RCGP CYMRU WALES

Welsh Affairs Committee
UK Parliament

13 January 2025

Dear Clerk of the Committee,

Thank you for the opportunity to contribute some thoughts towards the Welsh Affairs Committee's evidence session on cross-border healthcare. RCGP represents over 52,000 GPs across the UK and over 2,100 in Wales. In preparing this letter, we have sought to take on board a plurality of views both from GPs close to the border who experience the daily challenges of cross-border healthcare and from those elsewhere in Wales who may not see the tangible differences on their doorstep but are still affected by the differences in decision-making either side of the border.

For purposes of clarity, if a GP's primary surgery is in one country and they run a satellite surgery in the other, both fall within the area of the health board/Integrated Care System (ICS) of the primary surgery. This is the case with our current RCGP Cymru Wales Chair Dr Rowena Christmas who has a primary practice in Trellech, Monmouthshire and a satellite surgery in St Briavels, Gloucestershire.

Secondary care interface

There are practical challenges related to interface with and referrals to secondary care in cross-border situations. An example of this is that because Welsh GPs do not have access to Cinapsis referral software. Patients from England being served by Welsh practices will routinely be referred to accident and emergency rather than medical or surgical assessment units. This results in the patient being treated as if they had not seen a GP in the first place, duplicating work and using up precious A&E time.

Blood tests and X rays taken in Welsh general practice cannot consistently be viewed by secondary care consultants in the English ICS due to variations of the computer system.

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This can lead to duplication of work, as the procedure will need to be repeated.

Referral pathways vary between England and Wales causing potential confusion for clinicians.

The experience of cross-border referrals is varied with some good examples cited such as patients from the Wrexham area receiving minor injuries care at Oswestry. However, in other instances concerns were raised about the restrictions on pathways for referring patients out of one health board to an English ICS.

The logic of the health board approach to referrals is not always consistent with the practical considerations of a patient. For example, transport links from North East Wales may make a hospital appointment in Chester or Merseyside more convenient for a patient than one elsewhere in North Wales.

There is a reliance on the English NHS for some services, such as gastric banding and IVF, the funding transfer mechanism can cause a delay for Welsh patients.

Simple confusion too often causes delays. One example is a patient in England needed a PET scan, but it could not be requested as the English patient's practice is in Wales. This was incorrect but takes time to resolve for the practice team and poses a delay for the patient.

Welsh GPs do not have access to the English cervical screening system. Applications for the relevant smart cards were made but nothing has come of it to date.

Social care interface

There is a disparity in services offered for palliative care between hospice services on either side of the border which the GP must navigate.

Prescriptions

GPs along the Welsh border have noted that their patients with English addresses will bring hospital scripts to the GP in Wales to dispense so that provision of the medicine is free of charge. This increases the workload on dispensing GPs in Wales near the border.

Patient expectations can differ from what is possible for us to prescribe. For example, a neighbouring English GP would have a different scope of dispensing to one from Wales, but to the patient who is trying to understand why someone from the same town or village received a different medication it can cause confusion.

Continuity of care

An example was provided of a patient from England with a GP in Wales who was informed that they could not see an English palliative care team because they were registered with a Welsh practice. As a result, the patient re-registered with an English practice, but in doing so lost the valuable continuity of care relationship with their long-term GP.

In another example, a patient with an NHS diagnosis of ADHD in England on medication moved to Wales and was required to go through the whole diagnosis process again before being able to access the drugs. This caused a duplication of resources and was unsettling for the patient.

Recruitment

The continued existence of separate Performers List is a purely bureaucratic obstacle to recruitment of GPs from one nation to another within the UK. This disproportionately adversely affects Wales the most because such a large proportion of the population live close to the English border. It would be simple to amalgamate to a UK Performers List allowing a smoother process for a qualified GP from one part of the UK to work in another.

Ambulance services

Concerns have been raised about the willingness of ambulance services based in England or Wales to take patients to the most appropriate hospital when that is across the border. In one example, a patient from England who should have been taken to a hospital in Gwent was denied an ambulance because the location was outside of their area. In this instance the Welsh Ambulance Service stepped in but only after the GP contacted them directly which led to a use of GP time and a delay for the patient.

Constitutional matters

It is important to view the provision of healthcare from the perspective of the patient. It might be logical to a health board or ICS to keep services within their area but wholly illogical to a patient who is not bound by such geographical constraints. To the patient, a taxpayer, who regards the NHS as a universal free at the point of use service, it can be hugely frustrating to see delays caused by two different NHSs failing to communicate effectively across a national border.

While it is a matter for the Welsh Government to decide how to spend the block grant calculated on the basis of the Barnett Formula, the health component of that formula is

calculated on the basis of the needs of the health of the population on England and not specifically that of Wales. Furthermore, the Barnett Formula process results in an inevitable delay in the equivalent resources being made available in Wales in comparison to England.

While the decentralisation of power has offered many opportunities it has tended to be the case that conversations subsequently have taken place on the basis of whether what has been devolved should be expanded or remain the same. There should also be scrutiny in place as to whether specific aspects of care can actually provide a better patient experience if they were not devolved. Such objective testing of the process will only improve the rigour of our constitutional settlement.

We are grateful for the opportunity to contribute these thoughts and experiences to the Committee and hope that members find our letter useful.

Yours sincerely

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