

Welsh Affairs Committee

Oral evidence: [Cross-border healthcare arrangements between England and Wales](#), HC 65

Wednesday 24 June 2026

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

Questions 133-188

Witnesses

I: Juliet Brown, Chief Commissioner at NHS Wales Joint Commissioning Committee, Professor Iolo Doull, Medical Director at NHS Wales Joint Commissioning Committee; and Melanie Wilkey, Director of Commissioning for Specialised Services at NHS Wales Joint Commissioning Committee.

Examination of witnesses

Witnesses: Juliet Brown, Iolo Doull and Melanie Wilkey gave evidence.

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 of the Committee. Today is the Committee's third session in its inquiry into cross-border healthcare arrangements between England and Wales.

Yesterday, the Committee heard evidence from the seven local health boards in Wales, which raised some concerns about the opacity of the cross-border healthcare process. We are therefore very grateful to have members of the NHS Joint Commissioning Committee before us today to shed some light on how cross-border healthcare operates. Thank you so much to the three of you for appearing before us in person today.

Do any Members have interests to declare? No; that is fine. We will carry on. Can I begin by asking you all briefly to introduce yourselves and your role in the JCC?

Juliet Brown: Thank you for inviting us here today to talk about something that is really important: people accessing good-quality outcomes in healthcare. I am Juliet Brown, chief commissioner for the Joint Commissioning Committee. I will be totally honest: this is about my 12th day in post, so please bear with me. I will try my best to answer the questions you direct to me, but I may need to bring in my colleagues to support. Obviously, if there is anything we cannot answer, we will take it away and come back to you. It is very nice to meet you all.

Melanie Wilkey: I am Melanie Wilkey, director of commissioning for specialised services within the Joint Commissioning Committee.

Professor Doull: My name is Iolo Doull, and I am the medical director for the JCC. My background is that I led the specialist paediatric respiratory service for south and mid-Wales before I went to the JCC, so I hope that I am an advocate for rare and very rare conditions.

Q133 **Chair:** Thank you. We may ask you to speak up a little, Professor Doull, because the microphones need to catch every word.

Juliet, the JCC obviously replaced the old specialised services commissioning committee. How has that changed the way cross-border healthcare is commissioned?

Juliet Brown: The members of the JCC are the seven health board chief executives. It is chaired by an independent chair and has some lay members. The JCC is a sub-group of all the health boards, and we have a small staff who work on behalf of that committee, including me. The benefits of the JCC are that it brings together different organisations that have responsibility for different elements of commissioning—ambulance

services in one organisation, for example, and specialist surgery and other specialist services in another.

That does two different things. First, it brings everything together under the health boards' jurisdiction. We are part of the health boards and integrated into local services, right through to specialist services. Yes, we are managed as a special unit within that, but it enables cross-conversations and gives our health board chief executives ownership of every element of a patient's pathway, from local primary care through to the most specialist care. That is a really big advantage of bringing those organisations together. We work to look at improving outcomes and reducing inequality, and that has to be a big step towards that.

The second point is that, by bringing all specialist commissioning together under one organisation, you build up a real centre of expertise on how we do this effectively. You also have a single point of contact so that, in this context, when we are working with English providers and the English NHS, there is one organisation and one place for them to come to. We are embryonic; we have been in existence for only a couple of years. Are we there yet as a beacon of excellence and a specialist centre of strategic commissioning? We are probably not 100% where we want to be, but we are on that journey, and that has to be the right thing for commissioning for Wales.

Q134 Chair: You have outlined a number of the aims and aspirations of the JCC. Where does cross-border healthcare rank in your priorities or work remit?

Juliet Brown: Our main commissioning intention, and our role, is to look at the population health needs of all the people in Wales and how we best meet those needs. How do we ensure that everyone who lives in Wales has equal access to the healthcare that will provide them the very best outcomes?

When we look at specialist services, as much as we want to provide all care locally, we cannot, because the specialist skills may not sit there and, equally, you need a critical mass of population to get those very good outcomes. We therefore commission services from England, and it is appropriate that we do. If we look at those numbers, the referrals going cross-border for those very specialist services are increasing by about 5% per year. I suspect that it is an area that will continue to increase when it is right to do so.

The other thing we need to think about going forward is that that care does not all have to be cross-border. With digital technology and everything coming in, we should be able to do the majority of it, potentially using the specialist skills from specialists in England, so that people can access it locally to where they live. That is one of our challenges going forward: how do we work and change how healthcare is delivered, even if it has a cross-border component?

Chair: I am sure that we will come back to that shortly.

Q135 Ann Davies: I will concentrate for a little while on specialist services.



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Melanie, what criteria do you use to determine which specialist services should be provided in Wales? Let us keep it local first.

Melanie Wilkey: We do not have specific criteria for what would constitute a service that would be provided in Wales. We would look at the population need, the particular specialism, what the evidence is for the efficacy and outcomes of patients of those services, and what might warrant a good, sustainable service with positive outcomes for patients. A variety of criteria would be assessed when we are asked to consider what might be delegated to us, as opposed to remaining with the health board's responsibility.

Q136 **Ann Davies:** Which specialist service has had the greatest increase or has become most prevalent?

Melanie Wilkey: For a lot of the specialised services we commission, we are at the end of pathways of care that start in health boards. Those are the things where we see increases that are potentially driven by lifestyle factors, for example cardiac specialties and—perhaps not so much cross-border, but for the services that sit in my portfolio—renal services and so on. Those are the areas we see consistent growth in.

As Iolo referred to, we also look at the highly specialised end, which might be genetic and those sorts of things. Those are much more likely to be provided in a single, specialised centre—either for the UK or more regionally—that may or may not be most appropriately delivered in Wales.

Q137 **Ann Davies:** Do you have the capacity in the JCC to meet that demand in Wales?

Melanie Wilkey: That depends on—

Ann Davies: I presume not for the specialist services, but what about renal and cardiac, shall we say?

Professor Doull: If I could build on what Mel said, for some things, it is a back-of-an-envelope calculation. If you work out the population of England, it is roughly 20 times greater than Wales. If we take a very rare condition: there is a condition called epidermolysis bullosa where you see blistering of the skin. It is a very disabling condition, but the number of patients is relatively small, so there are four centres in the UK for that condition: two for children and two for adults. In that situation, it would be wrong to try to deliver that specialist service in Wales, because you do not have the number of patients or the expertise to develop the skills that you need. In contrast, for cardiac surgery, south and mid-Wales is big enough to maintain probably one cardiac surgery centre. As Mel said, it is about working out the population need.

Q138 **Ann Davies:** Does the JCC get the capacity so that we can treat our patients in Wales for renal and cardiac—the two that you said are increasing more than anything else?

Melanie Wilkey: It would depend on the specialty, but yes, when we commission a service in Wales, we generally commission the capacity



needed to meet the demand. For example, for cardiac surgery, the majority of patients in south Wales will be treated in south Wales centres, unless there is a particular complexity that needs a level of expertise. For north Wales, we commission cardiac services from Liverpool. North Wales patients flow into Liverpool, so the appropriate level of capacity is commissioned from there. Where we proactively commission services, we commission the capacity that the population need indicates.

Q139 Ann Davies: That has answered my next question: if we do not have the capacity, do we go across the border rather than forcing patients to wait or, perhaps, to get substandard care?

Melanie Wilkey: The patients will be on a pathway within the commissioned service. Unlike the health service in England, there is no patient choice on which centre they are treated at in Wales; patients are expected to come into the commissioned pathway, so we would expect them to come into a local service where that is commissioned.

We rarely commission out for capacity reasons: we would look to our local providers to manage waiting lists, and it would be part of our performance management with those providers to manage the waiting times within the specifications that we have set out. But, as Iolo outlined, where we do not have the critical mass, we look to centres outside to make sure that we have the right, safe outcomes for patients.

Juliet Brown: May I add just a bit of flavour to that? There are different dynamics in north and south Wales on this. To answer your question, the other thing is that the best, closest and easiest-to-access place for those patients is sometimes outside, in England, rather than in south Wales. Could we commission more cardiac surgery in south Wales and force pathways from the north? Potentially, but that is not the right solution for the patients.

Let us stay with the example of cardiac: if you look at the numbers, across all the specialties—cardiology, cardiac surgery and cardiothoracics—about 15,000 patients a year go into England. That is not a huge number. Over 80% of those patients go to Liverpool; that is the north flow, because that is the right, closest service to them.

Q140 Chair: We do understand that the geography is about east and west, not north and south.

Juliet Brown: I get that, but I thought giving you some of the numbers might help to illustrate that.

Q141 Henry Tufnell: Thank you very much for coming in today. Could you clarify something rudimentary for me? We have health boards that potentially have established contractual relationships—we have heard about established cancer pathways and, for instance, Betsi using neonatal services in the Wirral and Hywel Dda using services at Agnes Hunt and in Bristol—and on top of that, we have IPFRs, which are often used for high-cost medication or more specialist services. There is then potentially a third route, which we took evidence on yesterday, that sits outside those



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two routes: about a third of patients can be referred for care not through IPFRs or contractual relationships. What is the role of the JCC in how that works?

Professor Doull: Shall we discuss IPFRs first?

Henry Tufnell: I am more concerned about this number of patients; I do not understand where they are going, how it works for them and why they are not linked with you. I would rather explore that first—I think we are going to come to IPFRs later.

Professor Doull: We need to distinguish between secondary and specialist care. Part of the confusion can be that going to see a specialist often means going to see a secondary care physician or surgeon, and, from the JCC's perspective, our specialist care is more at the tertiary level. Secondary care may be referred from Hywel Dda to Agnes Hunt or Bristol.

Q142 **Henry Tufnell:** I understand that bit, and I understand that happens with other health boards, like Betsi referring to the Wirral—I get that. I also get the IPFRs, which we will come to later in respect of high-cost medication. What I do not understand is where there is this third batch of patients, and how they are being referred for cross-border healthcare. I do not understand how they interact with the JCC.

Professor Doull: The question is, for this third group, are they JCC specialist or are they health board secondary care specialist?

Q143 **Henry Tufnell:** Can you explain the JCC's role in interacting with that group of patients?

Professor Doull: I am not sure that I understand what that group of patients is, I'm afraid. Some of the health boards may refer to English providers for their secondary care, and that would not usually be our responsibility.

Q144 **Henry Tufnell:** You mentioned Hywel Dda. They have 631 patients who go outside of their contractual relationships and outside of IPFRs to English providers. What is the JCC's role in respect of those 631 patients? For instance, I represent Pembrokeshire, so some of those 631 patients will be my constituents. How are they accessing healthcare in England? How does your role as the JCC work in that? I don't understand.

Juliet Brown: Shall I try? As Iolo says, who are that group of patients? Let me try to describe it; there are two sets that I can think of. First, do we commission all the specialist services through the JCC? We know that there are some services that are not commissioned through the JCC at the moment. Health boards will commission those directly, and they will go outside of their health board borders.

Henry Tufnell: Those are the contracted relationships that I touched on before.

Juliet Brown: They will have contracted relationships. Now that the JCC is established, it might be that there are specialties that it would be better

for us to bring together and commission once across Wales. We and the chief executives will explore that going forward. That is one group of patients. There is another group—

Q145 **Henry Tufnell:** You won't have a role in the contractual relationship.

Juliet Brown: We do not have a role in that—

Henry Tufnell: That is fine; we know that. We know about the IPFRs, and we know that you have a role in respect of that. But there is this third group of patients.

Juliet Brown: Which may be the pre-approved patients.

Chair: Yes, that is it.

Juliet Brown: Is that it? The pre-approved patients have a set of conditions that we do not have contracts for. It might be something that is extremely rare, and we know about it, but there are not enough numbers to have a contract. Those conditions go through a similar process to the IPFRs—I think that is where Iolo was coming from—which is simpler. They are pre-approved and bought through the JCC that way. It is a similar process to the IPFRs, but simpler. Iolo can provide the detail now that we have analysed that group of patients.

Melanie Wilkey: I think what you are referring to are some prior approval patients. Those will either have care that is commissioned on an individual patient basis, which is not outside IPFR—Iolo will come to that later—or on a small cohort basis, so we do not have a contract for them. There will be variation. Some of the things will sit in a health board commissioning responsibility, because they relate to secondary care, as Iolo was describing, and some of the things will relate to specialist services, so we would be responsible for the process, because they relate to the suite of services that we commission.

Those will be things that are potentially NICE approved but are not offered in a health board footprint at this point in time, so the patients would be approved on either a small cohort basis or on an individual basis. The indication for those patients will determine whether they sit in a health board commissioning responsibility or ours. The patients do not need to know that.

Q146 **Chair:** Can you give us an example? The pre-approved route is new to us—we learned about it only yesterday—so it is fascinating. You said 600; that is a large number of patients to us. Can you give an indication what sort of conditions we are talking about here?

Professor Doull: First, I think we need clarity from Hywel Dda on exactly who these patients are.

Henry Tufnell: The evidence that we heard yesterday was: "there are times when a patient does not fit with the JCC or the contractual arrangements we have in the long-term agreements...in our health board"—this is Hywel Dda—"we have the prior approval process for that,



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and it equated to 631 patients last year where our patients would have gone to another provider in England that could meet their need.”

Professor Doull: I think that a lot of those are the health board’s responsibility for commissioning—things that we do not commission. For prior approval, I can tell you that we have—

Henry Tufnell: So you have nothing to do with those?

Professor Doull: Some of them, maybe. But most of those are not—

Henry Tufnell: You do not think that they are your responsibility?

Professor Doull: No. I will tell you why. The data we have generated for ’25-26 shows that we considered 1,218 prior approval applications, of which 803 were to non-Welsh providers, 222 were to Welsh providers and 193 were to private providers—that is usually in renal. Given that we have only 1,200, I would be surprised if all 600—

Henry Tufnell: That is from one health board.

Professor Doull: No, that is from the whole of JCC. That is why I think 600 from Hywell Dda would be unusual. I would not expect it to account for over half of all the prior approvals that the JCC has received.

Q147 **Henry Tufnell:** I still do not quite understand. You are the body responsible for commissioning services that you cannot provide in Wales—

Professor Doull: I am not sure that is the case. There are services that we do not commission that patients would go outside Wales for.

Henry Tufnell: Which are established through those contractual relationships that already exist. I understand that. Evidence that we have had before has shown that those are quite successful: there is quite a streamlined process because the relationships are established and that is quite smooth. The fear is that the IPFRs are quite complicated—we are going to come to them—but if there is another batch of patients for whom we are not really sure what the process or the bureaucracy is like, that creates added barriers to the constituents that we represent accessing care that they require and need in England.

Juliet Brown: I asked the same questions earlier and it was helpful to have the examples that Melanie gave me of the conditions. I think that may help.

Chair: Yes, that will help. Thank you.

Juliet Brown: But also, as Iolo will go on to explain, we are doing an IPFR review and part of that is we have got quite a lot of people—as you are explaining, Mr Tufnell—going through the pre-approval process. Actually, now that we have so many we have a critical mass, would it be more effective if we put a contract in place and made that smoother for patients? At the moment we are looking actively at where we go with those. We obviously need to work with the health boards because, as you



have pointed out, it does not just sit with the JCC; there are two groups of patients. There are the JCC pre-approvals and then each health board will have similar but different conditions. That is probably what separates most of them. We want to look at that in its entirety. Do you, Melanie, want to give the examples that you gave me of the type of conditions that may be included?

Melanie Wilkey: An all-Wales prior approval policy that sits alongside the IPFR policy and most of the IPFR panels will consider the prior approvals under a separate section of that, so there is not a separate process per se; there is not a missing group of patients. But for the JCC we might look at things such as home parenteral nutrition, where patients are looking for individualised packages, and things that the health boards might be looking to take over on an individual prior-approval basis. It might also be some of the newer, more novel cancer treatments for cancer sites that are not delegated to the JCC.

Henry Tufnell: I think I have taken this as far as I can, Chair.

Q148 **Ben Lake:** I should like to turn to IPFR, but before doing so, I would like to follow on from Mr Tufnell. With the prior approval process, the established pathways or those SLAs that a health board might have with relevant centres in England, what sort of consideration does the JCC make of that? If it sees that there is a critical mass emerging from south Wales health boards through a particular SLA, would the JCC look at commissioning it in Wales? Does that happen? Equally, I appreciate that the prior approval processes do not always sit with the JCC, but is there a way of feeding back to your good selves so that if there is a significant increase in patients being referred through the prior approval process for a particular condition, you can then incorporate that into your own planning and work? Does that happen?

Melanie Wilkey: Yes. There are some national bodies in Wales. The All Wales Therapeutics and Toxicology Centre and the All Wales Medicines Strategy Group hold a central database of all the IPFR requests and look for patterns. At a health board level, or at a JCC level, we might see one or two of something. Those national bodies are looking for patterns and whether they would want to do an evidence review. They then might recommend some more formal commissioning on behalf of the population of Wales. From a JCC perspective—I will hand over to Iolo, and he will talk about what we are doing with IPFR at the moment—we would also then say, “Well, actually we started to get a critical mass for these, so now we will seek to put in some contractual arrangements and contractual flows for these patients”.

Q149 **Ben Lake:** Again, I know that there is a risk of oversimplifying, but in an ideal world, the prior approval process would be for exceptional cases; it is not a routine pathway.

Professor Doull: There are things that we need to sort out with our own governance and structure. There are quite a lot of prior approvals that probably should be business as usual, but there are other things that



come through for prior approval, such as stem cell transplants for children with immunodeficiencies, where their immune system does not work well. Most of those children will go to Newcastle, and the cost is about a third of a million pounds. From a signing-off, that would probably be inappropriate to be a prior approval. I think we need some degree of financial governance if nothing else.

Q150 Ben Lake: Thank you; that is very useful. Forgive me for fixing on prior approval, but I have a final question: you mentioned that there are certain conditions for which we know the specialisms, and there might only be one, two or three centres in the UK, so it is unfeasible to have one in Wales alone. Is there a mapping exercise, where we think, "if somebody were to have this particular neurological condition or disorder, and we know the centre is in London, Newcastle or wherever, that is going to be an established pathway, even if we may only have one person from Wales a year needing to go there", or would that be done under prior approval?

Professor Doull: I think they would stay under prior approval. A third of a million pounds is a lot of money, so I think there does need to be some scrutiny. Prior approval does offer that. I do not know whether the Blueteq system has been mentioned.

Ben Lake: I do not believe so, no.

Professor Doull: For all the medicines that the JCC commissions, we use a system called Blueteq. NHS England uses Blueteq, and Blueteq is a good way of getting data and making sure that the right patients get the right medicine. There is a funding directive from the cab sec that every new medicine that NICE approves has to be provided within 60 days. If that is a medicine within the JCC's area of responsibility, we will set up a Blueteq form and the Blueteq form will have whatever the NICE criteria are.

There is a new medicine called Givinostat for people with Duchenne muscular dystrophy. These are boys—they are virtually all boys—who have progressive weakness. The NICE guidance will say that to receive Givinostat the patient should have Duchenne muscular dystrophy—it should be confirmed genetically—and they should still be able to walk around, and the medicine will be provided within a certain contract price. We would therefore generate a Blueteq form that has exactly those same four questions. In that way, the prior approval is taken away, because we get automatic prior approval, but we make sure that only the patients who fit the NICE criteria receive the medicine—we can see exactly what is going on.

NHS England used the same system and we had to adopt it, because with a lot of the medicines, there are massive rebates, and to get the rebates we had to have very good data. That is how we generate the data we need to claim the rebates. Some of the rebates are eye-watering, so it is very important to us. We therefore use the Blueteq system, and for some of the prior approvals we aim to move to Blueteq. First, that will give us good data and, secondly, it will not only ensure that it is the right patients, but

from the clinician and patient perspective, as soon as they do the form, they have prior approval straight away.

Q151 Ben Lake: Thank you, that is a very useful answer. My next question you have touched on already, which is about when the JCC might deal with an IPFR versus a health board. When considering established pathways or the service-level agreements with particular providers in England, at what point does the JCC step in to identify the need? "Look, we clearly have a critical need here. It has reached a critical mass, so we need to have an established pathway, versus an individual agreement between a health board and the provider in England." When does the JCC take the lead in that work?

Melanie Wilkey: There will be a balance of those things. Sometimes, some health boards will have regular flows over the border, and they will have those sorts of contractual arrangements for relatively small numbers. Where it is for things that are delegated to us as part of our directory of services—where it is a development in that particular area for a similar cancer site or a similar type of cancer treatment—we would then seek to bring that within, but we will look at those in terms of prioritisation in line with our planning, because obviously we are looking at the quantum. We look to prioritise against the services that we already commission, whether that be novel therapies or extensions to existing pathways.

Q152 Ben Lake: I am on to my final two questions, you will be relieved to know. Again, I am asking about a general case, although I appreciate that an IPFR is very complex and individual. Is there any data about the typical length of time that an IPFR review will take?

Professor Doull: First, I would argue that the IPFR system works relatively well. I think you have heard evidence that clinicians were unhappy, and I echo that. The form is terrible, and I have written to a number of people and had discussions with the chief medical officer and the deputy chief medical officer. I think there is a will now that the medical directors of the health boards in Wales, along with the JCC, will try to redesign that form, because it is antiquated and burdensome, and I have yet to meet a clinician who likes it.

Putting that to one side, however, the IPFR process within the JCC, I would argue, works relatively well. It is worth noting that the system in Wales is quite different from that in England. Juliet has come from an ICB in England, and it was very helpful to have their data. On the IFRs, as they are called in England, clinicians—friends of mine—have told me that the chances of getting a successful IFR in England is very low. In Juliet's ex-ICB, it is about 5%. Last year, our JCC success rate for an application was 79.3%. If you look at the health boards in Wales, the variation in successful applications is between about 70% and 90%. Health boards will go up and down, but it generally sits around 80%. That has increased over the past nine years.

Secondly, from a speed perspective, the JCC generally considers about half of all the IPFR submissions in Wales. This year, we are slightly lower,



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but usually we do a number of IPFRs that all the health boards together will consider. We have a panel every two weeks. We have a lay chair and two lay members, and we have a clinician representative from all the health boards. We aim to be representative of the health boards. We have a meeting every two weeks, but if it is an urgent application, we will have a chair's action. On Friday, we had two chair's actions. We had two applications that needed the treatment to start on Friday, and we turned it round in two hours. I would argue that the process within the JCC works well. We had a recent internal audit, but it came down as good across the board. It was very unusual to see. The IPFR process within JCC works well.

Q153 Ben Lake: The evidence the Committee has received has centred very much on the form. I believe that a clinician wrote into us to say that it takes hours. You mentioned that there might be a review of that form and that bit of the process. Would that require regulatory changes or could the JCC oversee it?

Professor Doull: I think the JCC, with the health boards, can oversee. The JCC was instrumental in rewriting the policy. We had an unsuccessful judicial review. Following that, David Lock KC, who was our counsel, rewrote the policy, so it is hopefully legally tight now. If we can revise the form, that would be important.

Melanie Wilkey: The All-Wales IPFR policy does have timescales attached to it. In the popular form, the clinicians can choose 24 to 48 hours, one to three weeks, or four weeks to six weeks as timescales in which a decision would need to be made. When the information is entered on the database, there is a regular quality assurance done on a national basis. Both health boards and ourselves would be reported if there were any breaches to the timescales asked for the clinicians.

Q154 Ben Lake: Do those timescales apply equally whether the IPFR goes to a health board or the JCC?

Melanie Wilkey: Yes, that is the All-Wales policy.

Professor Doull: There is a quality assurance group that sits within the All Wales Therapeutics and Toxicology Centre. They will audit the performance on an annual basis. There is a report that comes out every year that lists all the health boards and the JCC. It is very transparent.

Juliet Brown: Clearly, it is a really important process and it is good to have the opportunity to explore it. For context, last year, 35 patients applied for IPFR for cross-border care, and 31 of those were approved. They are very important applications. These are some of our illest patients, but it is not a very big number of people.

Q155 Ben Lake: In terms of the IPFR applications that are made to the JCC, as opposed to those through the health boards, are they typically the most complex cases, where you have specialist tertiary requirements rather than more routine secondary care?

Professor Doull: They would all be specialist, because they are within the JCC's remit. As to whether they are more complex, sometimes they are.



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Interestingly, a lot of the health board representatives quite like coming to the committee, because the level of discussion and the challenges are quite considerable.

Q156 Ben Lake: Is there a particular role or policy to dictate when an IPFR will be dealt with by the health board versus the JCC, or is it just a patient's or a clinician's choice?

Professor Doull: Not if it sits within our remit. If it were for a cardiac surgery intervention, it would come to us. If it were a pacemaker intervention, which is health board, we would not see it.

Q157 Chair: Juliet, you mentioned that 31 were approved out of 35. What happened to the other four? How do you follow those through and support them? Obviously, that is a patient and their family.

Juliet Brown: I will ask Iolo to answer that. Can I just give another number? I do not want to inadvertently mislead you. There were 35 applications for cross-border, and there were an additional 129 for treatment within Wales. That is the whole of the cohort. Of those 129, 99 were approved. That goes back to the 80%, and Iolo will answer about the other four.

Professor Doull: The IPFR submission has to be made by the clinician. The rules are that the panel's decision is conveyed to the clinician within five days, and it is then for the clinician to feed back to the patient. A letter goes to the patient, but it does not give them the outcome; it just says that they should go back to the clinician.

Chair: So it is reliant on the clinician to follow up and support where appropriate.

Q158 Henry Tufnell: Why is there such a big differential between the approval rates in Wales and England? I think you said it was 5% approval in England, and you are at 79% in Wales.

Juliet Brown: Different processes and different eligibility criteria. On one level—

Henry Tufnell: Are those your eligibility criteria? Do you set the eligibility criteria?

Juliet Brown: I have to say that I do not know all the details around the English system, but there will be different cohorts of patients, because it is under different legislation. We have to be really careful when we redesign this form, because we do not want to put in a simpler process that ends up with more people being refused and more appeals processes, which lengthens the whole thing. The interesting thing to know about the English process is how many appeals it generates and how that goes on. As part of this, we will be linking in with English counterparts to see what joint learning we can get.

Q159 Henry Tufnell: Is there any way that you could provide evidence to the Committee about why there is that massive differential?



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Juliet Brown: I can certainly take it away, and we can talk about what the different definitions are.

Henry Tufnell: It is quite big.

Professor Doull: I cannot speak for the health boards, but they have similar rates to us. As an advocate for rare and very rare conditions, I can say that Wales spends probably 40% less per head of population on specialised services than England. There are a number of conditions for which we think we should commission, but the chief executives make the decision and they have decided that they do not want to commission something.

Last year, there were three applications for a medicine called anakinra. There is a group of rare conditions called periodic fever syndromes, or auto-inflammatory disease. It is usually children who are admitted, and they look to have a severe infection: their temperature is up, they are flushed and the blood tests suggest that they have infection. The standard treatment is that you take the blood to culture what the germ is and give antibiotics. After 48 hours, if you haven't grown anything and the child is better, you send them home. Then a month later, they come back with the same thing and again you find no infection. After three or four of these, someone twigs that there is actually something wrong. It is that the immune system has an exaggerated response, which is why they look to have infections.

Once you identify that that is the cause, there are a number of medicines, one of which is anakinra. Anakinra works very well, and NHSE commissions it, but we took that to our process and it was decided that we should not commission it in Wales. We have the difficult situation whereby the clinician will submit compelling—overwhelming—evidence that this medicine will make the patient better, but we do not have a process at present for developing anything new for these patients, so we will take them through IPFR. So quite a few of our IPFRs are a reflection of the fact that we do not commission as many specialist services as England does.

Q160 **Chair:** Who made the decision not to commission in Wales?

Professor Doull: The joint committee—the chief executives.

Chair: The health boards?

Professor Doull: Yes.

Chair: Thank you very much.

Gerald Jones: Thank you all for being here today. I want to ask about patient data and records. In the surveys we have done, 64% of respondents ranked patient records and data transfer as one of the most pressing issues around cross-border healthcare. Melanie Wilkey, how are you working with Digital Health and Care Wales to ensure that when patients are referred across the border, their records are transferred with them?

Melanie Wilkey: In terms of transferring information and the patient pathway, we do not have a lot of issue with that. We have established pathways. We do sometimes have issues with data coming back. I will hand over to Iolo in a minute on some of the data sharing issues that we come across.

Digital Health and Care Wales operate on behalf of all of Wales, looking at those digital systems, and they will support in collecting and collating the central information that we all then have access to. We work with them on a daily operational basis to secure the information that we need, and then we work with our providers because, in our contractual arrangements, we will have expectations of data provision and the timeliness of that data provision, either into centralised systems or directly to us. That does not always happen, and we manage and monitor that through our performance management arrangements directly with those providers. Where we see patterns of that, we obviously work with Digital Health and Care Wales to make sure that the data is flowing.

Q161 **Gerald Jones:** Do we know where health boards are with the move to digital patient records?

Melanie Wilkey: I cannot speak on behalf of health boards and the move to digital patient records—that is outside my area of expertise—but I know that there are sometimes issues with diagnostics that are done across health board boundaries that other health boards cannot see. We experience some of those same issues when patients go and some of the information that is already there is not available, and it takes some time to get some information transferred sometimes.

Professor Doull: Data sharing between health boards is not always ideal. I keep saying that we are not a massive country. One of my other responsibilities is that I chair the All Wales Medicines Strategy Group, which advises the Welsh Government on medicines strategy. It was suggested that Wales was the last country in Europe to have electronic prescribing in secondary care—EPMA, or electronic prescribing medicines administration. That has now been rolled out across the health boards, but we have three different systems for electronic medicines prescribing. From a patient safety perspective, it is not good to have that many doctors rotating between health boards and having to learn new systems each time. Sometimes, it would be helpful to have a “Once for Wales” approach to data sharing.

Juliet Brown: And we can extrapolate that across the border. This is one of our biggest challenges as we go forward. Maybe something that we can get out of this review is a reminder to our English colleagues that, when they are looking at data system procurement, we start that cross-border conversation right from the start. It is easier to do it right from the beginning than to fix it afterwards, and it will become increasingly important as we move to having more and more digital access.



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Professor Doull: On the Blueteq system, because we use the same system as NHS England, NHS England prescribers can use our Blueteq forms in England for Welsh patients.

Juliet Brown: We have an example of where it works really well and where we had that joined-up working, and it would be great if we learned from that into the future.

Gerald Jones: It is an interesting example. As a small country, having a universal system, not having a number of different systems, should work in our favour. It should be a prerequisite, really. It is not rocket science, is it? It is just about getting people to agree and give up their empires, I guess, but there we go.

Q162 **Andrew Ranger:** Good afternoon and thank you all for coming today. Iolo, who makes up the membership of IPFR panels?

Professor Doull: I can only speak for the JCC, and we have recently changed our constitution. We have a lay chair, two lay members, clinical representatives from all seven health boards, although we do not always have a full quoracy, then myself or the director of nursing from the JCC.

Q163 **Andrew Ranger:** In yesterday's session, we heard about delays before getting to the decision point for IPFRs. One of the delays mentioned was around acquiring the membership for the whole panel to get together. Is the process around IPFR decision making too reliant on individuals having to turn up and be there?

Professor Doull: Health boards would say, not unreasonably, "You are spending our money. We would like to have assurance that you are spending it appropriately." So we came up with a quoracy where four out of the seven health boards should be there for our panel. If that does not occur, we would then have a chair's action, which is usually either the chair plus myself and the director of nursing or the senior member of the exec, the JCC—it would be Juliet and myself and the director of nursing. It depends on what the clinician has put on the form. Do they want it within 24 hours, one to three weeks or four to six weeks? We would aim to meet that target.

Q164 **Andrew Ranger:** Would you say that your experience of putting that in place is making IPFR decision more robust and prompt? Is it having an effect?

Professor Doull: The audit we had undertaken was very complimentary. It is a cause of frustration for us, because a lot of our staff spend a lot of time trying to chase up who is going to attend.

It is difficult. Last week, we had 10 cases. There was a lot of work to read all that. For the clinicians who have done all their homework to then be told, "Sorry, you're not needed," I would imagine that is a frustration. We spend a lot of time on that. Some health boards are very good. Powys, for example, has a limited number of staff. To be giving up two hours every other week, plus a lot of reading—we have got to be realistic in what we ask of them.

Q165 Andrew Ranger: Bearing in mind what you have just said, is there anything in consideration about how we make that process more robust and efficient? Is anything happening to look at that?

Professor Doull: Our chair writes out regularly to the chief executives asking to make sure that people attend. In fairness, since we have started regularly writing to the chief executives, things have improved. We have very good representation from the health boards. It is a very high standard and quality of discussion over very difficult cases. I think it is very defensible.

Steve Witherden: In January 2025, Stacey Taylor said of cross-border arrangements: "By and large, the arrangements within the current system are effective." Reflecting on Stacey's statement from more than a year ago, do you agree, Juliet, that cross-border arrangements are effective? I think for someone to think that, they would have to be living on another planet.

Juliet Brown: We are responsible for the commissioning arrangements over the border and not necessarily the actual patients accessing the care and the day to day. The conversation about records going over is about a local clinician and patient—I absolutely understand the frustrations on that.

On the commissioning of services, we have already alluded to how we could improve them. There are other services that we can start looking at whether we can commission them, but I think we have robust contracts with centres. If I look at our cross-border activity, for each of the specialties we commission, approximately 80% usually goes to one provider and then the other 20% is provided across others. That is replicated across most of our specialties. That is good, because it means we have one main contract.

We have to accept that the number of patients we are sending is relatively small compared with what the local ICB will be commissioning or from across England. So how do we do that? We use the payment-by-results mechanism for the funding, so the funding flows relatively smoothly. We will tend to and try to build relationships with the local ICB and sort of piggyback on their local commissioning arrangements, because they have the bigger contract. How do we benefit from their expertise on that? Because most of our activity is in one major provider, it means we can then follow up and we can look at the quality.

If we think about what we are trying to achieve with the commissioning, we are trying to purchase services that best meet those needs and check that they are meeting those needs. We have a team under Iolo but, importantly, also under our chief nursing officer, who will go out and visit the centres they are able to go in. There are obviously regulators like the CQC and others as well, but we can go in and check. For example, one of our contracts in Bristol was not working very well, so the team went in and they could see why. We could put them under special measures, for want

of a better word, but then work with that team to see how we could improve it.

When it comes to the commissioning arrangements on the services we commission, I think Stacey is right. We are improving and getting better all the time in respect of how we become more of a strategic commissioner and more able to look at that, but the funding flows that support those pathways go well. There are agreed protocols and processes across Wales so that each health board is working to the same procedure, and there is therefore equity built into who can access that, and we have the follow-up with the quality around it. I think there are many positives with that.

As we say, there are other areas that we could look at potentially commissioning, whereby we could therefore bring that contracting and commissioning approach that could improve mainly the quality and the ease of the administration that sits behind it.

I have read and seen the views of some of the GPs working on the border and some of the patients who access those services. I can absolutely see the frustrations about the practical things that get in the way. Some of them are common in going across regions or across county borders in England. We know we always need to do it better. I am not saying there are not frustrations, but we are responsible for looking at the commissioning part of it.

Q166 Steve Witherden: You have jumped on to what I was going to ask next. The constituency I represent is 35% in the Betsi Cadwaladr area and 65% in the Powys teaching health board area. Do you think patients in the Powys teaching health board area, where there are no district hospitals, would agree that cross-border healthcare arrangements are effective?

Juliet Brown: Again, I cannot talk for Powys health board. That is really important because we do not manage—

Steve Witherden: The patients.

Juliet Brown: Yes. I can talk for the patients accessing the specialist services. I would like to think—as I said, I am quite new, so I have not actually tested this—that their access to those services is as robust as it is for others working across, but obviously the majority of their healthcare needs are not the services that come through the JCC. None of us really wants to use specialist healthcare services, do we? We hope we are not put in that situation. Our job is to ensure that when people do need to use them, it works.

One of the benefits that we hope will come from the JCC, as I know from conversations with the chief executives, is commissioning expertise. If across Wales we can really put that focus on how to commission effective care and work in partnership with health boards to support them as they develop that approach for their services—that is something that we aspire to do in the future.



Professor Doull: I think your figures are perhaps not incorrect, but the majority of patients from Powys and Betsi who go cross-border will go for non-specialist services. They will be secondary care issues. It is the same for Betsi: most of the patients who cross the border would not be for JCC specialist services.

Q167 **Steve Witherden:** One point that I think really needs to be made is that the Committee has just done an excellent survey on this, and 60% of respondents said that they had experienced delays in the healthcare they received due to cross-border problems. Do you feel there is a risk of a disconnect between the JCC's perception of cross-border healthcare and the lived experience of patients in in my constituency?

Juliet Brown: The lived experience is the proper test, isn't it? We can sit here and talk about how well it is working all the time, but if that is the real experience of people living on the border, that is absolutely not acceptable. Unfortunately, we can only talk from the perspective of the services we commission. That does not mean that I do not feel for those people, or that we should not learn from that survey; we need to be working with our health boards to ask what we do about that. What sits with the health board for them to implement? What sits between us to which we can bring our collective expertise? What is the learning for the JCC? There is always learning from patient experience.

Chair: You can see the evidence we are getting in, and it is not levelled at one particular area. You know your system, but a patient trying to navigate the system does not know any systems. They may be in pain and anxious about waiting for results or whatever, and you can see the lack of data transfers and all those things. We are now going to talk about another issue with David Chadwick.

Q168 **David Chadwick:** Many of my constituents in Powys feel they are treated like second-class citizens when it comes to healthcare. They feel they have been completely forgotten about—as if mid-Wales does not exist in some people's minds. When you were talking about pathways earlier, Juliet, you talked about there being different needs and pathways in north and south Wales, but you did not mention mid-Wales. You totally forgot mid-Wales. That emphasises the point that people in Radnorshire, particularly in places like Llandrindod Wells, just feel totally forgotten about. Why did you forget about Radnorshire?

Juliet Brown: Apologies. One of the things with Powys is—as you know; I do not need to say this—the size of the county. In reality, we have different flows from Powys. It is not a matter of forgetting it, but for some Powys patients access to specialist services is closer in the north and for some, it is the south. Obviously there are unique challenges in Powys. It does not have its own acute hospital provider, so the challenge is how we work seamlessly to enable and support that population to access health. I started off by talking about inequalities, making sure that we are continually questioning the health outcomes from our commissioning and reducing the health inequalities. That does not mean we have to commission the same service for every area. We have to reduce



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inequalities, which means different approaches in different places. That is what we need to be cognisant of.

David Chadwick: Well, please do remember Radnorshire.

Juliet Brown: I will do.

Q169 **David Chadwick:** Have you been to Llandrindod Wells?

Juliet Brown: I have been, not as chief commissioner but as a member of the public.

David Chadwick: I highly recommend it, particularly in terms of putting yourself in the shoes of someone who is told, "Your follow-up appointment for this surgery," or whatever they need, "is going to be on the other side of the border in England," or it could be going for radiotherapy in Cheltenham. Going through that process from the point of view of my constituents—how on earth are people supposed to get there? Could you please talk a bit about how you adapt the commissioning of non-emergency patient transport services to support cross-border patients?

Juliet Brown: I am very happy to talk about the transport services but, in response to that, it would also be great to pick up some of the digital things. Getting transport right is part of it, but if we could treat those patients by them accessing specialist opinion in their own homes, through digital interfaces, we could do away with the need for transport. So both those things come together.

I had many youth club holidays in Llandrindod Wells when I was younger, so I have a soft spot for it.

Interestingly, I was talking to our lead for commissioning for emergency transport services before I came away. Let us look at what we commission for the services in terms of hours of ambulance availability per head of population. In Powys, there are 0.89 hours of ambulances available per head of population, compared with 0.25 hours per head of population in Cardiff and Vale. The availability of ambulance services in Powys is virtually four times what we have in some urban areas. That is a fact; I am not saying it is right or wrong. You would expect to have more, because you have got to reach people in much more rural locations, but the response times are good compared with urban areas. We have a good base to build on. I am not saying that we cannot do more about it, but we do have that in place.

Digital is another area where we should be challenged going forward, and it is where cross-border working will get really important. There is nothing stopping us, even with the quite basic technology we now have. We could have dialled into this meeting from Wales. I know you did with chief executives yesterday. What is stopping that sort of conversation happening between a patient and a specialist in another hospital? That is where we need to be questioning and pushing.



You gave the example of radiotherapy, and patients will have to travel for things like that, but when it comes to certain elements of that pathway, as we dock into the neighbourhood healthcare agenda in England and the community agenda in Wales, we cannot forget tertiary services, which have the power to transform our services more than some of the others.

David Chadwick: This will come down to the needs of the people who require the services. Typically, in Powys, the population is very elderly, and more likely to live in a rural area. If you are talking about digitising more services, you have to factor in that the people who would be trying to use them will be older; they are probably living in a village or hamlet with a poor mobile signal, so they won't be able to do two-factor authentication, for example, and they probably don't have full-fibre broadband to the premises, so they will find it really difficult to download anything you would like them to download. How does the eligibility criteria for non-emergency patient transport services consider the distinct needs of patients?

Juliet Brown: There is a here and now and there is a future on that. We have criteria agreed across Wales for eligibility for the transport services and all our patient transfer support services. The emergency service is obviously there and available in an emergency. We have criteria for our pre-bookable transport services, and any patient can apply to Welsh Ambulance to be considered for that. There is very clear criteria about what is acceptable and what is not. I have not got that criteria, but if you are interested, I will take it away and we can provide that policy. But there are a set criteria that would play into that agenda.

Q170 **David Chadwick:** You mentioned digital solutions. I have highlighted some of the potential problems with those.

Juliet Brown: Agreed.

David Chadwick: What other solutions are you looking into for cross-border patients who may not be eligible for non-emergency patient transport services?

Juliet Brown: On digital, I can talk more through my previous role than my role on the JCC. We absolutely understand people's different ability to use technology, both in terms of their ability and familiarity with it and whether they have broadband, without which they cannot do it, but it doesn't necessarily need to be black and white.

I have been involved in pilots where we put professionals alongside somebody, to be in that appointment with them, so that they could access it. I know you still need the fibre broadband, but there are options, such as transporting someone to a local centre where they can access some of this, which is still much better than transporting somebody miles and miles across a border to somewhere.

We have to really challenge ourselves to be brave and, as you said at the start, put the patient at the centre and ask how we can work with them to get the right solution. Digital provides some of that, but it does not



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provide the answer to everything. Getting the right patient transport provides the answer to some of this.

We have examples of services—my colleagues will be able to give the examples—where we have clinicians from the specialist centres come into, particularly, Betsi and others to provide clinics more locally if the critical mass of people are there. What I am saying is that there is not one answer, but you are absolutely right to challenge us as to how we make sure we are commissioning the right, patient-centred way of access.

Q171 **David Chadwick:** Thank you very much.

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Q172 **David Chadwick:** Thank you very much. I would like to finish with a very quick question about funding. Which side of the border does the funding for all this come from? Is it NHS England, or is it all on the health boards in Wales?

Juliet Brown: I will be corrected if I am wrong on this, but the funding for Welsh patients living in Wales comes from Wales.

Q173 **David Chadwick:** And that is for all transport?

Juliet Brown: I believe that is right.

Q174 **Henry Tufnell:** I want to build on this digital point, and I am also going to do a shout-out for west Wales for my colleagues over there, because you missed out west Wales.

Ben Lake: The west is best.

Henry Tufnell: Yes, the west is best. You mentioned digital and that, if a service is cross-border, you might want to move to virtual consultations with a particular consultant in that area—for instance, in our constituencies out west there is big rurality and very long distances. It was also raised yesterday that you might want to look at changing that appointment to facilitate that transport.

I am not talking about the future; I want to talk about what is happening right now. Is that something that you are working on, or is that flexibility in how the patient is going to access those services part of your commissioning?

Juliet Brown: I guess this is where we work jointly with the health boards and the referring clinicians.

Q175 **Henry Tufnell:** One of the health boards said yesterday that it is currently “pathway by pathway, service by service and clinician by clinician”, and that it happens in particular instances but not routinely everywhere.

Melanie Wilkey: I agree that that would be similar for the specialised services, in that where we are notified that there is an issue, we would work on a pathway-by-pathway basis. Arguably, later starts for patients



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with longer travel times would not routinely be part of the commissioning arrangements that we have at the moment.

Q176 **Henry Tufnell:** So you are not factoring in the difficulties that patients will face if they are living in a more rural setting, for example.

Melanie Wilkey: Historically, we have not, but this is obviously part and parcel of the conversations that we are now having about how we can commission differently and collaboratively to make sure that some of those difficulties are overcome, particularly as there is increased regionalisation at a health board level, as well as in the national and specialised commissioning.

Q177 **Henry Tufnell:** How are you working with NHS England to facilitate travel?

Melanie Wilkey: We do not work particularly with NHS England itself, but we work with individual providers where we know there are difficulties and challenges. Where we have our greatest critical mass of patients, there are things that are more routine healthcare, so we would have those sorts of conversations with our larger providers, or we may have special arrangements in place. For example, for our renal dialysis patients, we have a special hub for organising non-emergency transport, and those things will be factored into their times, and the times of the clinics that are run.

Q178 **Henry Tufnell:** It does not feel very streamlined. From what you are describing, it feels a bit ad hoc and scattergun. Is that a fair assessment?

Juliet Brown: I think healthcare in general—

Q179 **Henry Tufnell:** This is about transport and access.

Professor Doull: There are two issues here, the first of which is the issue of transport in that the JCC is responsible for the NEPTS service. However, a lot of what you are talking about is probably secondary care. We will commission cardiac surgery in Cardiff and Swansea, and some patients will go to England. I think this is how your survey is very powerful—I do not want to say that it is not our responsibility and that we should not learn from it.

Henry Tufnell: But you are saying that it is not your responsibility.

Professor Doull: If a lot of it is secondary care, we do not commission that. From a Powys perspective and from a Betsi perspective, most of the patients who require transport across the border will be secondary care, not specialist care. However, we have responsibility for NEPTS and we have to take on board what you are saying. I am not saying there are not lessons for us as specialist commissioners, but a lot of that is health board commissioned, and I do not think we can be held responsible for health board-commissioned services.

Juliet Brown: May I come in on the non-emergency patient transport, because I think that that might be the nub of what you are talking about?



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We commission that as a service from Welsh Ambulance. Even the secondary care providers, the health boards, are using that and they are sorting out each individual patient, but the contract does sit with us.

There is the contract that is there. There is also the ability for health boards and for us to request additionality, so if a patient did not meet the criteria for the non-emergency patient transport, in exception, we are able to overrule that. That could be because they need repatriating as soon as possible back to Wales, and that is helpful, so let us support them coming home quicker and we will go over and above, and pay for that. There is already that ad hoc bit.

One of the things we have just kicked off—it only started in April—is working with the health boards on a review of our non-emergency patient transport service. To pick up some of the things that I think you are getting at, we have to start looking at this as what the outcomes and inequalities embedded in stuff are, rather than we are just contracting for a service. While we do not have the right answers for you now, I can say that we have started doing that review. Its first report is coming in September. That is one of our eight priorities to look into this year—how we make sure it meets the needs of the people who use it, and is not just a contracted service.

Q180 Chair: We look forward to that report. I am sure we will have a copy of it. In the meantime, you can understand the frustration. As a Committee, we are trying to understand the pathways. There are lots of different pathways and we are looking at it as an overview, but we are not patients, we are not in pain and we are not trying to travel wherever, so just bear with us. As you said, not all of it is your responsibility—I understand that—but, equally, the health boards said yesterday that it is not all their responsibility. We worry about patients falling through the gaps.

Juliet Brown: Completely. As I said, I am new into the service, so I am asking all those questions as well. Some of it is perplexing—I will be completely honest about that. I think where the health boards and we would completely agree, though, is that that complexity needs to sit in the background. As a patient, I need to be able to ring up the Welsh Ambulance Services when I need the transport. I have very clear criteria, which we all work to, that say, “Are you eligible?” If so, ticked, booked, and I can get there. If not, then let us talk about what the alternatives are. That is where we need to be and that is where we need to learn from the patient survey.

It is complex, and probably rightly so, because tertiary services need to have their own focus, otherwise they get forgotten in the vastness of primary care and secondary services—but patients should not feel that. They really shouldn't, and we do not have that quite right. I can see that.

Henry Tufnell: May I read something out quickly, before we move on, because it is important? It is about the statement of principles and values. One of them is: “The overriding principle of this statement is that no treatment will be refused or delayed due to uncertainty or ambiguity as to



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which body is responsible for funding an individual's healthcare provision." That was important to read out, given what you just said.

Chair: That is something that all Welsh health organisations have agreed and signed up to. That is something that we are measuring against here. Let me bring in Steve Witherden. I am conscious of time and I am conscious we are all very hot, so I am sure we will be succinct and concise.

Q181 **Steve Witherden:** I have another question for Juliet on the topic of responsibility. One thing that I and many people in Montgomeryshire and Glyndŵr think beggars belief is that there is no formalised, legally binding agreement that dictates responsibility and the principles of cross-border healthcare. Do you think that there should be?

Juliet Brown: I am again going to be honest—I have not worked in it long enough to see the difference that that would make. I did listen to Nicola talking yesterday, giving an example—only one patient example—of how actually in that situation legality would not make a difference, because we are quite good at just making it work. I would say it is probably the same for specialist services. We have the relationships, which is really important. We also have agreed across Wales protocols that the Welsh Government issue and that we all work to, as to who is eligible and who is not. I think that system works well, but we obviously do have differences. NHS England does commission different services from NHS Wales, so there will always be that ambiguity. Would legality make a difference? I will pass that on to my colleagues. I am afraid I cannot answer that, because I have just not worked in it long enough at this point.

Q182 **Steve Witherden:** Stacey Keegan, the chief executive of the Robert Jones and Agnes Hunt orthopaedic hospital, or Gobowen orthopaedic, as we call it in the constituency, was supportive of the statement of values and principles having a legal footing. Is that the JCC's position on this issue? Is it consistent with that of health providers that deliver cross-border healthcare?

Melanie Wilkey: There are subsets of guidance on cross-border healthcare. We follow that guidance in terms of who pays and the commissioning body responsible for funding the care for that patient. I am not sure what added value putting it in legality would make, but strengthening those arrangements and making it really clear that they are the standards to which we must adhere, rather than a set of principles, could be helpful. However, I do not know if putting it into law would change the approach we take in order to secure healthcare services for our population.

Professor Doull: When I introduced myself, I said that I used to run services for south and mid-Wales. One of the models that we have not explored is the specialist going out to the patients. I used to do a clinic in Haverfordwest. I used to do a clinic in Aberystwyth. I did a clinic in Swansea. The idea that specialisms cannot be offered close to home needs



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challenging. I fully agree with Henry's statement. I would have no qualms at all about signing up to that.

As to whether it needs to be put in law, it should not change anything, because we should all be aiming for the same thing anyway.

Steve Witherden: We should be, but that is not the experience of people on the ground.

Q183 **Ann Davies:** I will make a quick comment before my question. Like Henry, Steve and Ben, we do not have reliable wi-fi in west Wales. It works in Carmarthen, and it might work in Ammanford, but there is no way that people in our most rural areas will be able to get into a Zoom call. Even if you have the most proficient person sitting there, it is not going to happen. I am not saying, "Knock it on the head", but just be very aware that it is not going to work for everybody.

Juliet Brown: It is part of the jigsaw, but I am totally with you.

Q184 **Ann Davies:** I am going to move on to Llais, because you have a representative of Llais on one of your sub-committees. Llais said in evidence to us: "When something goes wrong, people don't know whether to complain to the English provider, the Welsh health board, or both." What is the JCC doing to clarify that position? Who do people go to when a surgery or treatment they receive across the border does not work out and something goes terribly wrong? Where do they go? Who takes responsibility?

Professor Doull: The complaint should initially go to the provider, be that NHS Wales or NHS England. We would normally expect the provider to do an inquiry and a report. We would expect to be copied in and we would make sure that the health board of the residence of the patient was copied in as well.

Ann Davies: So it goes to the hospital first.

Melanie Wilkey: We maintain that information on our website. This goes back to the point about patients not needing to know who their commissioner is, but should it be for a JCC commissioned service, we would direct the patient to the provider if they came to us either through our public-facing communications on the website or directly. If a patient was not satisfied with the response, or if we had a pattern of concerns from a particular provider, we would look to our quality and governance structures, either to make a quality visit or to manage the provider and its action plan to support the resolution of those concerns.

Sometimes when concerns are raised with providers, if it is a JCC-commissioned service, notification of that concern goes to the resident health board, but it would know that it related to a JCC-commissioned service. So things would happen in the background, and we would be aware that that concern had been raised.

Q185 **Ann Davies:** There have been a few issues where it has not been clear



where people should go, so it is important, isn't it?

Juliet Brown: It is really important. Again, it is one of those things that should not make a difference to a patient. We have had the same things in England as well, but you should be able to put your complaint in. If you send it to the health board or the JCC rather than to the provider, then in the background, we should be linking up and passing that on, which we do. But yes, it is really important to promote where to go and make that clear to people. Can we all do more on that? Probably. Should we all be in the background supporting so that patients get supported? Absolutely.

Q186 **Andrew Ranger:** Obviously, in England we are seeing lots of reforms in the NHS: changes to NHS England, the combination of ICBs, a big churn in staff and the anticipated move towards more community-based work, away from hospitals. Similarly, we have a new Government in Wales, who have suggested changes along similar lines, moving care out of hospitals and into communities. That could present lots of challenges and questions about cross-border healthcare.

My first question is to you, Juliet. Given all those changes and disruption, how will you ensure that cross-border patient pathways are protected? When things are changing on both sides of the border, how do we make sure that we do not disrupt those pathways?

Juliet Brown: One advantage I hope I bring is that, for the last 12 years, I have worked in the largest ICB in England, so I have lived through those changes and completely understand the disruption. We went from 1,200 staff to 400 staff as we merged ICBs, and that is huge. Therefore, we need to be working proactively with our neighbours to mitigate that.

One of the biggest concerns, probably more for health boards than for us on the tertiary side, is the loss of organisational memory, because ICBs did not commission tertiary—specialised—services. As we have probably heard, it is not just about organisational memory of how things work but those relationships. I know our team have been proactively reaching out to ICBs, keeping those relationships going and knowing who to pick up the phone to when things are not working. That is important.

There is the loss of memory, and a change for us in how specialised services are commissioned. We have benefited from the fact that those services have been commissioned by NHS England. It has been very useful—I know Iolo docks into that a lot to have clinical conversations, as does our chief nursing officer—that they have been commissioned centrally, therefore you have that central vision in England. We have been able to work very closely. Our chief nursing officer sits on the English thing that the chief nursing officer from England does.

We would not want to see that disappear. One of the dangers—however many integrated care boards we end up with and if specialist commissioning gets devolved to all of those—is about how we get that voice for those services, which is so important. As you say, that is particularly on the agenda when we are all moving to neighbourhood and community healthcare.



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A lot of the specialist services transitioned at the beginning of this year, so we are still working through that. The body at NHS England is still in place, and that is great. It will be interesting—we would love your support on this—as we go to April 2027, and more gets devolved and NHS England moves into the Department of Health and Social Care. That national view on tertiary services and specialised commissioning will be really important for us.

That is the first two parts. The third part is the neighbourhood health framework, as it is called in England, or community by design, as it is called in Wales. Effectively, both are aiming to do the same thing, and both are really important. Again, we all want people to access healthcare as locally as possible. As a resident and as a patient, that is what I want. It is much easier to think of that for primary care services and local hospital services, but I urge that we always keep tertiary and specialised services on that agenda as well. As we have talked about, be it digital solutions, patient transport solutions, or whatever the solution is, if we can marry that localism agenda, and neighbourhood and local community agenda, with the specialist, we are going to make a better patient experience.

I sit on the board for Wales for community by design, so it is built into how that is organised that we have that voice at the table and on how we take that forward. I know that Iolo is on the clinical working groups and working through that, and Mel is equally involved. So I think we have the right architecture in to help it succeed; we just need to ensure that that focus continues.

Q187 Andrew Ranger: You have touched on the second part to my question already, so I will bring that in now. Sarah Walter, the deputy chief executive of the NHS Alliance, said in recent evidence to us that there has been a loss “in the commissioning capability within the NHS.” That was a point you were talking to. How do you anticipate the NHS England reforms will impact on that, and on cross-border specialised commissioning as well? Iolo or Melanie, you might want to come in on that and add any extra thoughts on top of what Juliet was saying.

Melanie Wilkey: I think commissioning has been a very under-represented discipline in Wales for a long time. That is partly because of how the integrated health boards have been established: that formal commissioner-provider relationship within local health systems does not exist in the same way that it does in England—although, arguably, an integrated health board is in and of itself a commissioning body because it is securing those health services for its population.

We are therefore ideally positioned in the JCC to support, collaboratively with the health boards, how we strengthen our own commissioning arrangements. I think we will start to see that developing as the JCC develops. But reflecting on what Juliet has said around the fact that we have lost some of the relationships—you ring up somebody who you spoke to a couple of weeks ago and they are no longer there—there will be an impact from that.

Also, some of that movement to more local commissioning could actually be helpful for us, because our largest cross-border relationships are with trusts in the north-west and the midlands for the mid-Wales and north Wales populations. Having an ICB that is also responsible for specialised commissioning from those providers will be helpful for us in those sorts of local relationships. So I think a more local approach from the English commissioners will be beneficial to us in the long run, but we need to make sure that we maintain and sustain the relationships as we go forward.

Professor Doull: It is important to emphasise the complexity of specialised and highly specialised services. I think NHS England had around 200 different services. The more common specialised services have been devolved to the ICBs, but 50 services are retained by spec comm, which will move to the DHSC.

We have always had close links with spec comm. I sit on the clinical priorities advisory group in spec comm, and on the rare diseases advisory group and the specialised services oversight group, which was a UK-wide group looking at specialised services. Currently, spec comm—or the rump of it—will still be holding the ICBs that will be leading on specialised services to account, but it will be interesting to see how the funding works out with NHS England. But yes, we do have close links with them.

Chair: Thank you. I will bring David Chadwick in for one more tiny question in this last minute.

Q188 **David Chadwick:** Juliet, I think you mentioned a potential fear about the removal of the chief nursing officers, or a similar term. Could you quickly flesh out what that would mean and what they contribute?

Juliet Brown: It is not the removal of chief nursing officer from ICBs; I was sort of giving an example. Our chief nursing officer sits on the committee—I think it covers England, with the devolved nations included, rather than being UK-wide—that looks at specialist services across England. That is still working at the moment, despite some of the specialist services having been devolved.

My worry—it is a fear; I have nothing to base it on, and I have not spoken about it—is that, as more services get devolved, with the changes with NHS England, moving to DHSC, and just the uncertainty as staffing changes, it is important that we keep those clinical links. Iolo has talked about a few; these are highly specialist services that not many people in our countries combined have experience of, and we do not want to dilute that expertise by losing that coming together of them.

Chair: That makes sense, and certainly we will be looking out for that as we go forward. Obviously, if there is any impact on Wales, we will instantly be looking at that, so please be reassured that we will be looking.

I am just conscious of time, and of the heat, so thank you so much to the three witnesses, Juliet Brown, Melanie Wilkey and Professor Iolo Doull, for



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coming before us in person today in spite of the heat. I wish you safe travels home. I now declare this session closed.