The Government Response to the Welsh Affairs Committee interim report on the provision of cross–border health services for Wales

Presented to Parliament by
the Minister of State for Health Services
by Command of Her Majesty
January 2009

Cm 7531 £5.50

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Introduction

1. The House of Commons Welsh Affairs Committee published its interim report 'The provision of cross–border health services for Wales' on 10 July 2008. The Government warmly welcomes the Committee's report. This Command Paper sets out the Government's response to the report and provides the additional information requested by the Committee.

2. The Government agrees with the Committee that the border between England and Wales should not represent a barrier to the provision of health care. In reality, it is not a barrier; people living in Wales have always accessed health services in England and people resident in England have crossed the border to access healthcare in Wales. This is particularly the case where the nearest GP practice to a person's home may be across the border. There are also established flows of patients between GPs and commissioners in one country and hospitals in the other while Welsh residents may access specialist services further afield.

3. The core principles of the National Health Service apply across the UK and an inevitable and healthy consequence of devolution has been some divergence in health policy between England and Wales. Such divergence is entirely appropriate and to be welcomed. It provides an opportunity for each part of the NHS to innovate and experiment with different models for the provision and organisation of healthcare services, within a common framework of NHS principles, and to learn from each other in doing so.

4. It is for the Welsh Assembly Government (WAG) to determine its own health policies and priorities to meet the needs of people in Wales and we welcome the opportunity to learn what is successful in their approach, and in the approaches adopted in Northern Ireland and Scotland. Similarly, they may wish to learn from the success of the NHS in England. To this end, it is proposed that formal structured arrangements are put in place for regular dialogue between Ministers and officials from each of the home nations on health matters.

5. The need to manage the differences between England and Wales is perhaps more pressing than the need to address other differences between the home countries because of the population distribution along the border. Unlike the England-Scotland border, there are many areas where the nearest GP practice to a person's home can be on the other side of the border. Equally, there are well-established relationships and flows of patients between GPs and commissioners in one country and hospitals in the other.

6. The number of patients involved is significant. In 2007, 20,000 people resident in England were registered with a GP in Wales and 15,000 people resident in Wales were registered with a GP in England.

7. In 2005, the Department of Health (DH) agreed with the Welsh Assembly Government (WAG) an interim commissioning protocol to address some of the implications of this divergence. The protocol determines which commissioner is responsible for the care of a patient who lives on one side of the border and is registered with a GP on the other. The interim protocol has been renewed annually and is currently in place until April 2009. It is supported by an annual transfer of funds from DH to WAG – currently £5.6m – to cover the costs of providing secondary care for the larger number of patients who live in England but have a GP in Wales.

8. The intention has always been to replace the interim protocol with a longer-term agreement on commissioning responsibilities. As health policy continues to develop within the two administrations it will become increasingly important for patients, clinicians and managers to understand the implications of the choices they make about using cross-border services. It will also be important to ensure that funding appropriately reflects patient flows.

The Government's Response to the Committee's Report

9. The Committee's report identified four key criteria for cross-border health policy and made a number of requests for clarification or additional information. In this response, the key criteria are addressed first. The requests for clarification or additional information are then addressed in the same numerical order, for ease of reference, as they appear in the Welsh Affairs Committee's report.

10. The focus of this paper is on health care as the commissioning and provision of social care services is the responsibility of individual local authorities.

11. This paper discusses:

    - the extent to which cross-border health services are currently provided for and accessed
    - arrangements to co-ordinate cross-border service provision
    - the commissioning, funding and quality of cross-border services
    - the extent to which mechanisms are in place for identifying and resolving cross-border deficiencies.

Key criteria for cross-border health policy

The Committee's report identified four key criteria for cross-border health policy, these were:

Clinical excellence as close to home as possible

Clinical excellence is the key to the provision of all health services. The provision of health services as close to home as possible not only enhances clinical effectiveness by allowing rapid and convenient initial and follow-up care, it allows networks of family and friends to visit patients as conveniently as is possible within the boundaries of clinical safety. In certain cases, this will mean that to achieve clinical safety as close to home as possible, Welsh and English patients will receive treatment on the other side of the Welsh-English border. This should be accepted by policy makers in England and Wales and the necessary funding arrangements should be in place to provide a seamless service to patients according to need.

12. The Government accepts this principle, indeed it is fundamental to the programme of reform set out in the *Next Stage Review*. The border between England and Wales should not represent a barrier to the provision of high quality clinical services close to people's homes.

Border proofing of policy and practice

Policy developed in England and Wales should be "border proofed" in order to ensure that policy developed within one jurisdiction does not have unintended consequences for patients in another. Whether developed on a regional or national level, policy and practice must consider the east-west as opposed to north-south direction of travel that characterises Welsh life, particularly in North and Mid Wales. Policy development should also be based on research and data that has been commissioned with cross border issues in mind. The continued collection of data and research on an All-Wales and All-England basis will do little to address cross-border issues if they continue to provide incomparable and incompatible data.

13. The Government supports the development of a more sophisticated understanding of the impact of different policies on patients and the public. We will continue to work with the devolved administrations on these issues.

Cross-border citizen engagement

Governments in England and Wales have rightly placed citizen engagement at the heart of health policy development. More needs to be done to deliver this engagement in practice. Citizen engagement should not stop at the border. Where services are accessed by patients outside the administrative boundary, all efforts should be made to ensure that clear avenues for engagement are provided to them, regardless of their residency. Such avenues must be clearly outlined and accessible for citizens; they should not be faced with a complex web of cross-border bureaucracy.

14. The Government supports the principles of effective citizen engagement and elsewhere in its report the Committee acknowledges the effective work of Foundation Trusts in this area. We would welcome the opportunity for more proactive engagement with border communities and the Department of Health will encourage Strategic Health Authorities and Primary Care Trusts to take this forward with their Welsh counterparts.

Transparent and accountable co-operation between localities, regions, and governments

The key to providing patients with high quality health services on an equal basis is ensuring co-operation between policy makers at local, regional and national levels. Divergence is inherent in devolution. However, its impact should not be felt in a negative manner by patients receiving their treatment from a UK-wide National Health Service. In reviewing and developing the structure and future of the NHS in England and Wales, consideration must be given to the extent to which patients flow across the border to access their health care. Transparent and accountable links between jurisdictions should be established and maintained in order to ensure that the interests of cross-border patients are served as well as those of patients accessing services within administrative borders. More sophisticated mechanisms of scrutiny between the Welsh Affairs Committee and the National Assembly for Wales will help to ensure that decisions taken for cross-border patients aim for the best outcome as opposed to merely a different outcome. Co-operation of this kind will ensure that a common framework of NHS principles for all UK citizens is maintained and in so doing would strengthen a truly National Health Service.

15. To facilitate co-operation between localities, regions, and governments this paper has proposed that formal structured arrangements are established for regular dialogue between Ministers and officials from each of the home nations on health matters. These would enable formal and regular consideration of strategic and operational issues and the principles that underpin the National Health Service.

The Government's Response to the Committee's recommendations and requests for additional information

Cross-border access to health services is natural and inevitable given the geography of Wales, and should be co-ordinated by the Department of Health and the Welsh Assembly Government. More needs to be done to avoid unintended consequences of policy, particularly as a result of decisions taken in isolation by health bodies on either side of the border. (paragraph 9)

16. The Government believes that the border between England and Wales does not represent a barrier to the provision of health care. A devolution concordat was agreed in 2001 to provide a framework for co-operation between the Department of Health and the departments or directorates concerned with health and social care. This sets out the over-arching principles within which the Department of Health and Welsh Assembly Government co-ordinate cross-border services.

17. The Department of Health has responsibility for all of the UK (England, Scotland, Wales and Northern Ireland) in areas where national co-ordination or leadership is required. These include:

    - International and EU business, including the negotiation of legal agreements
    - Co-ordination of planning for pandemic influenza;
    - The licensing and safety of medicines and medical devices – led by our Executive Agency the MHRA;
    - Certain ethical issues such as abortion and embryology.

18. The legislative positions in England and Wales have not as yet defined precisely which local NHS body is responsible for commissioning care for people who live on one side of the border but are registered with a GP on the other.

19. In 2005, an interim protocol was agreed to address commissioning responsibility issues. Without the protocol, commissioning responsibility would be determined entirely by residence. This would cause some confusion for patients and commissioners regarding what service a patient is entitled to receive when their GP is across the border.

20. The interim protocol relates to patients living along the border in Flintshire, Wrexham, Powys, Monmouthshire, Denbighshire, Cheshire West, Shropshire County, Herefordshire, Wirral and Gloucestershire. It confirms that for people resident in these LHB and PCT areas the commissioner which has operational responsibility for their care will be determined by GP registration in all cases, rather than residence. (The legal responsibility remains with the body covering the area in which the person is resident.) This protocol has been renewed annually since 2005 and is currently in place until April 2009.

21. The principles according to which service providers in either country treat patients from across the border have been established in WHC (2005) 12, and in letters from Department of Health to the English Strategic Health Authorities. They confirm that Welsh providers are required to work to the standards and targets that are set by the Welsh Assembly Government for all the patients who they see and treat.

22. The NHS in Wales is – subject to consultation – currently undergoing a period of significant organisation and system change, including a reduction in the number of NHS organisations and a change in their function from commissioning to planning bodies. In view of this, it is proposed that it will be more appropriate to build on and extend the scope of the current interim protocol, until the impact of these changes is clearer, rather than to completely overhaul the current arrangements.

23. We propose to end the short-term focus of the interim protocol by extending it to a longer-term agreement. This will end the annual uncertainty for local NHS organisations and allow for the impact of proposed system changes to be better understood.

24. Patient safety and well-being must be paramount at all times. No treatment must be refused or delayed due to uncertainty or ambiguity as to which commissioner is responsible for funding the healthcare provision. If a Trust has admitted patients to its hospital there should be an automatic assumption that treatment would proceed.

25. It is anticipated that a more permanent and sustainable protocol will be agreed shortly.

The Committee welcomes the continued ability of borderland citizens to register with general practitioners of their choice and to receive treatment via primary care services on a cross-border basis. (paragraph 11)

A key criterion which future arrangements for health services in England and Wales must meet is the continued ability for Welsh residents to obtain the most appropriate and cost effective secondary health care regardless of the border. We would welcome further evidence of where, if at all, this criterion is not being met as a result of funding or other administrative arrangements, and proposals to prevent this occurring. (paragraph 15)

Given the geography of Wales and the need for a critical mass of patients to make specialist health provision viable and effective, cross-border movement is inevitable and natural. A key criterion for the success of health policy developed by the Department of Health and the Welsh Assembly Government is that it should not inhibit these flows or restrict access to effective specialist care. (paragraph 18)

26. The impact of devolution on the NHS has been positive, allowing each home nation to learn from the experiences and innovations of the others. The benefits have outweighed the minor administrative challenges of managing the consequences of the differences.

27. Devolution has led to some divergence in policies, but even without devolution there have always been differences in treatment policies and priorities between local commissioners, whose role is to identify and respond to local needs. Equally, it has always been the case that the health systems in England,

Scotland, Wales and Northern Ireland have been structured and managed differently. The critical point is that the core, defining principles of the NHS have applied across the UK and continue to do so.

28. In England, PCTs are responsible for funding the healthcare provision of all patients registered with GPs in practices forming the PCT. PCTs are also responsible for residents within their geographical boundaries who are not registered with a GP.

29. The Department of Health provides funding to enable PCTs to meet these responsibilities. Revenue allocations are made to PCTs based on the relative needs of their populations, to enable them to commission appropriate levels of health services for their populations. A weighted capitation formula is used to determine each PCTs target share of available resources. The components of this formula include the size of the population for which PCTs are responsible, their relative need (age and additional need) for healthcare, and unavoidable geographical differences in the cost of providing healthcare (known as the market forces factor).

30. Similarly, the Welsh Assembly Government allocates resources each year to Local Health Boards (LHB) and Health Commission Wales (HCW), which commissions specialised services, to pay for the costs of hospital treatments provided by NHS trusts and other independent healthcare providers.

31. PCTs, LHBs and HCW commission services to meet the needs of their population through contracts or service level agreements with service providers.

32. The *NHS Plan* (July 2000) set out the Government's intention to link the allocation of funds to hospitals in England to the activity they undertake. It stated that in order to get the best from extra resources there would be major changes to the way money flows around the NHS and differentiation between incentives for routine surgery and those for emergency admissions. Hospitals would be paid for the elective activity they undertake through a system of Payment by Results.

33. This reformed financial system offers incentives to reward good performance, to support sustainable reductions in waiting times for patients and to make the best use of available capacity. It is based on a nationally agreed set of prices or tariffs for services at specialty level, based on volumes adjusted for case-mix using Healthcare Resource Groups. Payment by Results has now been largely mainstreamed.

34. The system of Payment by Results operates only within England. The fact that the English system of Payment by Results does not apply to Welsh commissioners using English hospitals, or to English commissioners using Welsh hospitals, has given rise to some tensions between a number of providers and commissioners regarding the agreement of appropriate prices for services.

35. Where there are cross-border service issues a number of mechanisms exist to address these. Officials from the Department of Health and Welsh Assembly Government have been working together, with support from the NHS and the Wales Office, to address these matters. Consideration is being given specifically to issues around the funding arrangements for Welsh patients who use English hospitals and a final agreement is expected shortly. Arrangements for resolving disagreements between providers and commissioners are also being reviewed. The Government's intention is that routine engagement at Ministerial level should be formalised.

36. A range of formal and routine mechanisms are also in place to bring officials and NHS managers and clinicians together on specific policy issues.

A key criterion of success for us is that the Department of Health and the Welsh Assembly Government ensure that policies pursued by both administrations reassure patients and clinicians that different funding and administrative arrangements do not represent a barrier to the provision of health care. (paragraph 25)

37. The Government is in full agreement with the Committee that patients living in cross-border areas must understand the implications of their choice of GP and the range and standards of service they will receive. For example, the majority of patients registered with an English GP who are referred to a hospital will be able to choose any secondary care provider across England, including all NHS Foundation Trusts, NHS Acutes and a large number of Independent Sector providers. We will ask border PCTs to ensure that information is available so that patients understand these implications when registering with a GP.

38. Work to review the existing interim commissioning protocol is ongoing, and any future agreement will confirm arrangements to clarify exactly what a patient who has a GP across a border should expect. A settled protocol will make it easier for people to understand the standard of service they should expect to receive. It will also minimise any potential uncertainty that arrangements may change in the future.

A key criterion of success for the future of health policy is ensuring that local populations feel a sense of ownership over the health services from which they receive treatment. Where NHS Foundation Trusts have been established in borderland areas in England, we welcome the fact that they have rightly recruited members from the whole of their catchment area, giving patients and communities in Wales an equal voice in the development of services. Citizen engagement should not stop at the border between England and Wales, and we commend Foundation Trusts in England for their engagement with their catchment populations. (paragraph 28)

39. We will work with NHS bodies on both sides of the border and with patient groups to ensure that patients are properly informed and can make appropriate choices.

40. The Government believes that the ultimate purpose of patient and public involvement is the delivery of improved services, which better meet the needs and wants of service users. The involvement of patients, carers and users of services is essential to the user led health and social care system people want, and which this Government is committed to delivering.

41. There are a number of different models of patient involvement operating across the NHS. The Department of Health monitors the performance of FT membership very closely and believes that, where it works well, it is a good model.

42. The development of patient and community involvement needs to be seen as part of the culture change and service transformation which we are working towards. It is a fundamental characteristic of health reform.

We note the First Minister's assurance that waiting times in Wales are falling at a similar rate to England, and that the median wait for a patient registered and resident in Wales to be treated for elective surgery is one day longer than a patient registered and resident in England. However, there was other evidence of larger differences in waiting times and we would wish to invite further evidence on this point and revisit it in our full report. We also note the First Minister's evidence to us that:

Cracking the waiting lists, which was the big English drive back in 1997 and which we followed about three or four years later, is one example where we have learned from England.

We urge the Department of Health and the Welsh Assembly Government to work together to continue to drive down waiting times for Welsh and English patients. (paragraph 31)

English providers emphasised in evidence that Welsh patients requiring emergency treatment in England will be treated immediately, according to clinical need. In the case of a Welsh patient seeking non-emergency "elective" treatment, we remain unclear how clinicians and administrators decide where a Welsh patient is placed on an English provider's waiting list. A key criterion for success will be to ensure that greater clarity is provided for patients and clinicians regarding the administration of cross-border performance targets of this kind and that decisions about the elective treatment of Welsh and English patients are based on clinical need as opposed to funding. People expect to be treated equally in terms of waiting times and this issue needs to be addressed. (paragraph 38)

43. The Government has made the reduction of waiting times across the NHS a key priority. The NHS in England is making excellent progress to reduce waiting times to 18 weeks.

44. Although the maximum wait target is 18 weeks, the vast majority of patients will receive treatment much more quickly; figures for August 2008 show that at an aggregate England level, the current median Referral to Treatment waiting time is 8 weeks for those patients requiring admission and just 4.3 weeks for non-admitted patients. This data also showed that for the first time nationally the NHS met the target to ensure that 90% of patients who require admission to hospital and 95% of patients treated without needing admission start their treatment within 18 weeks of referral to a consultant. This was five months ahead of the end of December 2008 deadline.

45. The NHS in England and Wales have both set maximum waiting time standards for individual stages of treatment, as well as the whole pathway, from referral to treatment (RTT).

46. The devolved administrations have chosen different targets from England.

47. There are differences in some of the technical detail around measuring waiting times – this is the case for example, for outpatient figures.

Table 1: Announced waiting times targets					
	2005	2006	2007	2008	2009
Outpatient wait from referral to first outpatient appointment					
England	13 wks				
Wales		12 months	8 months	22 weeks	10 weeks
Inpatient and daycase wait from decision to treat to admission					
England	6 months				
Wales	12 months		8 months	22 weeks	14 weeks
Whole patient journey from referral to start of treatment					
England				18 wks	
Wales					26 weeks

Note: Welsh rules for measurement for RTT times mean that a patient requiring onward referral from a secondary care provider to a tertiary provider will potentially have a second maximum wait of 26 weeks.

48. Table 2 illustrates the Referral to Treatment waiting times standards that providers are required to deliver. The Welsh Assembly Government does not require a Welsh provider to meet English waiting time standards for patients registered with an English GP. Table 2 shows that, for example, a patient resident in England, registered with a GP in England and treated in England will be subject to waiting times set in England.

Table 2: Applicable waiting times targets								
Patients resident in:	England	Wales	England	Wales	England	Wales	England	Wales
Patient registered with a GP in:	England	England	England	England	Wales	Wales	Wales	Wales
Treated in a provider in:	England	England	Wales	Wales	England	England	Wales	Wales
Are subject to the waiting times standards set in:	**England**	**England**	**Wales**	**Wales**	**Wales**	**Wales**	**Wales**	**Wales**

Note: This table shows the waiting time standards providers are required to deliver, depending on a patient's residence, the location of their GP and where they are treated.

49. It is the responsibility of English PCTs, who commission services for their populations, to ensure that their patients are treated within the maximum waiting times as set out in the NHS Operating Framework and the NHS Vital Signs. For example, the DH requires PCTs to ensure none of their patients wait more that 18 weeks from referral to the start of treatment, with an operational standard of 90% for admitted patients and 95% for non-admitted patients to allow for patient choice and clinical exceptions. If a patient were to choose to be treated at a Welsh provider, it is still the responsibility of their PCT to ensure they are given the opportunity to be treated within 18 weeks. PCTs based on the border do not receive a lower operational standard than any other PCT. However, as set out above, Welsh providers are required to work to the standards and targets that are set by the Welsh Assembly Government

for all the patients who they see and treat. This means that patients registered with GPs in England who choose assessment or treatment in Wales will be seen or treated within the maximum waiting time targets and other standards applicable to the NHS in Wales. This should be made explicit to patients at the point of referral and it should be noted that Welsh waiting times are measured on a different basis to those in England.

50. Equally, it is the responsibility of Welsh commissioners to ensure that they agree with English providers the waiting time standard that their patients are to be treated within where care is provided within England.

51. Officials in both England and Wales are working together to ensure that, as far as possible, we move to a situation of better comparability between waiting time data. However, a consequence of devolution and each home nation's ability to set its own healthcare priorities is that some differences in waiting times will remain.

52. Officials in England and Scotland have already held informal discussions on the issues of comparing information across countries. The aim is to establish a group at which officials from each of the four home countries can identify key areas of policy concern and work towards developing a broadly comparable set of data that can be used to inform and support policy development and performance monitoring within and between the four home countries.

We urge the Department of Health and the Welsh Assembly Government to clarify the procedures in place for the commissioning and funding of super-rare conditions and to enter dialogue with bodies such as the Muscular Dystrophy Campaign to examine the need for a UK-wide fund. (paragraph 42)

53. The advisory structure for the commissioning of rare conditions and specialised services in England, the National Specialised Group (NSCG) and the National Commissioning Group (NCG) includes colleagues from Wales, Scotland and Northern Ireland, working with NHS commissioners, clinicians and patient representatives. The Government does not believe it is desirable for that to extend to a single UK fund, as each administration is able to make an effective contribution through the existing infrastructure and make appropriate decisions within their respective countries.

As a consequence of the tensions over diverging funding regimes in Wales and England, evidence suggests that there is a perception that the English NHS is subsidising the Welsh NHS. Evidence also suggests that Welsh patients perceive that they are being treated as second-class citizens within the National Health Service. Both suggestions should be addressed immediately by the Department of Health, the Welsh Assembly Government and health service providers to ensure that patients receiving treatment on both sides of the Welsh-English border are treated fairly and equally, and that they believe this to be the case. Minister of State for Health Services Ben Bradshaw MP assured the Committee that cross-border financial conflicts are resolvable at a comparatively modest cost and that his Department is working closely with the Welsh Assembly Government to address the issue. A key criterion of success for us will be continued co-operation between both administrations and the achievement of a sustainable resolution as soon as possible. (paragraph 43)

54. Patients must be allowed to choose a GP, regardless of where they live, even if this is across the border from where they live. Indeed, for some patients there may be no practicable option to register with a GP in their country of residence. Funding arrangements will be adjusted on a sustainable basis to ensure that there should be no financial obstacle to patients accessing services on either side of the border.

55. A formal, settled protocol will make it easier for people to understand the choices available to them, give them the stability they seek and end any uncertainty that circumstances determining access to care may change in the future.

A key criterion for the success of future heath policy decisions will be to ensure that policy developed within one jurisdiction does not have unintended consequences for patients or providers in another. The continued viability of English hospitals located along the border, and hospitals providing specialist services for Welsh patients, should not be adversely affected by the decisions of policy makers who fail to consider long-standing cross-border flows of patients. (paragraph 45)

Establishing a permanent protocol on the commissioning and funding of cross-border health services would provide greater assurance and clarity to patients, commissioners and providers of health services as to the arrangements in place for accessing and providing health services on a cross-border basis. A key criterion for the success of any future protocol is that it provides clarity and sustainable solutions, and should be subject to extensive consultation with key stakeholders. The permanent protocol between the Department of Health and the Welsh Assembly Government should be agreed and published in draft form, for consultation, as soon as possible. We also believe that bilateral ministerial meetings between the Department of Health and the Welsh Assembly Government should be announced and that the nature of all discussions should be made public and transparent. (paragraph 51)

We expect further clarification from the Department of Health and the Welsh Assembly Government on the role undertaken by each of these patient representative bodies in relation to cross-border health services. We also urge both administrations to consider carefully how future arrangements for the development of patient and public involvement will impact on cross-border patients and to include these in a formal public agreement. (paragraph 53)

56. The interim protocol has been renewed annually and is currently in place until April 2009. It is supported by an annual transfer of funds from the Department of Health to Welsh Assembly Government to cover the costs of providing secondary care for patients who live in England but have a GP in Wales.

57. The Government is committed to working closely with the Welsh Assembly Government and with the NHS in England and Wales to ensure that patients receive the best possible care and that taxpayers obtain the best value for the use of NHS resources on both sides of the border. Patients will not be disadvantaged as a result of any of the differences in the two systems.

58. Detailed discussions have been taking place with Welsh Assembly Government officials examining options for replacing the protocol and these are approaching their conclusion.

59. We propose replacing the current interim protocol with a longer-term agreement. This will provide greater certainty for NHS bodies on commissioning responsibilities. A new agreement would also allow:

    - The protocol to include a more sustainable financial and pricing framework.
    - Inclusion within the protocol of a mechanism for resolving disagreements between service providers and commissioners across the border.
    - Parties to reach agreement on greater transparency and comparability of waiting times.

60. The financial transfer from the Department of Health to the Welsh Assembly Government that is associated with the interim protocol is currently renegotiated annually. A longer-term agreement would remove the need for this.

61. Negotiations for the renewal of the interim protocol and the financial transfer are still ongoing and are likely to be resolved in line with the timetable for next year's allocations.

62. Should the new cross-border protocol have an impact on the range or availability of health services to users, then a duty arises to ensure those users affected by the proposed changes are involved in the development of the proposals for change and decisions made about the proposals.

63. The Government awaits the Committee's final report with interest. The Department of Health and the Welsh Assembly Government are committed to working together, and with the NHS in England and Wales, to ensure that the consequences of policy and system differences are managed in such a way as to remove the potential for any confusion or inconvenience for patients and the public.

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