



Welsh Affairs Committee

Oral evidence: [Cross-border health arrangements between England and Wales](#), HC 404

Tuesday 18 November 2014

Ordered by the House of Commons to be published on 18 November 2014.

Written evidence from witnesses:

- [Welsh NHS Confederation](#)
- [Betsi Cadwaladr University Health Board](#)
- [Jesse Norman MP](#)
- [Action4OurCare](#)

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Members present: David T. C. Davies (Chair); Guto Bebb; Geraint Davies; Glyn Davies; Nia Griffith; Simon Hart; Mrs Siân C. James; Jessica Morden

Questions 1-81

Witnesses: **Alan Brace**, Interim Deputy Chief Executive and Director of Finance and Procurement, Aneurin Bevan University Health Board, **Angela Hopkins**, Executive Director of Nursing and Midwifery, Betsi Cadwaladr University Health Board, and **Helen Birtwhistle**, Director, Welsh NHS Confederation, gave evidence.

Chair: Good morning. Thank you very much for coming to talk to us this morning. We have quite a few questions—mainly of a factual sort, so nothing to worry about. Could I ask Siân James to start?

Q1 Mrs James: Good morning. The question is to all of you. It is on cross-border flows. What are the main reasons for cross-border flows of patients across the three categories—primary, secondary and tertiary?

Helen Birtwhistle: Bore da; good morning. Thanks for giving all of us the opportunity to take part in this session. Would it be helpful for me to give a brief explanation of where cross-border flows come from, and also of the structure of the NHS in Wales, which has changed since the last inquiry into cross-border arrangements in 2009? I think that is relevant to the reasons for the cross-border flows.

As I am sure you are aware, there are seven integrated health boards in Wales, responsible for everything to do with their population's health, from community and mental health—primary

care—to acute secondary care, and for providing or commissioning tertiary care. There are some elements there that will be very relevant to this question. Then there are three all-Wales NHS trusts. As you know, essentially, the Welsh health service is a planning system, so there is no purchaser-provider split and no internal market.

We are here to talk about cross-border flows on behalf of our members and organisations respectively and, therefore, on behalf of patients, who use cross-border services every single day. It is important for me to say that we are not here to speak on behalf of the Welsh Government or on Welsh Government policy.

The challenges faced by the NHS in Wales—very relevant to cross-border flows—are common to all health services across the UK: an increasing older population, rising demand for services, tighter finances and increasing costs. While the number of patients using services across border is relatively small, it is no less important that the service that each individual receives is the right one for them, and that it is safe and of high quality and delivered with compassion and respect.

In terms of the statistics—Wales has a population of 3 million, as I know you are all aware—it is perhaps surprising that there are more English patients registered with Welsh GPs than vice versa. We have more than 20,000 English residents registered with Welsh GP practices, so that is a cross-border flow from England to Wales.

Q2 Nia Griffith: I am sorry to interrupt you so early, but could I ask a question about that? We hear a lot about Welsh patients going to English hospitals. Does Wales receive money for English residents who are registered with Welsh GPs?

Helen Birtwhistle: There are 20,000 coming in and 15,000 registered the other way. That is not included in the—

Q3 Nia Griffith: There is nothing for primary care.

Helen Birtwhistle: No, not as such. I think that is right.

Q4 Nia Griffith: It is only at secondary care level that money changes hands.

Helen Birtwhistle: Yes.

Q5 Chair: So we are 5,000 down from a Welsh perspective.

Helen Birtwhistle: Yes, if we were looking at it in bald cash terms.

Q6 Nia Griffith: As the Chair said, we are providing GPs for 5,000 additional residents, and that is done free of charge to England.

Helen Birtwhistle: Yes. That flow may be surprising to some people. When it comes to secondary care, however, the cross-border flow is generally from Wales to England. This answers your question directly. That flow is most often in mid and north Wales. It is due partly due to geographic convenience, but also to the lack of secondary care in some areas. I am sure that you are aware, for example, that Powys Teaching Health Board has no district general hospital. Its patients are significant users, and therefore significant supporters, of services across the border in places such as Hereford. Those are the key reasons for the cross-border flows of patients.

Putting the individual patient at the centre—as we would all advocate that we should be doing—there are several key areas that we think should be improved in relation to cross-border flows. Those include improved communication with cross-border patients, which needs to be standardised and consistent across the Department of Health and the Welsh Government. We know

that many people do not really know the system under which they are receiving services, and why should they? They just want the best possible service, and that is what we advocate for them too. There needs to be better integration of information services to do with cross-border flows, and more joined-up consultation when service redesign that will have an impact on cross-border services is being considered. We are seeing that quite a lot at the moment.

Our aim here today as representatives of the NHS in Wales—my colleagues are Angela Hopkins, from Betsi Cadwaladr university health board, and Alan Brace, from Aneurin Bevan university health board, which are both health boards that have cross-border implications—is that patients receive the care and treatment they need, and that it is of the highest quality and offers them compassionate, respectful care, irrespective of whether they live in England or in Wales. We advocate that we are a national health service, and our focus should be on each individual patient.

With funding very tight, the fact is that the NHS has to make difficult decisions about the future shape of health care services and about priorities. On both sides of the border, we are facing very similar challenges—the demographic challenge, very tight funding, increasing technologies and increasing costs. The most effective approach for a cross-border service should be one that is always patient-centred and includes the input and support of the public, politicians and, indeed, staff on either side of the border. I hope that gives some context to your question and the reasons for those cross-border flows.

Q7 Mrs James: To tease it out a bit more, you mentioned Betsi Cadwaladr and Aneurin Bevan and you talked about the specific problems of not having a large district general hospital in the mid-Wales area. Can we assume from that that the main exchange is in those three areas—along the Monmouth border, up into the Hereford-Shropshire area and in the north Wales area, close to Cheshire.

Helen Birtwhistle: Yes, certainly when we are talking about day-to-day cross-border flows and people going for acute services. There are some very specialist services that are accessed by people from across Wales, but in the main what we are looking at today are the areas you have identified.

Q8 Mrs James: What are those specific tertiary services? Are they maternity services?

Helen Birtwhistle: No. They are very specialist cardiac services and things like that. Alan or Angela may have more information on those.

Alan Brace: It could be a range of things such as complex paediatric care or cardiac surgery. It could be individual patient treatments for very specific genetic conditions. There may be a centre identified in England that has some expertise in that area. Basically, it is a range of specialist services, from specialist children's services to adult services.

Q9 Mrs James: We read a lot, and hear a lot from our constituents, about the problems they have accessing those services in England. Do you pick up on any problems when you buy in tertiary services?

Angela Hopkins: I would say not, from a north Wales perspective. We have good working relationships with those tertiary providers. For example, Stoke is a hospital in England that we use for patients who have polytrauma—multiple, very complex traumatic cases. In north Wales we want to access the very best clinical services, with the clinical experts for that. Stoke currently provides that service for north Wales. We do not have difficulties. There will always be individual cases where difficulties will be cited, but it is about how we all work together—NHS Wales, NHS England and, in particular, the clinicians and commissioners who work on both sides of the border—to ensure that when there is a patient need it is addressed swiftly and we can access services appropriately.

In terms of cross-border flows for things like tertiary provision, I have been 40 years in the NHS and I can say that there have always been movements of patients for highly specialised services that may not be provided either in a region in England or in a part of Wales. While some of those highly complex cardiac services would be available in, say, Cardiff, our flows in the north Wales area are more towards the north-west of England. Access to services would be through that flow. With 40 years' experience, I can say that those flows have always taken place. It is about how we continue to work very closely. As Helen said, it is about the NHS as a whole, with the patient at the centre, being sure that we can access services for those individuals.

Q10 Mrs James: You touched upon communications and the integration of services. Is the cross-border protocol working? Do we need more pressure for improvements?

Helen Birtwhistle: An overarching view of that is that the cross-border protocol and its revision are certainly helping. There is still room for improvement in terms of tightening up relationships. My colleagues have more direct experience than I have, because we are a membership representative body for the health boards and trusts in Wales, but I think relationships are at the heart of how the cross-border protocol works. We have some good examples of very strong relationships between the health boards and trusts in NHS Wales and their counterparts across the border. That is where we are seeing real improvements for patients.

Q11 Chair: I really appreciate the way you answered that, but that is just the first question. Perhaps we could look on those as opening comments, but we may need to up the tempo.

Helen Birtwhistle: Of course.

Q12 Nia Griffith: We now have two systems developing, with the clinical commissioning groups commissioning services in England, and in Wales we have our LHBs planning and delivering. Can you explain a bit about the difference between the ways those two systems work and what it actually means for the patient seeking treatment?

Helen Birtwhistle: Yes, we have two different systems and two different architectures. I alluded to the fact that the NHS is a planning system, and there are integrated health boards, which are responsible for their population's health. The important thing in terms of the service for patients from the different systems and architectures in England and Wales is that the two talk to each other, and that there is some flexibility in making sure that the relationships between a commissioning system and a planned system are such that patients do not fall between two stools. My colleagues have direct experience of dealing with the commissioning groups.

Alan Brace: We should not lose sight of the fact that we are a planning system—a population health-based system—but to discharge those responsibilities we need both to commission with providers outside our own boundaries and to use some of the commissioning disciplines in terms of our own services and how they develop.

For me, one of the big differences is that you take a slightly more strategic view because of those responsibilities. We are trying to take a longer-term view of how we are developing health services and how we see some of the shifts away from hospital into primary and community services. It gives us an opportunity to look quite seriously at inequalities. There are very different geographical patches in my own health board. How we use and move resources to meet those needs is one of the developing features of the Welsh system.

The thing that I do not miss from when we had a commissioning and provider system is the transactional process, and the conflict that invariably goes with debates around contracts and money. Very often—I am a finance director—it became too much the preserve of finance professionals in terms of contracting and all that it meant. It is quite refreshing that now a lot more clinically-led change is going on within the Welsh system. That is becoming a developing feature.

Q13 Nia Griffith: Can I push this a little? Obviously we do not have somebody here from Powys. Leaving aside tertiary—we understand the need for specialist services and very specialist centres—would you say that the current situation is driving you to try to provide as much of the secondary as possible within Wales, rather than paying for people to go over the border?

Alan Brace: Not for me. Probably the early phase of being health boards was to have a long, hard look at what you do within your own services and what you commission outside. Aneurin Bevan health is a net commissioner; we spend £73 million of our £1 billion allocation outside our own boundaries. The bulk of that is with Welsh providers. It represents traditional, historic flows of activity to Cardiff or other parts, as well as the cross-border relationship. A lot of what we are doing now is looking to secure good outcomes—good patient quality and good patient safety—and to do that with good value. From our point of view, that may mean having a relationship with Bristol. Outside the protocol, we have fairly long-standing relationships with the two Bristol trusts, because for a lot of our population that is a natural flow. As long as they can assure us on the outcomes, and there is good value from the investment in those services, that becomes part of our longer-term planning in relation to capacity.

Q14 Nia Griffith: The other issue is registration. Obviously patients are registered where their GP is. What are the advantages and disadvantages of having registration based on the GP's location rather than the residency of the patient?

Angela Hopkins: It is often the case that it is the nearest GP to the patient. It is obviously patient choice, in terms of who they register with. Certainly in some of the border areas, there is a Welsh GP and there may not be an English GP who is as local. It is patient choice to engage with the GP and register there. The issue is how we ensure that patients who are sitting on the border can access services appropriately. As Alan said, we commission services with others, both inside Wales—within the integrated health system—and outside. We know that patients who register with Welsh GPs will gain the benefits of the Welsh health system. One benefit will be no prescription charges, for example. It is about how we ensure that patients, wherever they are placed, can access the best treatments, depending on their clinical need at the time.

Q15 Nia Griffith: Do you think the reason why some English patients register with Welsh GPs is that they can get free prescriptions?

Angela Hopkins: I would not like to say. Most of the patients we communicate with look for a GP who is local to them. We know that the vast majority of contacts in NHS Wales are in primary care. That is often the case in England as well. The majority of contacts—over 90%, in many cases—are with primary care, with the general practitioner, so people want their own GP to be local to them. If they are on the English side of the border but their nearest GP practice is in Wales, it is patient choice to register with the local GP, because that is where they will get the majority of their NHS services.

Helen Birtwhistle: I have something that may help. It is an example from Powys, which you mentioned, because there is nobody here specifically from Powys. It is about registration with GPs on either side of the border. Powys and the clinical commissioning group in Hereford identified that there was confusion with patients around community nursing because of where they were registered. There has been an agreement, which came to fruition only from September this year, that all patients registered with a Powys GP will have community nursing provided by Powys, and that all of those registered with a Herefordshire GP will have community nursing provided by Herefordshire, irrespective of postcode. That is an example of people going to the GP who is most convenient to them, as Angela said, but we are trying to eradicate some of the confusion that stems from their having cross-border registration.

Q16 Geraint Davies: You mentioned the benefit of being registered in Wales for getting prescriptions. As it happens, my daughter is now living in England as a student. She is registered in England and is finding that it takes something like two weeks to get a GP appointment; when she was in Swansea, it would take one day. Aren't people opting to have GP registration in Wales because the service for getting GP appointments is much better?

Angela Hopkins: It would be difficult for me to comment on the individual reasons why patients choose as they do, but our information shows that they choose mainly because of location. There are benefits on both sides. I could not comment on that particular example.

Q17 Geraint Davies: Do you have any data on waiting times for GPs?

Angela Hopkins: We collect the data for Wales. We have information, and we know that the increasing pressure on the health service as a whole, across the UK, is very regularly played through in the media, with patients citing long waiting times to access GPs in various parts of the country, regardless of which country you are in. That just demonstrates that the NHS as a whole is under significant pressure, for some of the reasons that Helen reported earlier, with the demographic changes in the population and an increasingly ageing population. It is a wonderful thing to be able to say that. It means that the NHS is working well and that people are surviving longer, which is something to be celebrated—

Q18 Geraint Davies: I know that we do not have the data, but do you agree that these delivery issues may be patchy? It may be the case, for example, that in Swansea the GP delivery is better than in some other parts of Wales or England; London may be worse than some other parts of England, or whatever. Nobody knows yet, do they?

Helen Birtwhistle: I do not have those specific data.

Q19 Geraint Davies: That is fine.

Helen Birtwhistle: It is always difficult when you pick on individual cases. I am sure that there are often cases—

Q20 Glyn Davies: My question is on the same issue. I would like to take it a little further. It is to do with the availability of GPs. In mid-Wales—in my constituency of Montgomeryshire—a typical wait to see a GP would be four weeks or more. The problem we have is securing GPs to come and work in rural areas. I went to a conference of GPs from all over the UK at Gregynog. It is fairly common across the UK that in rural areas it is now becoming very difficult to attract GPs. Is that a particular issue in Wales, resulting in very long waiting times simply because there is a lack of GPs?

Helen Birtwhistle: Recruitment issues are well documented throughout the UK. There are sometimes particular issues in rural areas. Reliance on GP practices and primary care is significantly greater in rural areas, for the reasons that we have given. In Powys, in particular, there is no district general hospital, so it is a different sort of system.

There are ways of attracting and recruiting GPs. One thing that is pertinent to the point you raised is the work force medical performers list that operates in England and Wales. At the moment, as I understand it, there are two separate performers lists, one for England and one for Wales. We would recommend a single, robust process that is followed rigorously across the four home nations, enabling GPs to have the freedom to work in whichever area of the country they wish. At the moment that can be a bit of a barrier. GPs have to apply separately for inclusion on the Welsh list. Sometimes, it is just something else they have to go through, and they might choose not to do that.

Q21 Simon Hart: On the point about availability, as Glyn raised it, I am in west Wales and some of these cross-border issues are just as relevant there, funnily enough; it is not all about being 25 miles from the border. On GP recruitment, to what extent has research been done into what the deterrents really are? I could take you to two or three surgeries in my own patch where it is not a money problem—you simply cannot get people to apply for the posts that are available. Some theories have been put to me as to why that might be. In a wider context, what theories do you think might be applied?

Helen Birtwhistle: I can see that Alan is itching to go here. In very general terms, the whole process of primary care is changing. Making it so that GPs are not the only people who are able to see patients on particular things—having much more integrated, multidisciplinary primary care practices—is the way to go. That will help to attract GPs as well. I know that Alan has some key points to make.

Alan Brace: It is a national problem. The first thing is the age profile of GPs. A lot of them are now at the older end of their careers. It seems that general practice generally is not that attractive to some of the new medical students coming in.

There are two things in the feedback that we get from our GPs. One is the demands of general practice, and the second is the model itself. Working in a small practice where you are expected to deliver the full range of care, from paediatric right through to complex elderly care, is becoming a more and more difficult model to work within. As Helen said, the response from most of us is to look to federate practices—to start to get practices working together differently to serve a population that is smaller but broader than that on normal practice lists. The second strand is to bring a lot more expertise into those practices—to strengthen nursing and community services and to work closely with social care—so that the demands on primary care are spread across a multidisciplinary team. There is certainly an issue around the attractiveness now of general practice for medical students, and that is a UK issue.

Q22 Simon Hart: It has been put to me—I do not know whether you agree with this—that the GP contract has a part to play in all of this. For example, I wonder whether any research has been done into the availability of GPs in practices. There seems to be a discrepancy between the availability of partner doctors and that of non-partner doctors in practices. It has been said to me that no politician wants to approach this because it is a bit of an elephant in the room. Do you have any evidence in your own areas of partner doctors not being that available in some of their practices and relying on a relatively overworked and under-resourced non-partner doctor? With a journalist in the room, you may not want to answer that question, but it has been put to me as a significant problem in west Wales. I wonder whether you have a view on it.

Helen Birtwhistle: I think GPs work very hard. I certainly have not heard that, anecdotally or otherwise. Personally, I have no evidence of it. As Alan said, there are different ways of modelling the way in which GP services are delivered. Some areas are going to create salaried GPs, who work in an entirely different way. For us, looking at health services as a whole, the shift that we are all advocating, on either side of the border, from a default position where everybody goes to hospital to one that is primary care based—not just GPs—is important. You will have heard about the concept of prudent health care, which is about only doing the right thing at the right time, with the people who are giving the service being the only ones who are able to give it, so that we make sure that GPs are not doing work that other practitioners could do. That is a really important point.

Q23 Chair: I am ever so sorry, but at this rate we will not get through everything. We may write to you and put some further questions afterwards. You very kindly explained in simple terms that Wales operates a planning system and England operates a market system, if you like. What happens if we are

using planning within Wales, based on historic activity, and three quarters of the way through the financial year one discovers that too much money has been given to one hospital and not enough to another? Is there a means of moving that money around after it has been allocated?

Helen Birtwhistle: We have a finance director here—

Alan Brace: Could I ask for clarification?

Q24 Chair: You put it in very simple terms, which I appreciate; that is good. Basically, in Wales you plan what you are going to have. A hospital in, let us say, Abergavenny previously used about this amount of money and had that many patients, so we will assume that it is the same again this year and we give it the money to cope with that. What happens if those patients do not turn up or if there is a sudden increase in the number of patients in one place and a decrease somewhere else? Planning is not going to cover all situations—all eventualities—is it? Do you have the capacity to take money out of one place that has been given it and put it into another that needs it?

Alan Brace: Yes, absolutely. Within our own services, planning is one dimension; the other is the way we have organised ourselves. For example, our surgical services are delivered, organised and managed across all of Aneurin Bevan. As a division of our organisation, they work flexibly between all of our sites. That will be around constant demand-capacity management through the year.

Q25 Chair: I should have been a bit clearer. What happens if more capacity is needed outside the Aneurin Bevan health fund and less within? Can you look at this at an all-Wales level, or does it have to be done at a health board level?

Alan Brace: No. If you take us as an example, we start the year with a plan for our own services, within our own catchment. Then we will have very formal agreements—what we call long-term agreements—with places like Cardiff, for our Caerphilly population. Then we will have contracts with Bristol and across the border in Gloucester. At the start of the year, we agree demand-capacity assumptions and money, and they form either contracts or heads of agreement. Then we monitor that on an almost monthly basis, with teams in Wales and teams in England. Very often, if they can offer more activity and we believe that we have demand, we flex that agreement to accommodate it and we pay some additional money at the year end to pick that up. If they do not deliver on the demand assumptions, the agreements normally allow money to come back to Aneurin Bevan.

Q26 Chair: When you commission services from England, you will, in very simple terms, say to an English provider, “We want x number of patients to be given this particular treatment. We are going to pay you a lump sum up front or at the end of the year.”

Alan Brace: Yes. Most of them will be annualised agreements for a certain level of activity, at a certain price cost. That is changing a little. It is not a Welsh-English relationship issue; this year for all of their referrals Gloucester are looking for elements of prior approval from all their commissioners, so we will almost prior-approve most of the activity that goes there, and that will feature as part of our agreement. If we use more activity than they have asked our approval for and we have approved, we will pay them an additional cost at the end of the year.

Angela Hopkins: In Wales, we are moving to a three-year planning framework as well; all the plans have to be delivered by this coming January. Across Wales, the health boards and trusts are developing three-year plans so that there is a much more integrated view in terms of all the services, the population demands, the known flows and how we then plan services within individual health boards, but cognisant of other pressures in other parts of Wales.

Q27 Chair: The basis of what you are saying is that one is a market-based system and one is a planning system. Let us say that you wanted to commission a provider to undertake 100 hip operations. If you were going to England, you would pay a fixed price for that and you would know what the price was, but if you wanted to do it in Wales, would you or wouldn't you know what the price was? If you would, what really is the difference between England and Wales? You are still getting a price from a provider for doing work, which is exactly what happens in England.

Alan Brace: In all systems, whether it is in England or Wales, there are basic elements of demand and capacity planning, whether it is market driven or a planning system. Then there is the whole question of cost and value, which is more linked to outcomes, and they do not differ under any system. In our agreement with Cardiff, they would want to understand what our demand assumptions were, exactly as Bristol would. We would then have a conversation about capacity and the costs of that capacity, as Bristol and Cardiff would. Then we would plan with both of them to put those arrangements in place.

Q28 Chair: It sounds as if the differences are a bit smaller than everyone is saying. Everyone is working on the assumption that there are huge differences between the NHS in England and the NHS in Wales. From what you are saying, in terms of commissioning there are quite a lot of similarities.

Alan Brace: Yes. All of us are trying to specify what we are trying to achieve to meet the needs of our population. The only real difference is how you transact it. In England there are very separate organisational models, with very high transactional costs, to do that. In our system we have tried to simplify all of that and break down some of those boundaries.

Chair: Thanks a lot. I would love to carry on with that but I had better not, given that I am having to shut everyone else up.

Q29 Jessica Morden: Access to services and the referral policy have been raised by quite a few people on the web forum that is up and running for this inquiry. Can you explain from the patient's point of view a bit about the process by which patients seek prior approval for a referral to a secondary provider outside Wales?

Alan Brace: In Aneurin Bevan, we have an out-of-area referral policy. There are probably three different ways that people access services outside our borders. One is through a long-term agreement or a contract, where we sit down with our provider and agree a certain level of flows. Another is when a general practitioner approaches us because they want us to consider placing a patient somewhere else, for some reason, for a service where we already have arrangements in place. The location of the service would go through our prior approval process. We would have a look at why somebody was looking to access a service that we could provide either ourselves or through some contract agreement, and we would consider each case on merit. The only other issue is what we call individual patient funding requests, where it is normally not about the location of the service but about the type of treatment. That goes down a separate process that is clinically led, where they look at the clinical reasons why the patient would need to go somewhere outside our normal services to access treatment. Those are normally the three ways that people access services outside our normal boundaries and services.

Q30 Jessica Morden: In 2012 you introduced a policy, which you referred to earlier, to minimise referrals outside Wales. In 2013 you changed the policy to allow some referrals to certain English hospitals. Can you explain a bit about how you came to change that decision?

Alan Brace: It started when we became Aneurin Bevan health board. We were formed from five former commissioning organisations and one big providing organisation. We inherited about £73 million-worth of flows of activity outside our normal services. A lot of it was based on the practices of the five former local health boards—the commissioning organisations. What we

sought to do as part of our medium-term planning was put that on a better footing—to make sure that there were good, valid reasons for it. In a lot of the engagement with our local population, people talked about more local access to services; car ownership was an issue. People were looking to us to start to develop services closer to their communities, and not to seek services outside. We were also going through quite a big hospital development programme, with new hospitals in Blaenau Gwent and Caerphilly, so we had that to consider as well.

We developed what we called the out-of-area referral policy, which was to try to make sure that we planned properly for all the activity outside our own services. A lot of that resulted in having more formal contracts in place and redirecting certain referrals to where we knew we could get good quality at a reasonable investment. The error that we made was, I think, for our English residents on the border registered with Welsh GPs, when we asked them to seek prior approval. We had a lot of appeals as part of that process. We were approving all of those because they represented normal and historic flows, so we revised the policy and put those arrangements back in place. That was probably the one that generated a lot of concerns among English residents registered with Welsh GPs, who had normally accessed their services, under the protocol, with English providers, so we just reversed that bit of it. The rest of the policy has been quite successful and has allowed us to develop a lot more services closer to communities.

Q31 Guto Bebb: First, can I support the anecdotal evidence of my colleague from Pembrokeshire? Not in my own constituency, as it happens, but in other parts of north-west Wales there is certainly the view that there is a difference between the work taken on by partners in GP practices and by some locums, for example. It is anecdotal, but you need to think about that.

In terms of north Wales, the first point is that I agree entirely with the comment about specialist services provided in the north-west of England; they have been part and parcel of the north Wales health service for as long as I have been alive, and I have lived in north Wales all of my life. It is important to highlight that it is not people fleeing from the Welsh NHS to the north-west; it is part and parcel of the way services have always been provided.

Concerns have been highlighted about the potential financial shortfall in Betsi Cadwaladr at the end of this financial year. Back in 2011 there were some concerns about heart surgery, in Liverpool, for example, not being commissioned because of financial concerns. Is there any possibility that that sort of problem will arise in the next three or four months, to the end of the financial year? Clearly, when your specialist services are provided in England, any threat to their being available is something my constituents would be very concerned about.

Angela Hopkins: Quite rightly. We appreciate that that is always a concern when the issue of finances in health boards—or indeed, in trusts in England—is considered. As Alan pointed out, for historic flows and when we are commissioning on a regular basis against a population base—for example, if we know roughly how many tertiary services we would need to use within a year—we commission those services. We have contracts with our external providers, which relate, as you rightly said, to those historic flows. As a health board, we are working very hard to address the financial deficits that are very much in the public domain, but there are no threats to services at this time.

Q32 Guto Bebb: None whatsoever? Is the same true for the rest of Wales, in your opinion?

Alan Brace: On specialist services?

Guto Bebb: Yes.

Alan Brace: Not that I am aware of.

Q33 Guto Bebb: The previous examples we have had will not happen in this financial year.

Helen Birtwhistle: The reality of the situation is that, as we all know, finances are extremely tight everywhere in the UK, on either side of the border. Part of what we say all the time is that that means that really tough, difficult decisions have to be made, which have to be about prioritising and modernising services. That work is going on all the time. We have to be realistic about the future pattern and provision of health services. On both sides of the border, we are still in many cases trying to prop up a system that is more than 50 years old, and things have changed; I am talking in general terms now, not about specialist services. Things have to change to be able to accommodate the increasing needs of the patients who need those services.

Q34 Guto Bebb: I accept that, but I was referring specifically to the concerns about the financial position of Betsi Cadwaladr.

There is another issue we need to touch upon, which relates to GP services as well as the difference between the English NHS and the Welsh NHS. The NHS Confederation made it very clear that the differences between the IT systems used in England and the IT systems used in Wales are increasingly becoming a problem in relation to the way information is then returned to GPs in Wales. What steps are being taken to try to deal with that? What is the consequence of that IT disparity between Wales and England when so many services in north Wales are dependent upon providers in England? How do you deal with that issue? How much of a problem is it?

Helen Birtwhistle: There are always issues with the compatibility of IT systems. As we are beginning to rely much more on IT and technology, we know that it is increasingly important. Hopefully I can provide you with the detail, if that would help. I do not have it at my fingertips, but I know that some very specific cross-border projects on relationships between the different systems are happening. We need a concerted effort, across the UK probably, to look at making our IT systems much more consistent and compatible.

Angela Hopkins: In terms of IT systems, in Wales we are looking at integration that goes across health and social care—that comes all the way through from primary care and, obviously, back, but also crosses social care boundaries, because patients, as we would classify them in NHS Wales, are also our population, and they are accessing social care as well. It is important that the correct information is shared.

We have information-sharing protocols between Wales and England. I will use the example of safeguarding information about children or vulnerable adults. That is absolutely critical information. There are good relationships between Betsi Cadwaladr and our partner organisations over on the Cheshire border. For example, on looked-after children, in north Wales we are net importers—if you like—of children who require care for a period of time. It is crucial that those information flows are improved further. They are good now, but the development of integrated IT systems would further improve the position. I give safeguarding as an example, but it applies right across the board in health and social care.

Q35 Guto Bebb: Clearly the answer is that developing streamlined and integrated systems is important.

Angela Hopkins: Absolutely.

Q36 Guto Bebb: Who should be leading on that?

Angela Hopkins: It is for both sides. It is for NHS Wales—the Minister for Health has taken a key interest in the development of integrated IT systems in Wales and is now chairing that group—but it is important that we do it on both sides. If systems are to be integrated, it will rely on both England and Wales working together to achieve that.

Q37 Glyn Davies: I live in Powys, so you will understand why I take such a huge interest in what happens in Shropshire. I probably spend a day every couple of months in Shropshire with commissioners and deliverers. We have reached the stage where the service in Shropshire is collapsing, in many ways, and it is going to have to be changed. It just cannot carry on as it is because of the implications.

I want to raise one issue that impacts on Wales. Where I live, A and E is probably the most controversial and concerning part of the service, and key to that is the ambulance service—the great distances and the availability of ambulance services. Last week they told me in Shropshire that ambulances were waiting outside the Maelor hospital, unable to discharge their patients. Sometimes patients wait there and are then referred back to Shrewsbury, to be treated in that A and E. That is freezing up the ambulance service and severely damaging performance in Shropshire.

I am not raising this as a complaint or anything like that. It just seems to me that the relationship between the ambulance services on the two sides contributes to the wait, and makes the hospitals in Shropshire much further away. The movement from Shrewsbury to Telford uses Shropshire ambulances only. Very often a patient who goes to Shrewsbury has to be moved to Telford, and vice versa. The ambulance service is freezing up the system. I am told—I do not know whether or not it is true—that ambulances are waiting outside the Maelor for longer, patients are not being taken in and sometimes they are being referred back to Shrewsbury because they have waited too long.

Helen Birtwhistle: Angela may have the specifics, but I will start on that. We know that the Welsh ambulance service has been under tremendous pressure. Demand has increased exponentially, and there are moves afoot. There is now a new system for the working through of ambulance services, which is very new and is being tested. There is an ambulance commissioner working on behalf of the health boards. They work with the ambulance service as an integral part of the whole unscheduled care service, which means the A and E service and transport of patients, both in Wales and outside Wales. Huge, concerted efforts are being made with the ambulance service, but we know that there are still some localised problems. Those are addressed very quickly on a case-by-case basis, but we know that it is not perfect and there is work to do.

Angela Hopkins: As you rightly say, A and E services are severely challenged—again, across the UK. Over the weekend we read in the media about the hospital in Colchester where they had very particular problems. In north Wales we have three district general hospitals. We manage demand as much as we can within those three hospitals, so obviously we are co-ordinating and liaising with the Welsh ambulance service to make sure that patients access hospital services, if they are attending A and E, as quickly as possible.

It is correct to say that there is some cross-border movement to the Countess of Chester hospital. Some of those are historic flows; for example, the ambulance service will generally take patients from Deeside to the Countess of Chester, because that is their nearest A and E department. It will take the patient to the nearest place in terms of clinical need. It is correct to say that there are challenges—not just on the borders—with A and E services. It goes back to Helen's point that all of us, across the nations, are having to look at how we deliver our hospital services, for both scheduled and unscheduled care, in a different way. With the demographics that we have now, there are significant challenges. A and E services, being at the front door of any district general hospital, wherever you are, tend to feel those pressures more. It is about how we look at the whole system, from primary care through, to make sure that we do not end up with ambulances waiting, which is always a situation of regret.

Q38 Glyn Davies: Can I move on to the waiting list position? Earlier one of you described the differentials in waiting lists between England and Wales. They have been there for a long time; we

know what they are. In Powys last year, for almost 12 months all referrals were 36 weeks, on a short-term basis, which was completely unacceptable.

The issue is public understanding and appreciation of the health service. I suppose that is more relevant in my constituency than in most others, because almost everybody goes over to Shropshire. They are waiting for a minimum of 26 weeks; last year it was 36 weeks. If they lived over the border, it would be 18. It is so obvious. We have seen that half the Welsh people think that Westminster is responsible for the NHS in Wales; they do not see the differentials between the two Governments. I find it hugely difficult to explain to people how my constituents have this very different and much less satisfying access to the health service. How do hospitals on the other side of the border deal with that level of expectation and disappointment?

Helen Birtwhistle: It goes back to what we said right at the beginning about communicating with patients and the public, and making information about the system in which they are operating and receiving care and treatment more readily available to people. The waiting time targets are different; those are the targets within which the different systems have to work. Generally, I would say that waiting times are just one element of a patient's treatment and experience. Another part of their treatment and experience is being talked to, engaged with, consulted and given relevant information. We have identified that we really need a much more consistent approach to providing information to patients who are accessing services, on both sides of the border.

Chair: I will have to ask for one or two very quick questions, because we have another panel.

Glyn Davies: I have a couple of questions to ask. I am sure you will stop me if you have to.

Chair: I may have to.

Glyn Davies: Are you going to stop me before I start?

Chair: I would not dare do that to a man of your experience, Glyn, but I really need to get the other panel on in about three minutes.

Q39 Glyn Davies: There are one or two issues I really have to ask about. What involvement are you having, as the Welsh NHS, in the future fit process over the border in England? I probably spend a day on it every couple of months, because it is huge. In Shropshire it will start in detail in about six months' time. The impact on people living in mid-Wales could be huge—services could be moved from Shrewsbury to Telford—yet we know that something has to happen. Shropshire is losing services to Wolverhampton because they are no longer sustainable. Cardiac services are going; it is really serious. What involvement do you have in what is happening over the border in Shropshire and, probably, south and north of Shropshire?

Helen Birtwhistle: On a good relationship basis, there is discussion and dialogue about services. One point we would make is that we think it would be really helpful if much more formal protocols were put in place for consultation when services quite clearly impact on a big chunk of the population across the border, as in Powys.

Glyn Davies: I will leave the other 25 questions that I wanted to ask.

Chair: I really appreciate that.

Q40 Nia Griffith: If a patient lives in England, is registered with a Welsh GP but then needs hospital treatment—secondary—in England, who pays?

Alan Brace: We do.

Q41 Chair: That is very interesting. I wish we had more time, but I am afraid we haven't. Thank you very much. If it is okay, we may write to some of you—or all of you collectively—with further questions.

Helen Birtwhistle: Of course. We can co-ordinate those responses, if that is helpful.

Chair: It was most informative. Thank you very much.

Helen Birtwhistle: Thank you very much. It has been a pleasure.

Examination of Witnesses

Witnesses: **Jesse Norman**, MP for Hereford and South Herefordshire, and **Pamela Plummer**, Action4OurCare, gave evidence.

Q42 Chair: Thank you both for coming along this morning. As you know, we are a bit short of time, so I will dive straight in and ask some questions. You do not both need to answer every one. Jesse, could you tell me why so many patients living in Herefordshire and Gloucestershire are registered with Welsh GPs?

Jesse Norman: I thank the Committee for taking this testimony. I come at this very much from a constituency representative position. I do not have a political agenda about it, but I do have a serious issue. I have a lot of constituents—about 3,500 in Herefordshire overall—who live along the border and are registered with Welsh GPs. In almost all cases, they do not have a choice about that; it is because their nearest GP is in Wales, and very often other local GPs will not accept them on their rolls.

The difficulty with that has come because in some cases those people are not being given the rights they are entitled to as English residents under the English NHS. The classic example would be one of my constituents who was pregnant and was looking for a nuchal scan. She lives in Herefordshire and wanted to have her baby in Hereford hospital, which has a very good maternity unit, as do other hospitals. It is one of those things where you have a narrow time to get the scan; you have to have it between 11 weeks and two days and 14 weeks and one day. Essentially, what happened was that she missed her scan. That is just one example among many.

Q43 Chair: Others will forgive me, but I am jumping ahead a little. We saw a letter in our pack from the Health Minister saying that she had given an instruction that in future English patients registered with Welsh GPs would have by guarantee whatever standards apply in England. As far as I can tell, that is officially Government policy, as of a few weeks ago. Am I right or wrong in saying that?

Pamela Plummer: You are absolutely right, yes.

Jesse Norman: If I may follow that up for a second, before Pam speaks, in her letter it looks as though that applies to primary care. A lot of the concerns that we have relate to secondary care—different waiting times between the Welsh NHS and the English NHS and access to the cancer drugs fund. There is a whole suite of rights to which people are entitled as English residents. The question is, should they get them? There is a worry from the Government's standpoint. If they do not honour the rights in full, they are potentially open to legal challenge, judicial review and criticism. I think they want to avoid that.

Pamela Plummer: To go back to the original question, the reason that so many of our residents in Gloucestershire are registered with Welsh-registered GPs is historic. When they registered with them years ago—lots of people have lived in their village for decades—there was a UK national health service. Secondly, it is about accessibility, because we live in a rural area; it is about the

local GP. Thirdly, as Jesse said, there is absolutely no choice. There are no English GP surgeries that will take you, because of home visits, although that has eased very recently because of what Aneurin Bevan health has done.

Uniquely in Gloucester, there are seven GP practices affected. Three of those surgeries are physically in England. For example, I moved to Gloucestershire from Monmouthshire. I registered with my local GP in 2002, when there was a UK national health service. I lived in England and my surgery was in England. Why would I bang on the door and ask them whether they are Welsh? You do not do that. You just do not think that is the case.

Chair: I didn't know you were a constituent at some point.

Pamela Plummer: Didn't you?

Q44 Nia Griffith: Essentially, your patients are resident in England but are registered with a Welsh GP. When it comes to secondary services, it is the Welsh NHS that pays. Do you think it would be easier if it were the English NHS that paid? That might circumvent some of the delays that you have experienced.

Pamela Plummer: We would like to see the money for secondary care channelled through to Gloucestershire clinical commissioning group, because that would solve a lot of the issues around representation, consultation and our legal rights. If Gloucester CCG were able to commission for the whole of Gloucestershire—which they should as it stands, because their own constitution says they commission for the whole of Gloucestershire, but in fact they don't; they commission for most of it—we would be able to hold Gloucester clinical commissioning group to account for all the decisions they make, through our democratic representatives. The way it is organised at the moment, Aneurin Bevan health board do our commissioning and are absolutely unaccountable for their actions through any democratic process. We have no representation whatsoever in Wales. The community health council is not allowed to represent us because we live in England. Healthwatch has no powers because we are treated as if we live in Wales. Gloucester CCG are sympathetic but powerless. We have no means of complaining or objecting to anything that Aneurin Bevan health do, which is why we ended up in a mess over a year ago, when they introduced their out-of-area referral policy, which prevented us from accessing secondary care in England.

Jesse Norman: To be fair to Aneurin Bevan health board, there has been lobbying on that; they have listened to it and put in place a temporary arrangement, but no one thinks it is a durable long-term arrangement. It applies only to certain trusts that they work with.

There is another anomaly, which is that Welsh patients who are registered with English GPs have all the rights that they get under the English NHS. There is parallel unfairness the other way as well.

Q45 Chair: Who pays for them? Is their secondary treatment paid for by the Welsh health board or by the English commissioning group?

Jesse Norman: I do not know what the financial arrangements are, but the principle is clear: the money should follow the rights. That would mean that people on both sides would have to be sorted out either way.

Chair: We will have to find out—

Jesse Norman: What I am focusing on is the rights, if you see what I mean.

Q46 Nia Griffith: You have covered most of it. As you say, initially Aneurin Bevan said, "No, we have to look at every single one." Then they said that there were four you could go to. How much

communication was there with patients and GPs about the new arrangements—that you could go to specific hospitals but not to others? Do you think there is more that ought to be done in that respect?

Pamela Plummer: Do you mean as it is now or what happened a year ago?

Q47 Nia Griffith: Initially, in 2012, they said that you could not go. Then, in September 2013, they said that there were specific, named hospitals that—

Pamela Plummer: In 2012, we wrote to Aneurin Bevan health board and had two letters back, one on 18 April and one on 20 June. In those letters they defended their consultation process and said that it was extensive. It was extensive, but not for Gloucestershire. There were no adverts in the local press, only in the Welsh press. One person from Gloucester PCT, Sarah Hughes, attended one meeting. Gloucester PCT was in the middle of being unravelled because of the reorganisations in England, so really there was no consultation whatsoever in Gloucestershire.

In terms of how people found out that they could not access services, I personally found out because my friend rang me up and said, “I can’t go to England for my hearing treatment any more.” When I asked why, he said, “Because Wales won’t allow us to refer to England any more.” In my naivety 18 months ago, I said, “What has it got to do with Wales?” I had no knowledge of the system or how it worked.

They changed their policy partly because of a public outcry. It was not just a rethink. We had a public meeting, and 270 people came. We had 800 people sign a petition. We personally delivered over 2,000 leaflets. Our MP and Jesse Norman helped as well. Parish councils and district councillors also got involved. There was a public outcry about what was happening because people’s care was being jeopardised to such a degree. That has been sorted out now, but it does not represent a permanent solution. On paper, as things stand, Aneurin Bevan could change their mind at any time they like, and we could go back to that in five years’ time. It also denies us our legal rights under the NHS constitution and the Health and Social Care Act. We always believed that to be the case, but Ms Ellison and the Department of Health have now confirmed it. We are now in a situation where we feel that we are not being treated lawfully.

Jesse Norman: Pam has explained it very well. Could I add a very quick grace note? In Herefordshire, where we had a similar outcry, three of the cases that I cited, which relate to eye care denied, an MRI scan and antenatal scans, occurred after the change in policy. Not only was it evidently not particularly well communicated, but it was not clear that they were following the policy even within the system after the change had been announced and supposedly promulgated.

Q48 Geraint Davies: Mr Norman, we have heard from you that you have constituents who live in England but have no option of registering with an English GP. They are required to register with a Welsh GP, but even though they live in England the money for their treatment is paid by Wales. Do you think that it would be better if their treatment were paid for by the English NHS, in order that they could make the demands and representations that you want where they are treated—namely, in the Welsh NHS?

Jesse Norman: If I may, I will not get drawn on that, only because the financial arrangements between the Welsh NHS and the English NHS are so complicated and cross so many different areas—secondary care, primary care and the ambulance service. An equitable settlement needs to be drawn up between the two. I am just insisting on the very obvious and boring point that if people live in England and have no choice but to use a Welsh GP, they should maintain their rights under the English NHS. They are owed that duty of care. There is a parallel case for Welsh patients who are in the other situation.

Q49 Geraint Davies: We heard from the previous witnesses that there are various commissioning arrangements between England and Wales where a health trust in Wales will pay England, or vice

versa, according to where they send their patients. That seems to work. It seems to follow from that, in principle, that, if you are a person coming from England into Wales, the money should follow the patient—and it does not. Surely that would be part of the solution. Why aren't you pressing for that?

Jesse Norman: As far as I understand it, that is the general principle. Of course, often the tariff arrangements do not work at all well. At Hereford hospital, we have always served Welsh patients, all the way up to Rhayader and Llandod. Often the tariff is inadequate for the work that is done, and paid late. There is a range of issues. I would like a consolidated solution to have the overall issues addressed.

Q50 Chair: In fairness to Geraint, he has a point, hasn't he? Shouldn't English residents who have registered with Welsh GPs pay their own prescription charges if they want to have English standards—English waiting times? Aren't people getting their cake and eating it at the moment? They are getting the free prescriptions, but they are demanding English standards on waiting times.

Jesse Norman: I see the force of the argument. I just do not know enough about the financial arrangements to comment. I would say that they are people who are forced to use those GPs. They are not people who are doing it as a matter of choice in order to avail themselves of free prescriptions.

Q51 Jessica Morden: Could you explain a bit more about why GPs will not take those patients?

Pamela Plummer: It is because of practice boundaries and locality. They have to do home visits. They will not cross the line to do home visits because it costs them money. Until very recently, we could access only Welsh GPs. After the public outcry, one GP practice in Lydney extended its boundary to take 500 more people, but that is not going to help the 6,000 people if they want to get to an English GP. We are locked into a situation where there is an absolute monopoly on us. There is nowhere else to go.

Q52 Nia Griffith: There is no patient choice.

Pamela Plummer: Absolutely—not even at the level of the GP. That goes against the NHS constitution as well, because you are supposed to be able to choose your GP. We are stuck, and there is nothing we can do about it. When the out-of-area referral policy came in, that was recognised by Aneurin Bevan health board in their board minutes; they actually commented that we could not move and, therefore, their GP practices were at a low risk of being destabilised.

Q53 Jessica Morden: You mentioned that there had been some changes to the boundaries. How have you achieved those?

Pamela Plummer: Sir David Nicholson wrote to the English GPs locally, apparently. He confirmed to us that that GP had extended its boundaries, but again it has not been communicated particularly well to English patients if they need to move. Most people do not even know about Lydney. We are doing leaflet drops on behalf of the NHS to tell people what is going on.

Q54 Nia Griffith: Are you lobbying NHS England to do that?

Pamela Plummer: Yes. We had meetings with NHS England in July and we have been exchanging e-mails ever since. In fairness to Mr Stevens, he asked us to be involved in the proposal communicated to us, but we are having quite a job trying to get NHS England to tell us what our legal rights are. We asked our MP, Mark Harper, to go to the Department of Health to get a statement because NHS England would not tell us. They kept telling us that they did not know and that it was complicated. The last e-mail said, "We will tell you when we have implemented it." We were about to say, "Sorry, but we would really like to know anyway," when we got the letter from Jane Ellison, which solved the problem.

Jesse Norman: I do not share Pam's view that it has solved the problem, because it only addresses the issue of primary care and does not reflect a settled agreement between the two NHSs, Welsh and English. That is what we want. I have also lobbied the English NHS on this issue. Let me give you an example. Patti Fender, a local campaigner who is well known to Pam and me and who lives in Welsh Newton, applied to be supported by Much Birch surgery and the one in Ross-on-Wye. Both said no. The result is that she has no primary care. She was with a Monmouth GP, but she is asserting her rights under the English NHS, and I think that she is perfectly entitled to do that.

Q55 Geraint Davies: Are you saying—I would agree with this—that someone living in England should have the right to register with an English GP, because they live in England, and, secondly, that if they are to be registered in Wales, they should have the money follow them from England to Wales to pay for that service and deliver the expectations that they have from living in England?

Pamela Plummer: In theory, yes. I think we have the right to have an English GP and that NHS England should be providing that. All I can say is that, when we held our public meeting and 270 people came to it, people said to us that they really like their Welsh GPs. The issue is not their GPs; their GPs are great. They are happy to stay with their Welsh GPs. They just want their rights to secondary health care under the NHS constitution.

Q56 Geraint Davies: But it should be paid for by England. That is the point I am trying to make—the money should follow them.

Pamela Plummer: I am not an expert on the money. Logically, I would have thought yes, because it makes sense.

Jesse Norman: These areas are very large. Even if the GPs were to open up their lists, in many cases it is not realistic to ask people to move.

Geraint Davies: I understand that.

Q57 Nia Griffith: But if the money followed the patient—

Jesse Norman: If the money followed the patient, it would be absolutely different.

Pamela Plummer: The situation in my area is that you could stay with a GP you know; they treat you well, they know your family and background and there is a good relationship. Then they just access NHS England secondary health care. The commissioning is done in Gloucester, so it is safe and protected, and it is all as clear as a bell. Gloucester commissions for 620,000 people. Another 6,000 would not make any difference.

Q58 Chair: Just to be clear about this, you both agree that the money should follow the patient around, broadly speaking.

Pamela Plummer: Yes, that makes sense.

Q59 Chair: It is complicated, but that is your position in simple terms.

Jesse Norman: I am not contesting that, but that general principle, which is the one the NHS adopts, has to be weighed against issues of fairness in the overall balance. We have a system that is not fair on both sides of the border. That needs a consolidated discussion.

Geraint Davies: Basically, the money should follow the patient.

Chair: There is almost some consensus. On that happy note, let us move on.

Q60 Simon Hart: We will soon put a stop to that. What would your constituents and your friends and neighbours think if they were listening to this debate now? Devolution is all the rage. Do they think that devolution has been for the benefit of health care in the border counties?

Jesse Norman: Are you asking me as a Member of Parliament?

Q61 Simon Hart: I am asking both of you.

Jesse Norman: From a constituency standpoint, as I think has been testified, they often do not understand the difference, and they do not care about the difference. What they want is good local health care and the rights they believe they are entitled to by virtue of where they live to be observed.

Q62 Simon Hart: Okay. I will come back to Pamela and ask the same question in a different way. Assuming that they now know, because they are watching this, or they read the transcript or you inform them of it, and with much discussion about further powers for the Welsh Assembly coming down the line—that seems to be a subject that never goes away—how do you think they would react to that?

Jesse Norman: Let us be clear—

Simon Hart: I will tell you why I am saying this. There is a real sense of frustration emerging.

Jesse Norman: Let us be clear. There is huge frustration and a great sense of injustice. I am taking the view that the Committee understands that, and therefore I am not going on about it now. Because of that, they may well have criticisms of the arrangements that were reached as a result of devolution, but that is not really the basis on which I am making my argument. I am making an argument about the unintended consequences of a specific set of circumstances, rather than the in principle question of whether it was right to have that.

Q63 Simon Hart: Fine. I suppose that what I am saying—I am talking to Pamela here—is that we have opportunities on the political horizon possibly to rectify some of this. If so, how would we do it? From everything you have told us so far, if I were just waiting for my care and were living in the border counties, I would be thinking the sort of things that *Hansard* don't want me to think. I would really be wondering. It would confirm all of my worst views about—

Jesse Norman: If you wanted to get really angry about it, you would look at the difference in ambulance crossings. There are 186 English ambulances going into Wales and 16 going from Wales to England. If you wanted to get angry about things, you might get angry about that.

Simon Hart: Absolutely.

Jesse Norman: Okay, but I do not think that is absolutely germane to what we are trying to talk about now, with respect.

Q64 Simon Hart: I am trying to change the subject; I am trying to make it germane and to shine a light on this bit. We keep highlighting problems. Let us pass the ball to Pamela a little bit. How do we rectify this? It is nonsense.

Pamela Plummer: Devolution is a fact of life. The Welsh Government are going to make their own decisions about their health care, and they absolutely should, through their democratic representatives. What they should not do is entangle English residents in your decisions. The Health and Social Care Act is really clear. It applies to absolutely everybody who lives in England. The cross-border protocol has overwritten that, but it has no authority or mandate to do so. The

legislation should stand for the English and for the Welsh Governments. You should make sure that, whatever you do with devolution, you do not deny English residents their rights.

What has happened to a lot of people in Gloucester is awful. I have goodness knows how many case studies of really poor care and appalling decisions. I can give you examples in generic terms of what has gone wrong. English residents who are registered with a Welsh GP and are being seen by a Welsh consultant have to jump to an English GP, through a GP fix, because nobody will take them. When we met him, the GP told us personally that he was absolutely livid that he had lost a patient of 20-odd years, who is now with an English GP, seeing the same Welsh consultant, so that he can get access to rare cancer drugs. Some of the machinations—

Q65 Chair: He is getting access to rare cancer drugs in Wales.

Pamela Plummer: In England, through his English GP, but still seeing the same Welsh consultant, who could not get him the drugs in Wales. People are leaping through all sorts of hoops.

Q66 Simon Hart: Can you illustrate that? What sort of delays have been built into the system that would not have been there if we had not—

Jesse Norman: I have a constituent who desperately needed an MRI scan, was not able to get it because of arguments about these things, and then discovered that she had a cyst on her spine. She very rationally and rightly takes the view that if the MRI scan had been forthcoming when originally requested, under her perfectly fair rights as an English patient, it might have had a meaningful impact on the diagnosis and treatment of her condition. These things get very angry very quickly, once you go into detail.

Q67 Chair: Mrs Plummer, I know you have an organisation that represents English patients who are looking to have their treatment in England or, at least, to English waiting time standards. As far as you are aware, are there patients in England who are opting to go to Wales or who are quite happy with the service in Wales?

Pamela Plummer: Some people want to go to Wales, as that is where they have gone in the past—they had their baby at Nevill Hall, they want to cross the border and they are quite happy to go to Wales. That could be accommodated, if you recognised the English rights. If Gloucester's clinical commissioning group commissions, they can commission contracts in Wales for those people, to maintain that flow. It is a no-lose situation if you do it that way.

Q68 Chair: Are there any particular services that people prefer to have in Wales, or where the standards are obviously higher? We are getting a sense that there are differences in different areas. Obviously people will always want to have their prescriptions for free, if they can. What else sends people to Wales?

Pamela Plummer: The main problem with Wales is the waiting times. If you had the option of going to England in four months' time for an operation, or to Wales in four months' time for an operation—as you are actually entitled to—and somebody said, "Wait six months," which one would you choose?

Q69 Chair: Yes, but are there some things for which you would wait a shorter time in Wales?

Pamela Plummer: Yes. Where we live, we are much closer to centres of excellence in Bristol than to centres of excellence in Wales. For example, one person wanted to go to Frenchay because his son had hurt his hand. He was sent to Swansea, 75 miles away, when they would not allow us to refer to England. Instead of being able to jump out of bed and see his son when he woke up from the anaesthetic, he was told that he would have to book a hotel in Swansea. He was told he would have to wait much longer—

Q70 Chair: That is more of a distance issue than a standards issue.

Pamela Plummer: But you also have good centres of excellence in Frenchay and at Southmead.

Jesse Norman: We have the cancer drugs fund, which we talked about. The eye hospital in Hereford is national if not world-class quality, but people are not able to use it.

Q71 Chair: But there must be some things we are better at in Wales. We are the Welsh Affairs Select Committee. What are we good at in Wales?

Jesse Norman: Inevitably, I know the ones in my constituency, so I do not know. I cannot comment on the contrast between Nevill Hall and Hereford hospital.

Q72 Guto Bebb: I have a brief point of clarification. You mentioned a cancer patient who was registered with a Welsh GP, seeing a consultant based in Wales but not able to access the cancer drugs fund.

Pamela Plummer: That is right.

Q73 Guto Bebb: He then transferred to an England-based GP, with the same Welsh consultant, and was able to access the cancer drugs fund.

Pamela Plummer: That is right. People are jumping through hoops to avoid the waiting list. Continuity of care—

Q74 Guto Bebb: I just wanted to clarify what I had heard.

Pamela Plummer: That is an absolute case. We had two meetings with GPs in Chepstow. We were told that by the GP himself, so I can say that it is true.

Jesse Norman: Could I add something very quickly, as a grace note? On organ donation, there is a difference of policy between the two. There is deemed donation on the Welsh side and not on the English side. I have lots of constituents who are worried that they may have organs deemed to be donated because they are registered with Welsh GPs, although they live in England. That could be sorted out just by communication and fiat. It is not a financial thing as such.

Q75 Geraint Davies: We understand that something like 20,000 people who live in England are registered in Wales and that 15,000 live in Wales and are registered in England. If the people who are resident in England get treated in England, even though they are registered in Wales, the Welsh health service pays for their hospital treatment in England. Do you think that is something that should be changed, because it is a very significant drain on the Welsh health service? These are people living in England, being treated in England and being paid for by Wales because they have chosen to register in Wales, and they are also getting free prescriptions. Do you think that is right?

Pamela Plummer: They are living in England, they are with Welsh GPs—

Q76 Geraint Davies: Yes, but they end up being referred to England for treatment Wales pays for. Do you think that should be changed?

Jesse Norman: In many cases, they have not chosen—they have been forced to register with a Welsh GP.

Q77 Geraint Davies: Why should Wales pay for that treatment?

Jesse Norman: There is a further question. The general principle in the NHS recently—over the last 10 years—has been that there should be free choice as to where you get treated. I am not sure that it is wise for the Welsh NHS to constrain where people registered under it get treated. It should not be a financial matter, in that sense. They should be treated in the best place they can be treated.

Q78 Geraint Davies: That is not the point. These are examples of people who are exercising choice. Who should pay?

Pamela Plummer: The point is that it is not about the money. How NHS England and NHS Wales organise their money is up to the managers within the NHS. Presumably there is a pot of money at Government level, which is spent however they decide. The issue is the legal situation based on residency. That is the bottom line. We are entitled to go to England. We have been entitled to go to England since the Health and Social Care Act in 2012. We are entitled to have access to the cancer drugs fund. We are entitled to choose our GP and to use choose and book. We cannot use choose and book at the moment. We are limited to four trusts where Aneurin Bevan has contracts. We had barely won those rights when there was an argument between Aneurin Bevan and UBHT. They did not pay their bills and a whole lot of people had their operations cancelled again. The current arrangements are not a permanent solution. They are tenuous and unjust. Sorting the money out should not drive the solution. The solution is to decide what is right for us and for the people in Wales and then organise your money. I do not see that we can solve the money problem here.

Q79 Chair: You may not know the answer to this, but would a Welsh resident registered with an English GP have access to the cancer drugs fund?

Pamela Plummer: Yes, under the current protocol arrangements. And they get treated in 18 weeks. And they can use choose and book. They have all the five rights under the NHS constitution that we do not have.

Q80 Chair: Would the treatment of that Welsh resident registered with an English GP be paid for by the English NHS?

Pamela Plummer: I do not know how the money works.

Q81 Chair: I do not see any more questions, so I will call this meeting to a close. Thank you both very much indeed, particularly Mrs Plummer, who has come all the way from the Forest of Dean.

Pamela Plummer: Thank you very much for listening to us. It is really kind of you.