships with Agnes Hunt and Bristol. If you want to move to a virtual consultation with a particular consultant in those areas, or if you want to change the appointment to facilitate that transport, what does that look like with those contractual agreements that are already in place versus the ones that are not?

Professor Kloer: That is a good point. The challenge with this work is that it is pathway by pathway, service by service and clinician by clinician at the moment. It is not mainstreamed in the consciousness of all clinicians. When you look back at the covid experience, we made a huge amount of progress with online GP consultations and online specialist consultations, and I think that there is still a lot of mileage in that.

In terms of the way the contract works at the moment, it is not as specific as that; those things are not specifically in the contract. At the moment, it is about negotiating either with individual clinicians or organisations to gradually move to that way of working. One of the advantages, in a way, is that Agnes Hunt and Bristol are the two main providers, so if we were aiming at the majority, we at least do not have myriad providers we need to aim for. A lot of it is about the way Abigail and I work together, because the majority of our commissioned activity is actually undertaken in Swansea Bay, rather than in the other health boards or England.

Q126 **Henry Tufnell:** So this is something that you are aiming towards rather than something that happens now.

Professor Kloer: It happens in particular instances, but you are right, Henry: it does not happen routinely everywhere now. There is a huge amount of opportunity, but I think we are probably at quite an early stage of the journey on that.

Q127 **Henry Tufnell:** Thank you. Can I come back to the question that Ben asked earlier about the JCC? We have had evidence from Llais and others. Let me quote some of the written evidence from Llais: "When something goes wrong, people don't know whether to complain to the English provider, the Welsh health board, or both. Different timescales and different ombudsmen make the process even more confusing." Is that something that you recognise, Paul?

Paul Mears: As Suzanne said, normally when there is a complaint about a service, you would expect the patient or their family member to contact

the service provider who delivered that care, because they are the people who delivered the care and employ the clinicians. You would expect that to be the first port of call—

Q128 **Henry Tufnell:** Why is there this gap between the patient's experience and what we have heard? That is what I was driving at.

Paul Mears: What I think you are articulating there is a conversation for us to have with the JCC, based on that feedback, about how we make sure that patients who are referred to English providers from Wales are clear on where to go if they have a complaint or a concern about their treatment.

As I say, the first tier would be to take that through the provider of that care. But obviously, as a commissioner of that care through the JCC, we have a responsibility to make sure that the care we are commissioning from providers in England is of good quality. If there are persistent complaints about a particular service from Welsh patients going into England for treatment, that should form part of the discussion with that provider about what they are doing more broadly, to improve the quality of service for their patients.

What you are highlighting is something we will pick up. I know you have the JCC coming before the Committee imminently, and that might be a topic to pick up with them. We can certainly pick that up with our colleagues on the JCC, so that it is made more explicit to patients what route they should take to raise a concern about a service they have received.

Q129 **Henry Tufnell:** Have you anything to add, Abigail?

Abigail Harris: Yes. I am aware that, in respect of complaints, the JCC's website—the public-facing website—does what Paul suggests and directs patients to make the initial complaint against the provider that provided their treatment. Before I came to Swansea health board, I spent a brief spell in the JCC, and I am aware of the processes. If individuals who have had treatment from an individual provider are not satisfied with the outcome of a complaint process, they can raise that with the JCC. When I was there, I was involved in a patient case where that was exactly the example. Paul is right. If that is the feedback that Llais and patients are giving, we can certainly pick that up as part of our conversation, as members of the Joint Commissioning Committee, on the need to provide further clarity for patients and make things more explicit.

Q130 **Henry Tufnell:** My final question is about whether you think this is working. What aspects of the collaboration require the greatest improvement in respect of your individual health boards and the JCC? I will start with Phil.

Professor Kloer: You are asking what aspects of the JCC collaboration need further work from our perspective as a health board?

Henry Tufnell: Yes.

Professor Kloer: Okay. There is one thing that we need to look at across Wales. First, I think the collaboration of all seven chief execs there is a positive thing. We have a good team of people who work on all the Joint Commissioning Committee arrangements. There are two good committees: the quality and safety committee, which I sit on, and the planning and performance committee, which other chief execs sit on. All those arrangements are positive. There is always a challenge when you have commissioners and providers sitting around exactly the same table. That is a challenge for Cardiff and Swansea, particularly, as they are part commissioner and part provider. Others of us are more provider, so there is difference in the seven health boards' experience of that.

One thing we have discussed is that we probably have some duplication of specialist provision in Wales. We are looking at that and at whether we are getting the best value out of the resource that goes into the JCC, given the duplication of services. I may need to think a little more on your question.

Q131 **Henry Tufnell:** Abigail, do you recognise that, in terms of duplication?

Abigail Harris: We are working through a couple of things that we as a committee are aware of. Inevitably, when we develop the commissioning plan, we have to make some really difficult choices, because there is not enough funding in the system to enable us to do all the things and make all the commissioning decisions we might like to. The development of the commissioning plan is inevitably a case where we have to make decisions based on the maximum benefit and the outcomes. That annual process enables us to focus on the areas that are obvious priorities.

Some areas are commissioned through the specialist commissioning arrangements in NHS England, not through the JCC in Wales. As Phil alluded to, we sit around the JCC table with our commissioning hat on, but as we are provider and commissioner, there are some frustrations around how we commission more specialist services that are not commissioned through the JCC. Suzanne and I have a provider partnership where we are working through some things on how to commission services—again, we have collaboration and conversations with chief execs. It is really helpful that there is a small number of us, that we meet very regularly and that we have vehicles through which to have those conversations.

The other thing that Phil briefly touched on was that we have a number of services that we need to review to make sure that we have got the balance right between being able to sustain the service into the future and having a critical mass of population—perhaps because the way that we deliver is changing or because we need a critical mass of population. The JCC is, jointly with us, reviewing cardiac surgery—Suzanne and I are both cardiac surgery providers—and neonatal services, for example. We have three neonatal units across south Wales, and the clinical expertise suggests that we might need to move to a different model. Clearly, we will need to engage patients and balance access with having sustainable services and the right, high-quality outcomes for patients.

Some of the challenge is that the JCC is a relatively small organisation, hosted by Paul's health board. Sometimes, we would like to go faster on some of the work that the JCC is undertaking, but capacity contributes to the timescale on some of the issues. As I said, in this year's programme of work, we have a review of cardiac surgery and of neonatal. We are also doing a deep dive into the IPFR process, because expenditure in that area has increased over the last three years. We will look at whether we can do anything to improve the process, and at what the outcomes and issues are around it.

We have a programme of work, and the JCC is still evolving. I believe you will be meeting Juliet, the new chief commissioner, who I think will bring a new perspective on commissioning. The other area of challenge for us as a committee is to make sure not only that we are getting the contracting arrangements right but that we are commissioning for outcomes. We should be very clear on what outcomes we want to achieve in the services that we are commissioning, from whatever provider, through the JCC.

Q132 **Henry Tufnell:** Paul, do you have anything to add? Do you recognise that lack of services compared with NHS England?

Paul Mears: As my colleagues have said, this conversation is about being clear on what specialist services we can provide in Wales and what services we need to work on in partnership with colleagues in England. There is very clear evidence showing that to provide these very specialist services safely and securely, they need to be provided at a scale that is for a population sometimes beyond that of the south Wales or north Wales corridors. There will always be things on which we need to partner with organisations in England, but we need some clarity on that.

As Abigail said, Swansea and Cardiff currently provide a number of services that probably need to be looked at. There is also a broader conversation. As medicine becomes more specialist and more genomically centred, these questions will become ever more important for us. We will need to have clarity about how we do that, and how we make the decision on when to provide something in Wales. Doing that comes with associated challenges around not just funding but having adequate clinical resources, estates and facilities to provide services. We need to do further work in that area. As Abigail highlighted, the new JCC chief commissioner, Juliet, will bring a lot of expertise to focus on that.

Chair: I thank all three of our witnesses for their time this afternoon, and for their patience during this truncated session. That was very helpful. We may well write to you to seek further clarification on some of the issues that you raised. Thank you very much for your time.