The Government's response to the House of Commons Welsh Affairs Committee report: 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
June 2009

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Introduction

1. The House of Commons Welsh Affairs Committee published its report 'The provision of cross-border health services for Wales' on 27 March 2009. The Government welcomes the Committee's report as a helpful contribution to the debate about the provision of health services. This Command Paper sets out the Government's response to the report.

2. Until devolution, health policy in Scotland and Wales was the responsibility of Ministers in the United Kingdom. With devolution in 1999, the Welsh Assembly Government became responsible for health policy and the delivery of health services in Wales, and policy and priorities began to diverge. Although this has been regarded as a natural and positive consequence of devolution it has brought with it implications for the administration, commissioning and funding of NHS services along the border.

3. Legal responsibility for patients is principally determined by residence, which has caused confusion among healthcare providers and commissioners when they were dealing with patients who were registered with GPs across the border. This inevitably led to tensions as health authorities tried to work out who should pay for a patient's treatment.

4. In 2005, the UK Government and the Welsh Assembly Government agreed an interim Protocol, whereby operational and commissioning responsibility for a patient would be determined by GP registration on behalf of the Primary Care Trust (PCT) or Local Health Board (LHB) of residence. This established that NHS Wales has operational responsibility for commissioning healthcare services for patients with a GP in Wales, even if those patients live in England. The same applies for Welsh patients registered with an English GP. The legal and funding responsibility remains based on residency.

5. This arrangement is convenient for patients and more practical for health services in both countries. It means that patients are able to exercise choice when registering with a GP. If patients were forced to register with a GP in their own country, many would find their new GP would be considerably further away than their current one, reducing their access to high quality primary care. The protocol aims to ensure that patients receive the health services they require, even if that is in another country and is delivered by the NHS system operating there.

6. The need to manage the differences between England and Wales is perhaps more pressing than the need to address differences between the other home countries because of the size of the population living along the border. The number of patients involved is significant. In 2008-09, some 20,000 people resident in England were registered with a GP in Wales and some 15,000 people resident in Wales were registered with a GP in England.

7. 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 and Welsh residents may access specialist services further afield.

8. While the core principles of the National Health Service apply across the UK 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 country to develop policies better attuned to their needs and circumstances. It also allows the NHS in different countries 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.

9. It is for the Welsh Assembly Government 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.

The Government's response to the Committee's conclusions and recommendations

We are very disappointed that a permanent protocol on cross-border health services has not yet been agreed between the Department of Health and the Welsh Assembly Government, or even published in draft for consultation. Our interim Report concluded that this was a critical issue in need of urgent consideration. The lack of a permanent protocol leaves clinicians and administrators in a strained position and risks adversely affecting patients as a result of cross-border commissioning and funding problems. In its response to this Report, we expect the Government either to announce the publication of its draft protocol, or to give a reasoned explanation for the delay. The Committee also expects a prompt response to its Report. (Paragraph 11)

10. Significant progress has been made since the Government submitted its formal response to the Committee's interim report in January. A revised cross border protocol for healthcare services has been agreed with the Welsh Assembly Government. This is effective from 1 April 2009 to 31 March 2011. The protocol will then be renewed in line with the three year planning cycle and the Comprehensive Spending Review (CSR).

11. The revised protocol was agreed after the Government responded to the Welsh Affairs Committee's interim report in January 2009. The Government had delayed its response to the Committee's interim report so that details regarding a revised protocol could be included in a response. Unfortunately, discussions with the Welsh Assembly Government were not completed in the anticipated timeframe. It was always critical that the protocol was agreed and in place in line with the NHS planning timetable and this was achieved.

12. The revised protocol is broader in scope than the previous interim protocol as a result of a new financial framework. It provides greater clarity on commissioning and funding arrangements and will lead to further improvements for patients who live along the border.

13. The protocol continues a financial framework to take account of cross-border flows. The financial arrangements supporting the revised protocol will continue to be reconciled annually. It agrees the principles and the basis for the funding of secondary care. As there are more people living in England who have a Welsh GP than there are people living in Wales with an English GP, the Department of Health pays the net difference for secondary care to the Welsh Assembly Government. In 2008-09, this amounted to £5.8m. In addition, the Department of Health will provide funding in the order of £12 million for 2009/10 to Welsh commissioners to pay English providers tariff prices under Payment by Results. This payment should help to remove the potential for tensions between commissioners and providers over pricing issues.

14. The revised protocol also clarifies standards for access for patients. Officials from the Department of Health will work with colleagues in the Welsh Assembly Government and the NHS to improve patient awareness of the implications of GP registration.

15. The UK Government and the Welsh Assembly Government are developing a framework to respond to changing health policies in both countries. Because policy on both sides of the border is dynamic, we do not think it practical to have an inflexible protocol that is set in stone. It is more important to have a protocol and framework in place that provides clarity for all while allowing both sides to respond to the local implications of policy changes on either side of the border.

16. Although the most significant and public cross border issues appear to have been resolved there remain areas, including patient awareness, care pathways and waiting times, where further clarity and guidance are required. This is particularly true for the services that fall outside secondary elective care. These will continue to demand close cooperation with colleagues from the Welsh Assembly Government and the NHS in both England and Wales.

17. As health policies diverge, it is important that we have in place mechanisms to clarify the implications for cross-border patients and ensure that funding appropriately reflects patient flows.

Cross-border health services

Our concerns were fully addressed when we welcomed the attendance of the First Minister who came for an extended evidence session, during which he expressed his full commitment and that of his Cabinet to a focus on patient needs and to treatment being provided as close to home as possible. His confirmation that the Welsh Assembly Government is determined not to allow the border to become a barrier was refreshingly direct and specific and we congratulate him on his commitment and clarity. (Paragraph 39)

The border between Wales and England is long and porous. Cross-border movements have been a fact of life for many years, as people resident in one country are naturally drawn to centres of population in the other. This is no less the case for health services. For those residing in immediate border areas, the nearest health provider may not be in their country of residence. Equally, whilst advances in technology mean that it is possible to provide more services in local hospitals, some complex conditions will always require treatment in a specialist centre, which may be across the border. All those who gave evidence to our inquiry agreed that there is no practical or realistic prospect of diverting these well-established cross-border flows, nor would it be desirable to do so. (Paragraph 40)

For these reasons, healthcare providers in England and Wales need to maintain close links to ensure that patients receive the treatment they need regardless of their country of residence. This will require commitment and good will from those concerned with policy and delivery by the NHS on either side of the border, particularly given the policy divergence that has begun to emerge as a result of devolution. Each Government will choose to fund what it considers to be the most important aspects of health care for its constituents, with finite resources. Indeed, the Committee believes that devolution provides an opportunity for the nations of the UK to learn from

each other's approaches. However, divergent policies must be implemented in a way which accommodates the continuing flow of patients across the Wales-England border. In this context, we support the solutions proposed in relation to the provision of neurosurgery services in North Wales by the Steers Review, and accepted by the Welsh Assembly Government, which would also provide an appropriate model for other specialist and tertiary services. (Paragraph 41)

18. The Government agrees with the Committee and the First Minister that the border between England and Wales does not and should 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 in Wales. This sets out the over-arching principles within which the Department of Health and Welsh Assembly Government co-ordinate cross-border services.

19. 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.

20. 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.

21. It is for the Welsh Assembly Government to determine its own health policies and priorities to meet the needs of people in Wales and we welcome the opportunity to learn more about what is successful in their different approaches, and in the approaches adopted in Northern Ireland and Scotland.

Funding and Commissioning

There is clearly a lack of effective communication between the Welsh Assembly Government and the Department of Health on these issues despite the practical nature of the problems faced by NHS providers on both sides of the border. The issue appears to be firmly lodged in the 'too difficult' tray by officials and Ministers and that is not acceptable. If Ministers cannot agree on a fair approach at a strategic level they should agree a form of arbitration which is neutral and independent and make a commitment to accepting its adjudications. There is an urgent need for enforceable protocols between the UK and Welsh Assembly governments to address the current unsatisfactory state of affairs. (Paragraph 61)

22. As indicated (response to paragraph 11), the UK Government and the Welsh Assembly Government have agreed a revised protocol.

23. The UK Government and the Welsh Assembly Government work together to deal with the practical consequences of devolution to ensure that patients are not inconvenienced. One of the mechanisms for dealing with differences between England and Wales is the cross-border protocol. The Department of Health and the Welsh Assembly Government have developed and extended

existing links between the two Governments. There is also a range of other mechanisms in place to bring officials and NHS managers and clinicians together on specific policy issues.

24. The Government will discuss with the Welsh Assembly Government the establishment of a cross border policy group, to meet at least quarterly, to address policy divergence as it arises and agree a process for resolution. Local cross border action groups could also be set up, building on the model of the Central Wales-West Midlands Strategic Forum. The Forum responds to strategic policy issues and opportunities for collaboration. It includes representatives from local, regional and national organisations, to examine policy issues including health, the environment, transport, housing and rural affairs.

Our evidence has demonstrated that there are problems with the cross-border commissioning of specialist care for the conditions such as Muscular Dystrophy and mental health care. The difficulties patients have experienced must be recognised and addressed in a holistic way and we are not convinced that the Minister is right to dismiss UK-wide commissioning out of hand. Given that this problem faces regions of England, even though they generally have far larger populations than Wales, it may be that some other form of high-level commissioning that goes across the boundaries of English regions and across the Welsh border would be appropriate for such specialised services. The solution should be driven by the need of patients rather than existing practice. (Paragraph 66)

25. The advisory structure for the commissioning of rare conditions and specialised services in England, the National Specialised Commissioning 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 NSCG team will continue to promote co-operation across borders within this framework. The National Specialised Commissioning Team have had initial discussions with colleagues in Wales about the feasibility of Welsh commissioners utilising the contracting model used for commissioning rare neuromuscular services for English patients.

To some degree, local re-negotiation of contracts may provide solutions to the funding and commissioning disputes outlined in this Report. However, these are unlikely to be resolved successfully in every case. For a genuinely sustainable solution to be developed, a holistic approach to cross-border issues must be adopted. The problems we have described will recur if not resolved in a sustainable way. (Paragraph 77)

Even if the Ministers are right to say that the figures are small and the financial implications marginal, any failure to resolve these issues will appear neither small nor marginal to the individuals affected, nor to their families. Tension between commissioners and providers may be inevitable, but they must be resolved without damaging patient care. (Paragraph 80)

There are potentially serious consequences of leaving individual organisations to cope with the tensions raised by different funding and commissioning arrangements for Welsh and English patients The opportunity for financial pressure to impact on health service provision must be removed. It is unacceptable that individual providers and commissioners have been left to negotiate ad hoc solutions to a problem caused by government-level decisions, apparently taken without regard for their impact on cross-border

commissioning. A solution must involve a sustainable and enforceable long-term agreement between the two governments so that future disputes will be avoided and that the patient experiences a seamless National Health Service which meets their needs and not those of accountants. We are therefore deeply disappointed that no permanent protocol has been agreed between the Department for Health and the Welsh Assembly Government, or even published in draft for consultation, almost a year after we were assured that a protocol was imminent. (Paragraph 81)

At present, both English providers treating Welsh patients and Welsh commissioners are left in an unacceptable position. Department of Health guidance states that English providers should continue existing arrangements with Welsh Commissioners, yet it also encourages them to devise management strategies orientated towards a market-led system in England. Conversely, Welsh commissioners see no reason to diverge from a long-standing system due to policy changes across the border over which they have no influence. Neither position is sustainable in the long term. (Paragraph 82)

26. The revised protocol addresses the significant issues that had been brought to the attention of the UK Government and the Welsh Assembly Government during the term of the interim protocol. Constructive links have been established by officials in both countries and there is ongoing work between the Department of Health and the Welsh Assembly Government on outstanding and emerging issues.

27. A key change to the 2009-11 revised protocol is that it has also been agreed that the Department of Health will provide funding in the order of £12 million for 2009/10 to Welsh commissioners to pay English providers tariff prices under Payment by Results. This payment should help to resolve local tensions between commissioners and providers over pricing issues.

28. There are also local agreements in place to facilitate care for patients living along the border. For example, NHS Gloucestershire has a contract with the neighbouring Monmouthshire LHB enabling them to provide a range of services. The PCT also refers patients registered with an English GP to Wales secondary care providers and similarly patients registered with a Welsh GP have access to English hospitals.

29. The protocol includes a three-tier dispute resolution process. There are two types of dispute that may arise: i) disputes between commissioners on establishing which of them is responsible for an individual patient; and ii) disputes between a commissioner and provider on issues such as funding, performance and the wider terms of their contract or service level agreement.

30. Under the terms of the protocol, a patient's 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 healthcare provision. Where there is uncertainty about who is the responsible commissioner, LHBs/HCW and PCTs need to work together to reach agreement speedily and fairly. If a Trust has admitted patients to its hospital there should be an automatic assumption that treatment would proceed.

31. It is recognised that further work will be required to embed Foundation Trusts, who have other reporting responsibilities, within the current disputes resolution procedure. However, it is expected that the principle will still be applicable.

While we were assured that those currently supplying cross-border health services were not influenced by the present perverse arrangements, the potential for detriment to patients is clear. It is to the credit of clinicians and administrators that high quality health care continues to be provided to patients despite ongoing disputes over funding. Nevertheless, we have heard some evidence that patients are beginning to suffer, at a time when they are least able to cope with bureaucracy, administrative confusion and delays in medical treatment. This evidence is necessarily anecdotal, but it is persuasive. We note that there is a deficit of robust research concerning cross-border healthcare and we therefore urge the Department of Health, as the UK-wide body, to undertake a study of the impact of cross-border movements on health services. It would be helpful to be able to compare crossborder issues between English regions to the issues across the border between England and Wales in order to distinguish between issues that are a consequence of devolution and those that are simply the result of 'normal business'. (Paragraph 83)

32. The Department will continue to engage with the Welsh Assembly Government and NHS organisations on the border to identify issues affecting patients in border areas. In line with the recommendation of the Welsh Affairs Committee, the Government will discuss with the Welsh Assembly Government the joint commissioning of research into the impact of devolution on patient experience. If the Welsh Assembly Government decides not to engage jointly in such a process we will work with the three border SHAs to better understand the position in England.

We reiterate the recommendations of our earlier Report on cross-border further and higher education, that meetings between Ministers and officials of UK Government departments and the Welsh Assembly Government must be made more transparent. This is in the interests of a healthy democracy and the effective operation of devolution. (Paragraph 84)

33. It is the Government's view that devolution was intended to allow administrations to introduce policies that they believe to be in the best interest of their populations and economies. However, there is much to be gained from Ministers and officials discussing policies and plans with colleagues in the Welsh Assembly Government and vice versa. Where services provided by one administration are used by the residents of another it is useful to have agreement about how those arrangements will work.

34. Considerable work is carried out between officials in the Government and the Welsh Assembly Government – in policy development, project delivery and policy implementation. Regular discussion take place between officials from the Government and the Welsh Assembly Government in a number of key policy areas.

35. The Government will discuss with the Welsh Assembly Government the establishment of a cross border policy group, to meet at least quarterly, to address policy divergence as it arises and agree a process for resolution. Local cross border action groups could also be set up, building on the model of the Central Wales-West Midlands Strategic Forum to address local issues as they arise.

Waiting times

Differential waiting times are likely to persist within the NHS, not only because of divergent policy in England and Wales since devolution, but also for reasons of local variation unconnected with the side of the border on which a service provider lies. At present there is an eight week difference in the stated target waiting times for the Welsh and English NHS. It is not clear to the Committee that Welsh patients are aware of this fact, or of the more general potential for divergence between the Welsh and English health services. Better information for patients must be made available, particularly in immediate border areas where the choice of a Welsh or English GP may have implications for later care. (Paragraph 97)

In practice, our evidence suggests that Welsh-registered patients accessing elective treatment in England are not, as a rule, waiting eight weeks longer than England registered patients. Actual waiting times are generally below English target waiting times both for England-registered and Wales-registered patients treated in English hospitals. Of course, this is little consolation for those individuals who do experience longer or much longer waits. (Paragraph 98)

The fact that the waiting time targets in England and Wales are measured differently severely hinders transparency and accountability. Equally, there is no publicly available costing of the shorter waiting times targets set in England compared to Wales. Even if there were a clear cost associated with shorter waiting times, hospital providers are currently left in a difficult ethical position. Many have told us that they will not operate two separate waiting lists which differentiate between patients solely on residence. It is the Committee's view that providers should not be in this position; the procedure that English hospitals need to operate in this situation is a matter for the Welsh Assembly Government and Department of Health to resolve at a national level. We recommend that, as a matter of urgency, the Welsh Audit Office and the Audit Commission undertake a joint inquiry into the facts of the matter in order to provide a clear evidence base to inform discussions between Ministers to agree how best to resolve these issues. (Paragraph 99)

36. The Government has made the reduction of waiting times across the NHS a key priority and the NHS in England is making excellent progress to reduce waiting times. Although the maximum wait target in England is 18 weeks, the vast majority of patients will receive treatment much more quickly. Figures for February 2009 show that at an aggregate England level, the median Referral to Treatment waiting time is 8.7 weeks for those requiring admission and just 3.7 weeks for non-admitted patients.

37. There is much in common between English and Welsh policy. Both countries have set maximum waiting time standards for both individual stages of treatment, as well as the whole pathway, from referral to treatment (RTT).

38. Where we differ is in the length of maximum waits set. In England, from 1 January 2009, no patient should wait more than 18 weeks from the time they are referred by their GP to the start of their treatment, unless it is clinically appropriate to do so or they choose to wait longer. The standard for inpatient admissions is a maximum of 26 weeks and a maximum of 13 weeks for a first outpatient appointment.

39. All NHS trusts in Wales must achieve a 26-week waiting time target for GP referral to treatment by December 2009. In Wales, the 2007/08 waiting time targets for admission as an in-patient or daycase, or for a first outpatient appointment, was 22 weeks. At the end of March 2009, the target reduced the maximum waiting time for inpatient or day case treatment to 14 weeks and reduce the maximum waiting time for a first outpatient appointment to 10 weeks.

40. Direct comparisons are difficult to make due to differences in recording information and data definitions. 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. In practice patients, including those with a Welsh GP, treated in an English Trust should receive their treatment within English waiting times. As a result of Welsh priorities, Welsh waiting times will apply as a maximum to patients from Wales referred to hospitals in England.

41. The UK Waiting Times Group brings together officials from the four home countries. The group looks to identify where comparable data is available, where policies allow comparisons and the stumbling blocks to meaningful comparisons. The group produces comparable data where possible so that such data can be used to inform and support policy development and performance monitoring within and between the four home countries.

42. We will work with the Welsh Assembly Government and NHS bodies on the border to ensure that patients are properly informed and can make appropriate choices.

Patient engagement

The Committee is encouraged by the positive evidence it has heard regarding hospitals which have included a cross-border dimension in their management structures. We believe that this model could and should be replicated in all hospitals near the border which serve both English and Welsh patients. We urge the Department of Health to promote cross-border engagement at [a] strategic level in English hospitals, and to consider the extent to which this has been achieved when making decisions about foundation trust status. (Paragraph 103)

We are concerned by the anecdotal evidence we have received suggesting that English residents with an interest in Welsh health services may find their engagement in those services limited. We recommend that the Department of Health include citizen engagement and patient ownership of cross-border services in negotiations with the Welsh Assembly Government to ensure that English residents' rights to contribute to Welsh services are protected by the Welsh patient engagement process, just as the rights of Welsh patients are protected in the structure of Foundation Trusts. (Paragraph 105)

43. The Department of Health will work with colleagues in the Welsh Assembly Government and the NHS to improve patient awareness of the implications of their GP registration. It is proposed that in England, at least, PCTs in border areas will provide information directly to patients in their annual guide to local healthcare services.

44. 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.

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

46. 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.

'Border-proofing' policy

It is clear that there is a lack of co-ordination at a national level for cross-border health services between England and Wales. Localised solutions have appeared in some areas, but even where these arrangements work well, patients should not have to rely on the good will of those involved to ensure that their health care pathways are coherent. The Committee considers that an improved government-level protocol is essential to standardise and clarify funding arrangements and accountability mechanisms. The result should be seamless care for patients based on clinical need. We are therefore very disappointed at the lack of progress regarding the development of a permanent protocol since we took evidence last year. (Paragraph 113)

47. The Government is committed to working closely with the Welsh Assembly Government and with the NHS to ensure that patients receive the best possible care and that taxpayers obtain the best value for the use of NHS resources. The Government believes that the border should not be a barrier to the provision of healthcare.

48. As of 1 April 2009, the UK Government and the Welsh Assembly Government have agreed a revised protocol for cross-border healthcare services. The protocol provides greater clarity on commissioning and funding arrangements and will lead to further improvements for patients who live along the border. Because health policy on both sides of the border is dynamic and changes over time, a permanent protocol is impractical. The current arrangements allow the UK Government and the Welsh Assembly Government to respond to changing health policies.

49. It is the Government's view that the devolved administrations will develop policies that are appropriate for their residents and their circumstances – that is the inevitable and healthy consequence of devolution. However, the advent of devolution does not mean that there should not be exchanges between Ministers and officials so that each administration understands the rationale and implications of policy decisions.

Conclusion

50. The National Health Service in England and Wales – and indeed across the United Kingdom – will continue to remain true to its founding values. A tax funded system, free at the point of delivery.

51. The Government and the Welsh Assembly Government will continue to work closely together to identify and resolve any issues that will inevitably arise in a changing policy environment to ensure that patients, whether English or Welsh, receive the full benefits of the National Health Service.

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