Agenda – Health, Social Care and Sport Committee

Meeting Venue:
Committee Room 2 – Senedd
Meeting date: 9 January 2019
Meeting time: 09.15

For further information contact:
Claire Morris
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0300 200 6355
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Informal pre-meeting (09.15 – 09.30)

1 Introductions, apologies, substitutions and declarations of interest

(09.30)

2 Legislative Consent Motion on Healthcare (International Arrangements) Bill: Evidence session with the Minister for Health and Social Services

(09.30–10.15) (Pages 1 – 39)

Vaughan Gething, Minister for Health and Social Services, Welsh Government
Lyn Summers, Head of HSSG Central Legislation Support Team, Welsh Government
Mari Williams, Government Lawyer, Welsh Government

Research Brief
Legal Advice Note
Legislative Consent Memorandum
Paper 1 – Letter from Cabinet Secretary for Health and Social Services to Lord O'Shaughnessy Parliamentary Secretary of State for Health and Social Care – 23 October 2018
Paper 2 – Letter from Cabinet Secretary for Health and Social Services to Lord O'Shaughnessy Parliamentary Secretary of State for Health and Social Care – 25 October 2018

Paper 3 - Letter from Lord O'Shaughnessy Parliamentary Secretary of State for Health and Social Care to Cabinet Secretary for Health and Social Services - 26 October 2018

Paper 4 - Letter from Cabinet Secretary for Health and Social Services to Lord O'Shaughnessy Parliamentary Secretary of State for Health and Social Care - 15 November 2018

Paper 5 - Letter from Cabinet Secretary for Health and Social Services to Lord O'Shaughnessy Parliamentary Secretary of State for Health and Social Care - 4 December 2018

Paper 6 - Letter from Lord O'Shaughnessy Parliamentary Secretary of State for Health and Social Care to Cabinet Secretary for Health and Social Services - 14 December 2018

Paper 7 - Letter from Cabinet Secretary for Health and Social Services to Lord O'Shaughnessy Parliamentary Secretary of State for Health and Social Care - 19 December 2018

Paper 8 - Letter from Lord O'Shaughnessy Parliamentary Secretary of State for Health and Social Care to Cabinet Secretary for Health and Social Services - 19 December 2018

3 Paper(s) to note

(10.15)

3.1 Letter from Welsh Government to Chair of Cross Party Group on Hospices and Palliative Care - 04 September 2018

(Pages 40 - 47)

3.2 Letter to Welsh Government from Chair of Cross Party Group on Hospices and Palliative Care Inquiry - 10 October 2018

(Pages 48 - 49)

3.3 Public Health (Minimum Price for Alcohol) (Wales) Act 2018: Letter from The Welsh Government to Chair of Health, Social Care and Sport - 07 December 2018

(Pages 50 - 53)

3.4 Letter from the Welsh Government regarding scrutiny of regulations arising from the European Union (Withdrawal) Act 2018 - 10 December 2018

(Pages 54 - 56)

3.5 Letter from Chair of External Affairs and Additional Legislation to Chair of Health, Social Care and Sport - 17 December 2018

(Page 57)

3.6 Welsh Government Draft Budget 2019-2020: Letter from Welsh Government to Chair of Health, Social Care and Sport Committee - 21 December 2018

(Pages 58 - 59)

4 Motion under Standing Order 17.42 to resolve to exclude the public from the remainder of this meeting

(10.15)

5 Legislative Consent Motion on Healthcare (International Arrangements) Bill: Consideration of evidence

(10.15 - 10.30)

6 Forward Work Programme: Consideration of forward work programme

(10.30-11.30) (Pages 60 - 84)

Paper 15 - Forward Work Programme

Paper 16 - Paper by the Centre for Excellence in Rural Health Research, Aberystwyth University on Brexit and the determinants of rural health

Agenda Item 2

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LEGISLATIVE CONSENT MEMORANDUM

Healthcare (International Arrangements) Bill

1. This Legislative Consent Memorandum is laid under Standing Order ("SO") 29.2. SO29 prescribes that a Legislative Consent Memorandum must be laid, and a Legislative Consent Motion may be tabled, before the National Assembly for Wales if a UK Parliamentary Bill makes provision in relation to Wales for any purpose within, or which modifies the legislative competence of the National Assembly.

2. The Healthcare (International Arrangements) Bill (the "Bill") was introduced in the House of Commons on 26 October 2018. The Bill can be found at: Bill documents — Healthcare (International Arrangements) Bill 2017-19 — UK Parliament

Policy Objectives

3. The UK Government's stated policy objectives are to enable the Government to respond to the wider range of possible outcomes of EU Exit in relation to reciprocal healthcare including the implementation of new reciprocal healthcare agreements. This Bill forms part of the UK Government's legislative response to EU Exit. Although the Bill is being introduced as a result of the decision to leave the EU, the legislation could also be used to give effect to healthcare agreements with other third countries.

Summary of the Bill

4. The Bill is sponsored by the Department of Health and Social Care.

5. The Bill makes provision:

- To provide the Secretary of State with powers to fund and arrange healthcare outside the UK:
- To make regulations to give effect to healthcare agreements between the UK and other countries, territories or international organisations, such as the European Union (EU); and
- To enable the designation of authorised persons for the purpose of data processing, which is necessary to underpin these arrangements and agreements.

Provisions in the Bill for which consent is required

6. It is considered that Clauses 1, 2, 4 and 5 require consent on the basis that they are making provision for a purpose that is either partially or wholly within the Assembly's legislative competence as they relate to health. (Clauses 3 and 6 make provision about interpretation, extent and commencement for the purposes of the other clauses in the Bill for which consent is required.)

7. **Clause 1** –provides the Secretary of State with a power to make payments and to arrange for payments to be made to fund healthcare outside of the UK.

8. Should new reciprocal healthcare arrangements be similar to current EU arrangements this could include, amongst other things, funding healthcare for state pensioners living outside the UK, providing healthcare for UK residents visiting countries outside the UK, funding healthcare for posted workers and funding for UK residents to receive planned treatment in other countries.

9. **Clause 2** – provides the Secretary of State with powers to make regulations in relation to Clause 1, in connection with the provision of healthcare outside the UK, and to give effect to healthcare agreements.

10. It is envisaged that should the UK exit the EU in a deal scenario, this power would enable the implementation of future healthcare arrangements with the EU, individual Member States or third countries from January 2021 onwards. In a no deal scenario, then this would enable the UK Government to give effect to new reciprocal healthcare arrangements on or after exit day.

11. Whilst it is for the UK to make bilateral or multilateral agreements with other territories and international organisations, the Assembly may legislate for the purpose of observing and implementing the UK's international obligations relating to devolved matters, such as healthcare.

12. **Clause 4** – provides powers to enable authorised persons to process personal data to facilitate reciprocal healthcare arrangements.

13. It may be necessary for authorised persons to share personal data, including medical data, with equivalent persons or bodies overseas to facilitate any reciprocal healthcare arrangements. Currently EU law provides the necessary powers to do this. This data processing gateway would support the operation of payments and arrangements for healthcare outside the UK provided for under Clause 1.

14. **Clause 5 –** provides a power to amend, repeal or revoke primary legislation, including a Measure or Act of the Assembly, for the purpose of conferring functions on the Secretary of State or any other person, or to give effect to a healthcare agreement.

15. Consent is required for these provisions as they fall within the legislative competence of the National Assembly for Wales in so far as they relate to health and the observance and implementation of international obligations relating to healthcare.

Reasons for making these provisions for Wales in the Healthcare (International Arrangements) Bill

16. The Welsh Government agrees that following EU Exit, legislation is necessary to make provision for reciprocal healthcare arrangements to give certainty and assurance to UK residents. These arrangements allow individuals to travel, work and receive treatment outside of the UK where this may not be otherwise possible. In the case of a no deal exit from the EU, it will be important to provide assurances for residents as soon as possible. There is, therefore, urgency to the timing of the Bill and the legislation made under it.

17. While the Welsh Government believes that there are benefits to having a UK-wide approach, any healthcare agreement entered into on behalf of the UK will affect the NHS in Wales and this legislation will therefore have a significant impact on a devolved policy area.

18. There are therefore outstanding concerns about the extent to which the Welsh Government will be involved in informing and shaping the healthcare agreements to be delivered under the Bill which will impact on the NHS in Wales. Whether or not legislative consent should be given, therefore, needs to be considered in light of legislative and non-legislative assurances given by the UK Government to ensure that the Welsh Government is involved in matters that affect devolved areas in Wales.

19. Further work to resolve our concerns will continue during the Bill's passage through Parliament and a supplementary Legislative Consent Memorandum will be brought forward if required.

Financial implications

20. There are financial costs associated with reciprocal healthcare arrangements. These costs relate to arranging to pay for the treatment of UK residents abroad and to providing healthcare for non residents in the UK. There could be increased or decreased costs depending on the number of countries with which the UK establishes reciprocal healthcare arrangements and the nature of these agreements.

21. Lord O'Shaughnessy wrote to the Cabinet Secretary for Health and Social Services on 26 October to give assurances that there will be no additional costs to the devolved administrations associated with the Bill. The Welsh Government is seeking clarification as to how this assurance will be provided for.

Conclusion

22. It is the view of the Welsh Government that it is appropriate to deal with these provisions in this UK Bill due to the urgency of the legislation and the preference for a consistent approach across the UK. However, given the significant impact on devolved areas it is crucial that Welsh interests are appropriately considered in the development of reciprocal health arrangements and that mechanisms are in place to ensure that the Welsh Government contributes to the making of decisions that affect Wales.

Vaughan Gething AM
Cabinet Secretary for Health and Social Services
November 2018

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: MA - L/VG/0662/18

Lord James O'Shaughnessy
Parliamentary Under Secretary of State for Health (Lords)
Department of Health and Social Care
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23 October 2018

Dear James,

I have received the UK draft proposal for a Healthcare (International Arrangements) Bill, and note that you intend for the first reading in the House of Commons to be on Thursday, 25 October.

Provision of health services is a devolved matter, and I am therefore surprised and disappointed to only be informed this week that you are looking to introduce this Bill. There has been limited engagement on the content of any legislative fixes, and no engagement on the wording of a healthcare specific piece of legislation.

As I am sure you will be aware I will be unable to agree to any legislation which has implications for the powers devolved to the Welsh Ministers, without thorough engagement leading to legislative reassurance. The proposed legislation is therefore unacceptable in its current form.

We can discuss this issue further in our telephone conversation on Wednesday.

I am copying this letter to the First Minister of Wales, the Secretary of State for Wales and the Chancellor of the Duchy of Lancaster and Minister for the Cabinet Office. I am also copying this to the Scottish Government's Cabinet Secretary for Health and Sport and the Permanent Secretary at the Department of Health in Northern Ireland.

Yours sincerely,

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health and Social Services

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25 October 2018

Dear James,

I am writing further to our telephone conversation yesterday setting out the concerns I expressed in relation to your proposed Healthcare (International Agreements) Bill.

Firstly there is clear acceptance by the UK Government that the Bill legislates in areas of devolved competence through the expressed need for a Legislative Consent Motion from the National Assembly for Wales.

As drafted, it is highly unlikely that such consent would be forthcoming and I see it in all our interests that the Bill is amended so as to avoid that situation.

As I stated our key concerns are:

- The Bill does not include provision to seek the consent of Welsh Ministers to the making of regulations (under Clause 2(2)) which will implement the detail of new healthcare agreements even though these would place obligations on the Welsh NHS which would clearly be within devolved competence.

- The Bill includes a general provision (in Clause 5(3)) which will enable regulations to be made which can amend, repeal or revoke a Measure or Act of the National Assembly for Wales.

As drafted, these provisions are unacceptable.

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If you accept the need to secure our consent to any regulations, then what is clearly required to ensure consent is forthcoming, is that you involve the Devolved Administrations in the negotiation of new agreements from the start and in any subsequent revisions to them.

I look forward to dialogue between our officials to address this, so that a Bill that reflects the role and competence of Wales on this matter and does not have wider implications for Welsh legislation can be achieved.

I am copying this letter to the First Minister of Wales, the Secretary of State for Wales and the Chancellor of the Duchy of Lancaster and Minister for the Cabinet Office. I am also copying this to the Scottish Government's Cabinet Secretary for Health and Sport and the Permanent Secretary at the Department of Health in Northern Ireland.

Yours sincerely,

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health and Social Services

Department of Health & Social Care

Lord O'Shaughnessy
Parliamentary Under Secretary of State (Lords)
Department of Health and Social Care
39 Victoria Street, SW1H 0EU

Vaughan Gething
Cabinet Secretary for Health
Welsh Government

26 October 2018

Dear Vaughan,

THE HEALTHCARE (INTERNATIONAL ARRANGEMENTS) BILL

Thank you for your time on Wednesday, further to our call as discussed I am writing with regard to the anticipated introduction of the Healthcare (International Arrangements) Bill. The Bill was considered at a PBL Committee meeting on 22 October 2018 and is expected to be introduced to the House of Commons on 26 October 2018.

I understand officials from my Department have been engaging with your officials on this piece of legislation for some time; however, I wanted to provide you with further information on the Bill and its underlying policy. Please find a copy of the Bill and an Annex outlining reciprocal healthcare and our European Union (EU) Exit plans enclosed in this letter.

This letter highlights the main provisions that relate to Wales or to devolved matters. I appreciated our discussions on Wednesday and hope you found them helpful. I have asked my officials to follow up immediately with yours, to follow up my commitment on the call. I would be grateful, once these discussions have progressed further, if you could write to confirm whether you agree with our devolution analysis and indicate if you will be content to begin the required legislative consent process in the Welsh Legislative Assembly.

This Bill confers powers on the Secretary of State for Health and Social Care to fund and arrange healthcare outside the UK, to give effect to reciprocal healthcare agreements between the UK and other countries, territories or international organisations such as the European Union (EU), and to make provision in relation to data processing which is necessary to underpin these arrangements and agreements.

The Bill is an important part of the Government's preparations for EU Exit and will ensure that, whatever the outcome of EU Exit, we can make appropriate arrangements to support UK residents to obtain healthcare when they move to or visit the EU, European Economic Area (EEA) and Switzerland. The Bill underscores our commitment to reaching an ambitious reciprocal healthcare agreement with the EU or where necessary making agreements with Member States and to exploring potential agreements with third countries.

Without such arrangements many UK citizens who currently live or work in the EU may still have good options for accessing healthcare but some could face additional healthcare costs. UK tourists and others visiting the EU, EEA and Switzerland would rely more on travel insurance and this might make travel difficult for the elderly and/or people with medical risk factors. It would not be as easy for the NHS to refer patients for treatment to the EU, EEA and Switzerland. There could also be costs to tourism, to the wider economy and to the NHS if UK citizens currently living overseas return to the UK to seek treatment here.

Given the range of potential scenarios associated with EU exit and the difficulty, for example, of predicting the final terms of numerous separate bilateral deals and the future economic partnership with the EU, the Bill powers being sought provide a straightforward and clear way to prepare for the range of eventualities. The powers in the Bill provide the necessary legal authority for the Secretary of State to give effect to and fund complex bilateral or international healthcare agreements, and provide for necessary data processing.

Devolved Competence

The UK is responsible for entering into international agreements, and will consult the devolved administrations as a matter of course before agreeing (or amending) anything that touches on a devolved policy area, such as healthcare.

The Bill powers deal with the domestic implementation of international agreements. They will enable the existing arrangements provided for under the EU Regulations, which benefit residents of England, Wales, Scotland and Northern Ireland, to be maintained, subject to EU agreement. They could also support implementation of other agreements with third countries in future for the benefit of all UK nationals.

Reciprocal healthcare as governed by EU Regulations pre-dates the devolution settlements and while international affairs is a reserved matter, domestic healthcare is devolved. As we take the Bill and regulations forward it will be important we do so in a way that is collaborative and respects the devolution settlement and conventions for working together. The UK Government is committed to working closely with the devolved administrations to deliver an approach that works for the whole of the UK.

The Bill has a strong international focus and is predominantly concerned with the welfare of UK nationals outside the UK including the making of payments abroad and data sharing to support that. It is recognised that in some parts of the Bill, powers may be used in ways which relate to domestic healthcare and consequently legislative consent motions will be sought to this extent only. These uses are summarised below:

- To fund and arrange healthcare abroad pre-authorised by the NHS, including NHS bodies in Scotland, Wales or Northern Ireland;

- to give effect to any healthcare agreement which concerns healthcare provided in the UK, the cost of which is met by another country, and

- to enable [Scottish Ministers/Welsh Ministers] to be designated as authorised persons for the purposes of data processing for the purposes of facilitating anything done under or by virtue of the Act in relation to the above (and therefore making a change to their functions).

I propose my officials discuss with officials in the Welsh government in more detail where Regulations might be required and how they might interact with the devolution settlement, for example, in giving effect to international healthcare agreements and any consequential amendments that might need to be made to retained EU legislation that is currently on our statute books. I would like to reassure you that, depending on the subject matter, we would expect an exchange of Ministerial letters before Regulations are laid.

Healthcare in the UK, including eligibility and charging of people from overseas, is a devolved competence and nothing in our proposals would change that. In practice, devolved administrations would need to ensure their cost recovery provisions align with any international agreement entered into by the UK, as you already do now.

I would like to reassure you that, as reciprocal healthcare arrangements are already conducted centrally on behalf of all parts of the UK by the Department of Health and Social Care, which

includes responsibility for all financial costs, there will be no additional costs to the Devolved Administrations associated with the Bill.

Next Steps
I understand my Department has been engaging with your officials and in addition to providing the draft Bill, has provided briefings on the policy intent of the Bill and our contingency plans. These conversations will of course be ongoing, and my officials would be extremely happy to provide further information should you require it.

As per our discussion on Wednesday, I want to again give you my categorical assurance that in no way do we intend for this Bill to impact the existing devolution settlement, and I am ready and willing to engage with you personally on the Bill as and when this would be helpful to you.

I am copying this letter to the Secretary of State for Wales.

James O'Shaughnessy

Annex A - Reciprocal Healthcare Background

Current EU reciprocal healthcare arrangements enable UK citizens to access healthcare when they live, study, work, or travel in the EU/EEA/Switzerland (and vice-versa for those nationals when in the UK):

- The UK funds healthcare for the 190,000 UK state pensioners living abroad (principally in Ireland, Spain, France and Cyprus) registered for the scheme, and their dependent relatives.

- We fund emergency and needs-arising healthcare when UK residents visit the EU/EEA (e.g. on holiday, to study, etc.). People who are ordinarily resident in the UK qualify for the European Health Insurance Card (EHIC) and 250,000 medical claims are resolved each year.

- UK nationals who live and work in the EU can access healthcare when they pay the same local taxes and contributions as other EU nationals (and are not otherwise UK funded). However, we directly fund healthcare for over 10,000 employees of UK firms / bodies working in the EU/EEA ('posted workers') and 'frontier workers' who live in the UK but travel to work in the EU.

- We fund UK residents to travel overseas to receive planned treatment in other countries (e.g. for procedures unavailable in the UK or returning home to give birth). Around 1,500 UK residents choose this option, and the NHS benefits from EU-funded patients who pay for NHS services under this route.

The Department of Health and Social Care, on behalf of the United Kingdom Government, reimburses other EEA countries and Switzerland for the cost of providing treatment to people that the UK is responsible for under the EU social security regulations. This includes people from or resident in Scotland, Wales and Northern Ireland. In the same way, other EEA countries and Switzerland reimburse the UK for the cost of the NHS providing treatment to people they are responsible for under the regulations, including UK nationals insured in another EEA country or Switzerland.

These schemes are popular across the UK and have broad parliamentary support. It is good that people who live or have worked in the UK can retire and travel in the EU/EEA without having to worry about healthcare access and costs. EHIC is good for the travel economy, reducing the cost of insurance and making travel more viable for the elderly and high-risk groups. Co-operation on planned treatment promotes patient choice and enables the NHS to access treatments overseas.

As you will be aware, there is a financial component too because the current EU arrangements involve Member States reimbursing one another for healthcare costs. The UK spends £630m per annum on healthcare for current or former UK residents who are visiting or have retired to the EU. We recover £50m from EU Member States under the same rules – this amount is increasing as the NHS improves at identifying visitors from the EU. However, the overall balance will be one of net spend because many more UK state pensioners and tourists go to Europe, than the other way around.

Overall, because of the clear benefits to the public and wider society, it is important we seek to ensure reciprocal healthcare arrangements continue post EU Exit whether this happens through an agreement with the EU or through agreements with individual Member States.

The rationale for the Bill

This legislation is necessary because the UK has only limited domestic powers to fund and arrange healthcare overseas, and to share data for those purposes, activities that are currently facilitated by EU regulations.

The majority of UK / EU reciprocal healthcare has to date been enabled by EU regulations (883/2004 and 987/2009 and their predecessors). The regulations set out detailed rules for who is eligible and reimbursement, and provide the legal authority for overseas payments and recovery of costs. Once we leave the EU, the EU reciprocal healthcare arrangements will no longer apply in the UK in their current form and we will need new legislation to provide future arrangements.

The EU (Withdrawal Agreement) Bill will allow us to continue reciprocal healthcare during the Implementation Period, and afterwards for people covered by the Withdrawal Agreement. However, it is not intended to support long-term arrangements covering the general UK population, does not provide for the unlikely event the Withdrawal Agreement is not ratified, and nor does it enable healthcare arrangements with countries outside of the EU.

The Healthcare (International Arrangements) Bill is therefore intended to provide the Secretary of State with statutory powers to fund and arrange healthcare overseas, and to share necessary data to facilitate this, after we leave the EU. Specifically, the Bill provides the Secretary of State for Health and Social Care with powers to:

- Make, and arrange for payments to be made, in respect of the cost of healthcare provided outside the UK;
- Make regulations for and in connection with the provision of healthcare abroad;
- Give effect to healthcare agreements with other countries or territories (both EU and non-EU) or supranational bodies such as the EU; and
- Lawfully process data where necessary for purposes of implementing, operating or facilitating the operation of reciprocal healthcare arrangements or payments.

These powers prepare us for a number of possible outcomes of EU Exit. I have summarised below what role the Bill will play when (as we expect) there is an agreement with the EU later this year, along with how it would support contingency planning should agreement not be reached.

Agreement with the EU

During the Implementation Period all reciprocal healthcare rights will continue and there will be no changes to healthcare for pensioners, workers, the EHIC scheme, or planned treatment until at least 31 Dec 2020. The Withdrawal Agreement will then guarantee longer-term rights for UK nationals / EU citizens living or working in the EU / UK at the end of the Implementation Period, or in a number of other specified circumstances, such as those who have previously paid into EU Member States' social security systems. This will all be legislated for by the European Union (Withdrawal Agreement) Bill which will be brought before Parliament soon.

However, we also want a more comprehensive reciprocal healthcare agreement. The Future Relationship White Paper sets out proposals for a UK / EU 'mobility framework', available at www.gov.uk/government/publications/the-future-relationship-between-the-united-kingdom-and-the-european-union. As part of this we are proposing reciprocal healthcare cover for future UK state pensioners, our participation in EHIC scheme, and co-operation on planned treatment.

In a deal scenario, the Healthcare (International Arrangements) Bill would support us in implementing a future relationship with the EU from 2021. It would also support us in giving effect to bilateral agreements with Member States if there is a need for to have arrangements over and above whatever is agreed at EU level.

No agreement with the EU

We are committed to reaching an agreement with the EU but are also taking responsible steps to prepare for all eventualities, including the unlikely event there is no deal later this year.

Without reciprocal healthcare arrangements many UK citizens who currently live or work in the EU may still have good options for accessing healthcare, but some could face additional healthcare costs. UK tourists and others visiting Europe would rely more on travel insurance and this might make travel difficult for the elderly and/or people with medical risk factors. It would not be as easy for the NHS to refer patients for pre-planned treatment in EU member States. There could also be costs to tourism and the wider economy, and to the NHS if UK citizens currently living overseas return to the UK to seek treatment here. In a no deal, we want to avoid these impacts wherever possible.

The UK and Republic of Ireland, recognising our unique relationship and the importance of the Common Travel Area, are committed to continuing reciprocal healthcare arrangements on a bilateral basis after the UK's withdrawal from the EU. An agreement between our two countries will set out arrangements for ensuring that UK and Irish nationals who move to or visit the other country can access healthcare, along with ensuring continued day to day co-operation on planned treatment. Negotiations with Ireland are still ongoing but once agreed, the Bill will enable the UK to implement this reciprocal healthcare agreement. We are committed to upholding our commitments under the Good Friday Agreement.

Further to this, and in the event of a 'no deal' the UK would like to enter into reciprocal agreements with individual EU Member States to ensure there are no changes in people's healthcare rights and so that there is a strong basis for ongoing co-operation on health issues. These will be subject to negotiation and we are in the early stages of discussions with Member States. However, the UK is open to maintaining reciprocal healthcare rights including for pensioners, workers, tourists and other visitors and others along with the current administrative arrangements including reimbursement of healthcare costs, for a transitional period lasting no less than the Implementation Period (i.e. 31 Dec 2020).

Looking to the future

Regardless of the outcome of the Brexit negotiations, the powers in this Bill will also allow us to implement new agreements to support UK nationals to obtain healthcare if they live in, work in, or move to third countries should this be desirable as part of a future policy on trade and international co-operation on healthcare.

The UK already has highly valued agreements with Australia and New Zealand and many of our Crown Dependencies and Overseas Territories, and we may wish to strengthen these or seek new agreements with other countries in future.

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health and Social Services

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15 November 2018

Dear James,

Thank you for your letter of 26 October following up on our telephone discussion on 24 October and the introduction of the Healthcare (International Arrangements) Bill on 26 October. I also spoke to your colleague Steve Barclay MP, Minister of State for Health, on 13 November.

The Welsh Government will want to play a constructive role in relation to the passage of this Bill, but our two governments are not starting from the best position. Whilst it is the case that the issue of reciprocal healthcare in broad terms has been the subject of discussion between officials for some time, the detailed provisions in the Bill certainly have not been. While a draft of the Bill was sent to my officials on 19 October, there was no suggestion that introduction of the Bill was imminent; the first indication of that came in the communication from your office on 22 October.

We need a much more effective process of discussion and negotiation if smooth progress is to be made with the Bill. However, we are where we are. I note the reassurances you have provided in your letter – most notably that there will be no additional costs to the Devolved Administrations associated with the Bill and a categorical assurance that in no way do you intend the Bill to impact on the existing devolution settlement.

Your letter recognises that the Bill as introduced does in part relate to Wales or to devolved matters and asks if I would begin the required Legislative Consent Process. I can confirm that the process is underway in accordance with the Assembly's Standing Orders, but I cannot say at this stage whether the Welsh Government will be prepared to recommend to the Assembly that legislative consent should be given.

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The following issues of concern will need to be addressed:

Welsh Ministers' consent for regulations made under Clause 2 of the Bill
As discussed on the telephone, I believe that there should be provision, on the face of the Bill, requiring the consent of Welsh Ministers before regulations are made giving effect to healthcare agreements (and to any changes to those agreements in the future). This essentially is the crux of my concern, that the Bill may potentially have direct implications for the Welsh Government and the Welsh NHS, yet there is no provision for any involvement of Welsh Ministers in those decisions and commitments.

Consent of the National Assembly for Wales to regulations made under Clause 5 which have the effect of amending, repealing or revoking a Measure or Act of the National Assembly for Wales
During our telephone conversation I flagged up my concern about this provision in the Bill without any consent provision also included. As I am sure you are aware, the consent of the Assembly is needed where a UK statutory instrument amends primary legislation that is within the Assembly's devolved competence, irrespective of whether the primary legislation to be amended is a Measure or Act of the National Assembly for Wales or a UK Act such as the NHS (Wales) Act 2006. Any such statutory instrument would be subject to a Statutory Instrument Consent Motion in the Assembly (and it would be for the Welsh Government to decide whether to support such a motion). It would be appropriate for the Bill to recognise this, with the insertion of an amendment requiring the Assembly's consent for such instruments.

Secondly, as to the scope of the order-making power in clause 5, you will be aware that the EU (Withdrawal) Act 2018 powers are specifically constrained, in that the Government of Wales Act 2006 cannot be amended by statutory instrument made under that Act; consideration should be given to an equivalent limitation being established for the clause 5 powers in this Bill.

Costs
As I stated above, I note the reassurances you have provided that there will be no additional costs to the Devolved Administrations associated with the Bill. In this respect I look for confirmation from you that:

- the full costs of the exercise of the powers in Clause 1 will be met by the UK Government; and
- funding to cover the full costs to the Welsh NHS resulting from all healthcare agreements with EU Member States made under the Bill that go beyond existing provision, and from any healthcare agreements with countries outside of the EU (not currently subject to any reciprocal healthcare agreements), will be transferred to Wales from your Department, on the principle in the Statement of Funding Policy that additional costs resulting from policy decisions to another administration should be borne by the administration implementing the change.

While what we require in terms of changes on the face of the Bill relate principally to the need for Welsh Ministers' consent to any regulations made which are within devolved competence, I want to reiterate a point I made when we spoke. There is no reason why there should be any disagreement between us on the sort of international agreements which the UK might enter into to secure reciprocal health care rights and obligations. The way to ensure that we do not end up in any unforeseen conflicts over changes to the law within devolved competence as a result of agreements which have been concluded is to associate the devolved administrations fully with the process of negotiating such agreements – from the initial scoping of a negotiating mandate through to the conclusion of a draft agreement.

I look forward to hearing back from you on the issues set out in this letter so that we that we can make progress on the question of Legislative Consent. I am copying this letter to the First Minister of Wales, the Secretary of State for Wales and the Chancellor of the Duchy of Lancaster and Minister for the Cabinet Office. I am also copying it to the Minister of State for Health, to the Scottish Government's Cabinet Secretary for Health and Sport, the Permanent Secretary at the Department of Health in Northern Ireland and the Head of Civil Service in Northern Ireland.

Yours sincerely,

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health and Social Services

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: MA - L/VG/0709/18

Lord James O'Shaughnessy
Parliamentary Under Secretary of State for Health (Lords)
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39 Victoria Street
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4 December 2018

Dear James,

Following our exchange of correspondence, officials have been in discussions relating to the Healthcare (International Arrangements) Bill. These discussions have mainly focused on regulations made under Clause 2 of the Bill, including the definitions set out in Clause 5. I have been concerned about the lack of recognition on the face of the Bill of the devolved nature of certain aspects of the provisions.

I understand your officials have suggested that the Bill be amended to include a statutory duty to consult Welsh Ministers where regulations under Clause 2 relate to devolved matters. This would include regulations which amend, repeal or revoke a Measure or Act of the National Assembly for Wales. I would note that any statutory instrument which amends Welsh primary legislation would of course also be subject to a Statutory Instrument Consent Motion in the Assembly, and it would be for the Welsh Government to decide whether to recommend that consent be given. This amendment would be underpinned by a memorandum of understanding setting out more detail as to how and when consultation would take place.

I would be content to recommend consent to the Bill on this basis, should the memorandum provide satisfactory assurance. In order to provide this assurance the memorandum would need to state that:

- Welsh Government would be consulted on the negotiation of agreements, with a role from the initial scoping through to the conclusion of a draft agreement;
- Welsh Government would be consulted on the initial development and subsequent drafting of regulations under the Bill which implement these agreements, with the UK Government making every effort to proceed by consensus with the devolved administrations. (Complying with the terms of the memorandum in this respect will of

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course make it easier for the Welsh Government to recommend that Assembly consent is given under the SICM process); and

- Welsh Government would be consulted where an agreement applied to or had implications for Wales, and on regulations giving effect to that agreement.

Should a memorandum be agreed which is acceptable to both UK Government and Welsh Government, I would be happy to provide a supplementary memorandum to the National Assembly for Wales to recommend that consent is given to the Legislative Consent Motion.

I would be grateful if you could provide the clarification sought in my previous correspondence on your commitment that there will be no additional costs to the devolved administrations associated with this Bill.

I look forward to hearing back from you on the issues set out in this letter so that we that we can make swift progress on amendment of the Bill and the development of a memorandum of understanding.

I am copying this letter to the First Minister of Wales, the Secretary of State for Wales and the Chancellor of the Duchy of Lancaster and Minister for the Cabinet Office. I am also copying it to the Minister of State for Health, to the Scottish Government's Cabinet Secretary for Health and Sport, the Permanent Secretary at the Department of Health in Northern Ireland and the Head of the Northern Ireland Civil Service.

Yours sincerely,

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health and Social Services

Department of Health & Social Care

The Lord O'Shaughnessy
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14 December 2018

Dear Vaughan,

The Social Security Coordination (Reciprocal Healthcare) (EU Exit) Regulations 2019, The National Health Service (Cross-Border Healthcare) and (Miscellaneous Amendments) (EU Exit) Regulations 2019

I am writing with regard to our continued cooperation and collaboration with the Welsh Government on reciprocal healthcare legislation to facilitate a smooth transition as we leave the EU.

To this effect, I am writing to advise the UK Government intends to bring forward Regulations under the section 8 powers in the European Union (Withdrawal) Act 2018 to prevent, remedy or mitigate deficiencies in retained EU law relating to healthcare abroad in the unlikely event of a no deal EU Exit scenario.

The first of these regulations will make amendments to EU Regulations 883/04, 987/09, 1408/71, 574/72 and 859/03 (the retained EU regulations), which relate to reciprocal healthcare. The second of these make amendments to prevent, remedy or mitigate other deficiencies relating to the retained EU regime on healthcare abroad, such as correcting domestic provisions implementing the Cross-Border Health Directive and making consequential changes following from EU Exit, such as correcting references to EU rights.

I have provided further information on each of these proposed statutory instruments in the enclosed Annex, and officials within my Department would welcome further discussion on these proposed pieces of legislation.

In so far as the proposed statutory instruments make provisions that could be made by Welsh Ministers in the exercise of their powers under the European Union (Withdrawal) Act, I am further writing to ask for your agreement to the UK Government's proposed approach. This is in line with the UK Government's commitment that it will not normally use the powers set out in sections 8 or 9 of the European Union (Withdrawal) Act 2018 to make provision that could be made by a Devolved Administration without the agreement of the relevant Devolved Administration(s).

The UK is committed to working with the Devolved Administrations on reciprocal and cross border healthcare. Once the outcome of EU Exit is clear I would recommend we have further discussions about the longer-term arrangements we would wish to see. We envisage using the Healthcare (International Arrangements) Bill to legislate for longer-term arrangements, respecting the devolution settlement and alongside domestic legislation we are each responsible for on domestic eligibility and charging.

Subject to your views, we intend to lay this SI under the Withdrawal Act in late January, and in order to facilitate this, we would be grateful for a response soonest.

I look forward to your response, and reiterate the UK Government's intention to work closely with the Welsh Government to deliver an approach that works for all of the UK.

I am copying this letter to the Secretary of State for Wales.

Yours sincerely,

Lord O'Shaughnessy

Annex A: Policy underlying the Social Security Coordination (Reciprocal Healthcare) (EU Exit) Regulations 2019

The retained EU regulations currently provide the legal framework for reciprocal healthcare, including the UK's responsibilities to:

1. Reimburse healthcare costs for UK residents living, working, retired in or visiting the EU (under the S1, European Health Insurance Card and S2 schemes). The regulations assume we pay the Member State but also, in certain circumstances, provide for direct reimbursement of individuals.

2. Provide healthcare to EU nationals living, working, retired in or visiting the UK (with reimbursement from their home Member State).

If we do not legislate any further, the Withdrawal Act will automatically retain these regulations. They would not be coherent or workable without reciprocity by Member States, and in certain circumstances could leave the UK responsible for unilaterally funding healthcare for UK tourists and EU visitors after Exit Day if we did not have reciprocal agreements.

Therefore, pending the implementation of new, longer-term reciprocal care arrangements under the Healthcare (International Arrangements) Bill, we are taking the approach of extinguishing the retained EU regulations, subject to the savings provision below.

We intend to selectively 'save' certain aspects of the regulations to deal with historical liabilities, provide for people in the course of treatment, and (more ambitiously) as a means of implementing short-term bilateral arrangements and supporting certain groups of people with healthcare costs.

First, we will be saving those aspects of the regulations that allow us to deal with our liabilities prior to EU Exit, including paying in arrears for healthcare used by UK residents and expats before 29 March 2019 (and for claiming costs back from Member State for their own nationals).

Second, we will save the health-related aspects of the regulations, so that they will continue to support the provision of healthcare to UK citizens in selected 'listed' countries (as well as healthcare provided in the UK to those countries' citizens). Countries would be selected and listed by the relevant UKG Minister. We envisage listing countries who reach agreement with the UK to continue the status quo for each other's citizens. This will allow us to implement reciprocal agreements with countries who take up the UK offer to continue the current arrangements transitionally until
31 December 2020. The saving would be time-limited (until the end 2020) and would not apply to countries who do not enter into agreements with us.

Third, we recommend saving the EU regulations for key groups in a transitional situation on Exit Day, irrespective of any reciprocity in place. In view of the cost and uncertainties associated with this, the group has been narrowly drawn to cover only those where we have clear legal responsibilities, such as those who have obtained authorisation for pre-planned treatment ahead of Exit Day, though not yet obtained the treatment.

The National Health Service (Cross-Border Healthcare) and (Miscellaneous Amendments) (EU Exit) Regulations 2019

These regulations give effect to English policy with respect to the Cross-Border Healthcare Directive (CBHD) (Directive 2011/24), as well as revoke certain EU decisions and make necessary changes and corrections to domestic law on reciprocal healthcare generally that are required following from the UK's EU Exit.

Cross-border Healthcare Directive

In 2013, the UK Government and Devolved Administrations transposed the CBHD into our domestic legislation. Separate legislation covers England and Wales, Scotland, Northern Ireland and Gibraltar. Currently, the CBHD includes:

- Giving UK residents automatic rights to receive NHS reimbursement for certain healthcare they purchase in the EU/EEA (but not Switzerland), which becomes problematic in a no deal for the reasons below.

- Preventing the NHS from charging EU/EEA (not Swiss) visitors more than domestic residents, which in the long-run could prevent full cost-recovery for EU visitors such as the 150% tariff or the Immigration Health Surcharge.

- Information sharing duties including running a National Contact Point to respond to queries from patients from the EU/EEA (not Switzerland).

Keeping CBHD reimbursement rights on our statute book would make the NHS liable for manually reimbursing substantial healthcare costs incurred abroad by UK tourists. This could expose the NHS to significant operational and financial risk and would also be inappropriate as we could no longer be sure that EU Member States would apply the Directive's constraints on excess charging. Almost all of the 250,000 EHIC claims per annum could in principle become reimbursable by the NHS and Devolved Administrations if we do not get bilateral arrangements with Member States. For these reasons our position is that the UK should not continue CBHD reimbursement in a no deal scenario.

Accordingly, our policy is to revoke the CBHD legislation for England with a savings provision to allow the policy to operate for certain listed countries for a transitional period (until 31 Dec 2020). This is the same approach as that adopted for reciprocal healthcare and would involve listing the same countries (who agree to maintain the status quo). This would allow us to maintain CBHD transitionally (for countries where we have established reciprocity) although it would be suspended for other countries.

As the CBHD was implemented by separate legislation in relation to Scotland, you will wish to give similar consideration to fixing deficiencies in that legislation under the European Union (Withdrawal) Act 2018 in relation to Scotland.

Miscellaneous Amendments

In addition to fixing miscellaneous EU references, such as those to Regulation 883/04, European Health Insurance Card, and EU rights and obligations in certain healthcare legislation relating to England, these Regulations will:

- Omit section 10 of the Health and Social Security Act 1984 and the related references in section 26 of that Act and in Schedule 1 to the National Assembly for Wales (Transfer of Functions) Order 1999; section 10 relates to the reimbursement of cost of medical and maternity treatment in Member States of the European Economic Community and extends to England, Wales and Scotland.

- Revoke the legislation implementing the CBHD and related legislation in relation to England, namely the relevant provisions of the National Health Service Act 2006, the National Health Service (Cross-Border Healthcare) Regulations 2013, the National Health Service and Public Health (Functions and Miscellaneous Provisions) Regulations 2013 and the National Health Service (Cross-Border Healthcare) (Amendment) Regulations 2015. The regulations will also make any necessary consequential amendments within that legislation and any other related legislation. Since the CBHD was implemented for both England and Wales by the same regulations, this will include technical, consequential amendments to ensure that, once the provisions relating to England are omitted, the remaining legislation works in relation to Wales.

- Revoke the relevant provisions of the National Health Service (Reimbursement of the Cost of EEA Treatment) Regulations 2010. These Regulations give effect to the judgment of the then European Court of Justice in relation to the case of *Watts v Bedford Primary Care Trust and Secretary of State for Health (2006)* – namely that the obligation under the Treaty Article relating to the freedom to provide and receive services (now Article 56), to reimburse the cost of hospital treatment provided in another member State, also applies to a tax-funded national health service.

- Revoke EU Decisions 2013/329/EU, 2011/890/EU, 2014/286/EU and 2014/287/EU. Decisions 2013/329/EU and 2011/890/EU concern EU networks on the evaluation of health technology (Health Technology Assessment) and networks on e-health respectively. Decisions 2014/286/EU and 2014/287/EU concern the operation of networks on rare diseases (European Reference Networks).

- Omit the second sub-paragraphs (a) and (b) of paragraph 10 of Schedule 2 to the Human Tissue Act 2004 (Ethical Approval, Exceptions from Licensing and Supply of Information about Transplants) Regulations 2006. This requires certain information to be supplied to NHS Blood and Transplant, by a person who has received material to be transplanted, namely, a statement indicating that the recipient was entitled to the provision of the treatment by virtue of regulations made under Article 48 TFEU or an agreement entered into between the European Union and another country.

The fixes are required to the above retained EU law, as they make provision for, or in connection with, reciprocal arrangements which will not exist or will not be appropriate, or otherwise contain EU references, which will no longer be appropriate following the UK's exit from the EU.

As mentioned above, the fixes will include appropriate savings provision to reflect the policy of maintaining certain reciprocal and cross-border healthcare arrangements, on a time-limited basis, for a list of countries with whom the UK has agreed continued arrangements (yet to be determined) and to protect certain groups in a transitional situation on Exit Day.

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19 December 2018

Dear James,

Thank you for your letter of 14 December, seeking my agreement to the UK Government's proposed approach to fixing regulations relating to reciprocal healthcare.

I note that the approach taken in these correcting regulations is intended to complement the Healthcare (International Arrangements) Bill. I wrote to you in relation to this Bill on 4 December and I understand that officials are currently engaged on this issue. Once we have reached agreement on the framework legislation, and the memorandum which will establish the foundation of cooperation on reciprocal healthcare, I will be able to consider in more detail the proposed approach to fixing legislation under the section 8 powers in the European Union (Withdrawal) Act 2018.

I welcome your offer of further discussion on the proposed legislation with officials within your department. I will write to you again once these discussions have taken place.

On the specific issue of consent, I will be able to consider the consent of Welsh Ministers to the proposed legislation when regulations are shared. I would be grateful if you would write again at this point.

I am copying this letter to the First Minister of Wales, the Secretary of State for Wales, the Scottish Government Cabinet Secretary for Health and Sport and the Permanent Secretary at the Department for Health in Northern Ireland.

Yours sincerely,

Vaughan Gething

Vaughan Gething AC/AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

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19 December 2018

Dear Vaughan,

HEALTHCARE (INTERNATIONAL ARRANGEMENTS) BILL

Thank you for your letter of 4 December. May I first take this opportunity to congratulate you on your reappointment as Minister for Health and Social Care. I look forward to working with you further on this and other issues.

Regarding the Healthcare (International Arrangements) Bill, I would like to underline from the outset that we have always acknowledged that the provisions in the Bill may be exercised in ways which relate to a devolved matter, and it is for that reason that we are looking to secure your support for recommending a Legislative Consent Motion.

I am delighted to hear that you are prepared to recommend consent to the Bill. This is a truly positive step forward and demonstrates that this Bill can be taken forward in the interests of the whole of the UK.

As discussed between our officials, we could amend the Bill to insert a statutory duty on the UK Government to consult the Devolved Administrations before making regulations under Clause 2 of the Bill that contain provisions which are within devolved competence. This would necessarily extend to any regulations that amend, repeal or revoke a Measure or Act of the National Assembly for Wales. We would like to make this change as soon as practically possible.

With regard to the Memorandum of Understanding setting out more detail as to how and when consultation would take place, we are very happy to provide you with assurances that the Welsh Government, and indeed all of the DAs, would be meaningfully consulted on the development and drafting of regulations. We can discuss this further as officials progress the drafting of an MoU.

As I am sure you can appreciate, this is a time-sensitive issue and it is in both of our interests to progress the passage of the Bill as a matter of expediency. We would very much like to work with you and all the DAs in good faith to proceed with the drafting of an MoU. The MoU would set out the detail of how UKG will consult the DAs to underpin the proposed statutory consultation requirement. If feasible, it would be helpful to agree the key terms before we amend the Bill.

This Bill is expressly concerned with implementing international agreements and the extent to which regulations implement new agreements. There is already an MoU between the UK and the Devolved Administrations concerning international agreements that deals with respective roles in the negotiations process which is under review and so this is not something we can currently open via the HIAB.

With regard to the clarification sought on financial arrangements, I believe our officials have discussed this at some length. To reiterate, we do not want the current administrative system to change and thereby place additional burdens on the Devolved Administrations. By this I mean that the Department for Health and Social Care will continue to fund and administer schemes that entitle individuals across the whole United Kingdom to access healthcare abroad. Where these schemes entitle foreign nationals to access domestic healthcare services, it will remain the responsibility of all the four nations to provide those individuals with that healthcare, to legislate for that provision through charging regulations, and bear the costs, accordingly. Going forward, and as part of our close working, we would expect to provide analysis on the potential costs and benefits of reciprocal agreements to the UK Government, to the NHS in England, Wales, Scotland and Northern Ireland, and to UK citizens and residents and to involve the DAs in formation of strategy in this area.

I would like to stress that my Department is fully committed to working with you and all the DAs in the interests of individuals in all the four nations and their access to healthcare abroad. I will make every effort to proceed by consensus in this area and hope that in doing so I am able to alleviate some of the broader concerns you have expressed throughout our discussions on this matter. Indeed, many of these concerns have been expressed by all the DAs and I hope that the measures proposed in this letter will provide assurances to colleagues in Scotland and Northern Ireland as well.

I look forward to hearing back from you and hope we can indeed move this forward at pace to ensure we can jointly provide individuals in Wales with confidence that the measures in this Bill will apply to them as well.

I am copying this letter to the First Minister of Wales, the Secretary of State for Wales and the Chancellor of the Duchy of Lancaster and Minister for the Cabinet Office. I am also copying it to the Scottish Government's Cabinet Secretary for Health and Sport and Cabinet Secretary for Government Business and Constitutional Relations, and to the Permanent Secretary at the Department of Health in Northern Ireland and Head of the Northern Ireland Civil Service.

Yours sincerely,

LORD O'SHAUGHNESSY

Vaughan Gething AC/AM
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Cabinet Secretary for Health and Social Services

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Mark Isherwood AM
Chair, Cross Party Group on Hospices and Palliative Care
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4 September 2018

Dear Mark

Thank you forwarding the final version of the Cross-Party Group (CPG) Hospices and Palliative Care Inquiry into inequalities in access to hospice and palliative care.

As you know I attended the CPG group meeting on 11 July to provide an initial response to the recommendations within the report and advised that I would be providing a more formal response once I had had time to fully consider the report over the summer months. Please accept this letter as the Welsh Government's formal response to the CPG report.

I would like to again reiterate my thanks, the secretariat and the members of the CPG for the time that you have taken to consider this often difficult subject and for producing a balanced report that focuses on both good practice as well as highlighting the challenges that need to be addressed.

The Welsh Government aim is for people in Wales to have a healthy, realistic approach to dying and to be able to plan appropriately for the event. We want them to be able to end their days in the location of their choice – be that home, hospital or hospice and we want them to have access to high quality care wherever they live and die, whatever their underlying disease or disability. That is why we continue to provide over £8.4 million annually and have identified end of life care as one of the areas that we will be focusing on in 'A Healthier Wales: our plan for Health and Social care in Wales'.

There are 11 recommendations in total and I will respond to each in the order that they are set out within the report.

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Recommendation 1. *The Cabinet Secretary for Health and Social Services should monitor, and have oversight of, progress against shared priorities between the Palliative and End of Life Care Delivery Plan and other Health Delivery Plans.*

Accept - This is already happening and many of the mechanisms to implement this recommendation are already in place. The Chief Medical Officer chairs a meeting of all clinical leads on a quarterly basis, Implementation Group co-ordinators are also convened on a quarterly basis and I meet with all 9 chairs of the major health conditions implementation groups together on an annual basis. Each of these meetings includes time for consideration of shared priorities, identification of common areas of interest and to seek opportunities to work collaboratively across the delivery plan agendas.

My officials are represented on all the implementation groups and promote collaborative working through regular attendance at health board medical directors, directors of primary care and director of therapies meetings. All of the implementation groups are chaired by health board/trust chief executives or executive directors and a number of the other health delivery plans such as the cancer, heart conditions and respiratory plans all contain end of life care actions within their plans.

The End of Life Care Board has previously collaborated with the Cardiac and Renal Networks and plans are in place to work with mental health and dementia teams to provide joint training around future care planning.

We will use these mechanisms to continue to seek further opportunities for progressing our shared priorities between end of life care and the other health delivery plans.

Recommendation 2. *The Welsh Government and End of Life Care Implementation Board should establish a target for increasing the number of people on General Practice Palliative Care Registers and introduce measures to monitor their effectiveness in supporting adults with all life-limiting conditions.*

Accept in Part

Year on year, numbers of patients on palliative registers are increasing. The palliative care practice register is maintained within the Quality and Outcomes Framework (QOF) and the frequency of multidisciplinary team (MDT) discussion is captured within QOF. The current contract introduced in 2014-15 also supports the review of the delivery of care at the end of life through case reflection to identify service development issues, barriers to the delivery of care and examples of good practice. Practices will develop plans based on population need, while individual health boards will provide updates.

Last year's annual statement of progress for the End of Life Care Plan showed that:

- 10,013 people were registered on a QOF palliative care register; this is an increase of over 62% since 2011-12.
- 11,171 patients received specialist palliative care. This is an increase of 5.4% from 2015-16. Of these, 60% (6,733) patients were under the care of the specialist care team in the 90 days prior to their death.
- 49.3% of all patients' deaths were supported by specialist palliative care, of these 69.2% of people who died from cancer, compared to 51.9% in 2015-16 and 24.6% of patients with a non-cancer diagnosis received specialist palliative care, an increase of almost 8%.

The Annual Statement of Progress estimated that of the 33,000 people who die in Wales each year, around 24,000 of these will require palliative care of some sort. Of these just over 10,000 are recorded on a GP palliative care register (2016-17) and will be in receipt of either supportive or generalist palliative care.

This suggests that GPs in Wales are probably capturing about a third of those with palliative care needs on a primary care palliative care register. Not being on the register does not mean that an individual is not known to the practice, or is not getting adequate palliative care. However, patients not on a "register" may be less likely to be getting comprehensive, co-ordinated, palliative care. Better information should become available when a unified clinical record is introduced.

Some people, particularly those with more complex conditions, will require access to specialist palliative care. In 2016-17, 15,459 patients received specialist palliative care from health boards across Wales; of these, 6,733 patients were referred to specialist care within 90 days of their death. This is an increase in total referrals of 3.3% from 2015-16, but a decrease of 1.4% in those in the last 90 days of life, suggesting the specialist palliative care teams are being involved earlier in patents' final illnesses, as well as more patients accessing specialist input.

Setting targets is not straight forward as QOF data identifies palliative care need only, not the actual diagnosis and whether care is of good quality. Placing greater numbers on a register can not be taken as improvement in care. Clinical data on quality of care will be held as part of the clinical record during the MDT and can be made available through practices.

It is therefore important that we get the right people on palliative care registers. We will consider what actions can be taken to increase the number of people with palliative care need who are on general practice palliative care registers and receiving best possible care.

Recommendation 3. *Charitable hospices and health boards should demonstrate how they promote improved awareness of the breadth of hospice and palliative care services.*

Accept - Whilst this is not a direct recommendation for Welsh Government, it is one that we are happy to support. Too often people see hospices as simply a place where people go to die with the associated negative connotations, but hospice care is about so much more than that. They provide a wealth of life enhancing services for those in need of palliative care and anything that can improve people's knowledge and understanding of these services is to be encouraged.

Recommendation 4. *Health boards should demonstrate how they consider end of life care needs in determining their out of hours coverage and work cooperatively to resource paediatric out of hours services at an all-Wales level.*

Accept - Again this is not a recommendation for the Welsh Government but is one we would actively support. The NHS 111 service in Wales will bring together the existing NHS Direct Wales services with the GP out of hours call handling and initial triage. NHS 111 in Wales will offer a single number for accessing out of hours health care in Wales, this will be linked to services that provide out of hours service and sign post patients to these.

111 will provide a real opportunity to co-ordinate and manage the demand of unscheduled care for NHS Wales, meet the needs of patients within their own communities, avoid unnecessary hospital admission and reduce demand on acute hospital services. The 111 number has been rolled out and is available in Abertawe Bro Morgannwg UHB and the

Carmarthenshire area of Hywel Dda UHB. There are plans in place to roll the number out in other parts of Wales later this year.

Recommendation 5. *Regional Partnership Boards should make use of pooled budgets to support the delivery of palliative care in care homes.*

Accept – This is something that already happens to a certain extent. Regulations under Part 9 of the Social Services and Well-being (Wales) Act 2016 require that regional partnership boards established pooled funds in relation to their care home accommodation functions from April 2018. These pooled funds are intended to support improved joint commissioning arrangements. The Welsh Government would expect therefore that these pooled funds would already include meeting the costs of any identified palliative care costs when care is commissioned.

Regional partnership boards are required to produce an annual report setting out how they have improved well-being outcomes. This would include setting how their pooled fund has supported improved commissioning arrangements.

Recommendation 6. *The Welsh Government Ministerial Advisory Group for Carers should address the specific support needed by carers of people at the end of life.*

Accept - Last November the Minister for Children, Older People and Social Care announced three national priorities for carers to help focus the work of Welsh Government and our partners in the statutory and third sectors on driving improvements for carers. Those priorities are:-

- Supporting life alongside caring
- Identifying and recognising carers
- Providing information, advice and assistance

The Minister also announced that he would be forming a Ministerial Advisory Group on Carers to target and monitor improvements against the three national priorities. The Group met for the first time on 27 June 2018. It is designed to improve the experience of carers of all types, recognising that carers in different circumstances will have different support needs.

The Ministerial Advisory Group needs to have members who are in a position to drive and influence change and also to be small enough to work effectively as a group. On that basis, it was not possible for large numbers of carers to join this group, nor for every different 'type' of carers' interest to be represented on the group. But that doesn't mean that the group will not pick up on those different needs. The Minister has committed to establishing an Engagement and Accountability Group to support the Ministerial Advisory Group. This group will allow for the representation of a much more diverse range of carers than is possible on the Ministerial Advisory Group itself. Ideas for establishing this group were discussed at the first meeting of the Ministerial Advisory Group.

Welsh Government officials met Catrin Edwards of Hospice UK (Secretariat to the CPG) on 17 July and discussed how the interests of carers of people at the end of life could be represented in the Engagement and Accountability Group.

Recommendation 7. *The End of Life Care Implementation Board should develop a robust action plan to address shortages in community nursing for both children and young people, and adults with palliative care needs.*

Accept – Much work has already being done to attract more nurses to Wales. NHS Wales is seeing and treating more people than ever before and our health service is meeting this challenge - in fact there are now more nurses working in NHS Wales than ever before. This should be recognised and celebrated. However, we are not complacent and recognise there are very real challenges around the recruitment of nurses in primary and secondary care and within the third sector that provide support in palliative care and end of life care.

The Welsh Government is committed to actively supporting health boards to meet the needs of the Nurse Staffing Levels (Wales) Act and understand what sufficient staffing looks like and will continue to work with health boards & trusts across Wales on approving Integrated Medium Term Plans recognising that our workforce underpins services. Section 25A of this Act sets out the NHS health boards and trusts duty to have regard to providing sufficient nurses to allow time to care for patients sensitively. It also clarifies that this applies both where nursing services are provided *and* where they are contracted or commissioned. This includes services commissioned to provide palliative care and end of life care.

However, it is a reality that there is a shortage of registered nurses not only here in Wales and the UK, but internationally with all developed countries reporting shortages in registered nursing staff. We continue to increase the level of investment in the future workforce of NHS Wales. In December 2017 there was an announcement of a £107m package to support education and training programmes for healthcare professionals in Wales. This represents a £12m increase on the package agreed for 2017/18 and will enable more than 3500 new students to join those already studying healthcare education programmes across Wales. The total number of people in education and training places for 2018-19 will be 9,490 compared to 8,573 in 2017-18.

This package includes a 10% increase in the number of nurse training places – an extra 161 – which will be commissioned in 2018-19. This is in addition to the 13% increase in 2017-18; the 10% increase in 2016-17 and the 22% increase in 2015-16 and continues our investment in nurse education numbers. In addition we are maintaining the student bursary for 2019-20 demonstrating our commitment to nursing – the condition for students who receive the bursary to commit to working in Wales post qualification, includes working in hospices as well as the NHS. We also provide help for staff to return to practise with funding up to £1,500 and we have retire-and-return schemes which enable us to utilise the experience these staff have.

In 2014-15 we were commissioning 24 district nurses training places, this increased to 41 places in 2015-16 and increased again to 80 places in 2017-18, this is over a tripling of our commissioned places. Further to this in 2018-19 additional resource through the Plaid Cymru budget compact of £1.4m has been set aside to support the release of community nurses by health boards to train as district nurses and to maximise the opportunity the additional commissioned places has provided.

We also launched in May 2017 our national and international campaign "*This is Wales: train, work, live*", extended to nursing, resulting in significant interest from overseas nurses as well as from nurses across the UK. We have already started to see nurses recruited into NHS Wales as a result of this campaign and we will continue to work with our health boards to build on these early successes.

We will work with the End of Life Care Board to consider what further steps can be taken to address shortages in community nursing for both children and young people, and adults with palliative care needs.

Recommendation 8. *The Welsh Government should introduce enhanced mandatory training in palliative care for hospital-based clinical staff.*

Accept in Part – To train all hospital based clinical staff in palliative care would not be practical or necessary. However, it is accepted that more can always be done to increase the number of professionals trained.

The call for mandated training in all areas of clinical care has to be considered within the overall context of the mandatory training programme which is already substantial and is principally aimed to ensure the safety of patients, health professionals and NHS Wales. However, where staff identify end of life care training as part of their appraisal, we would expect health boards to facilitate such training.

Health boards also receive funding from the Welsh Government and the End of Life Care Board to increase capacity in specialist palliative care teams with a specific intention, not only to provide direct care, but to create learning opportunities across the spectrum including both structured and non structured training for all care givers.

In 2015-16, the Welsh Government provided funding to create the 'serious illness conversation' training programme which acknowledged that staff without specialist training frequently cared for patients with end of life care needs and required specific training to enable them to recognise the patient was dying and to equip them with the skills to begin the relevant conversation. To date, this successful programme has reached 542 professionals including WAST and prison service teams. In addition, a number of online training programmes have been made available, including a bespoke online training programme for WAST and Talk CPR video books provided to each GP practice in Wales. In addition a GP 'Short Course' in palliative medicine has successfully trained approximately 500 GPs throughout Wales in basic specialist palliative care knowledge and skills

Many health and care professionals are required to undertake specific qualifications before they are able to practice. It is important to understand the contents of the current education and training programmes and to assess whether it is a matter of changes to these programmes or additional training that is required. For instance there is a plan at UK level to increase the palliative care content of postgraduate training in general (internal) medicine, following the 'Shape of Training' review report published in 2013. A wider analysis of what already exists is needed. On the basis of this analysis we will consider what more can be done in terms of training in palliative care.

Recommendation 9. *The Welsh Government and End of Life Care Implementation Board should identify gaps in data collection on adult and paediatric palliative care needs, and take steps to fill these, to ensure service planning and design is based on need.*

Accept -. The Social Services and Well-being (Wales) Act requires local authorities and health boards to jointly undertake an assessment of the population to determine the care and support needs in an area. Once this assessment has taken place, consideration to how palliative care will be provided will need to be taken into account based on existing services. Not all patients with palliative care needs require specialist input – things like access to voluntary hospice care and levels of additional community support will also be considered.

Welsh Government through the End of Life Care Board has allocated funding to work with NWIS to improve data collection through the transfer of the Canisc module onto an updated platform. Residual funding from 2017-18 was allocated to voluntary hospices to work with the Canisc lead on the End of Life Care Board to improve the ability to access key systems and consequently improve data collection and analysis in this area.

Establishing actual need on a real time basis is very difficult for two reasons. Firstly, that need is very much dependant on an individual, their circumstances (e.g. where they are living, are they alone, do they have complex co-morbidities) and their illness and its prognosis which is much harder to predict in some diseases than others.

Secondly, there is a significant difference between specialist palliative care and end of life care with the former needing to be provided by a palliative care specialist and the latter invariably provided by a generalist or other specialities with the support of a palliative care specialist if necessary hence the 24/7 on call rota of consultants and Clinical Nurse Specialists.

Research undertaken by the Cicely Saunders Institute puts need at around 75% of the dying population. The End of Life Care Board annual report suggests that around 49.3% are being seen within specialist care only.

We will continue to routinely review our data collection mechanisms and take action to improve our systems for identifying gaps in data as and when opportunities arise.

Recommendation 10. *The End of Life Care Implementation Board should support health boards and NHS trusts to improve their accountability by developing consistent reporting criteria to measure progress against meeting national palliative care priorities.*

Accept – This is something we already do. Annual reporting mechanisms changed in 2017 with health boards being required to submit annual progress reports to the End of Life Board rather than published annual reports. Health boards use a template to provide this information and focus on local priorities, achievements and areas for improvement. These will vary according to local need and resource. Health boards are required to report against specific reporting criteria which is then used to inform the annual report submitted by the End of Life Care Board to the NHS Chief Executive.

Data for palliative care is managed via the 'Canisc' system and the current Canisc data provides shared reporting measures which can be compared. More work could be done for health boards to be more consistent in how they produce their reports to enable comparison and ensure that their report should be easy to find on their websites.

The Acute Hospitals audit undertaken in 2016 and repeated in 2018 provides good data and allows comparison between Health Boards and with NHS England.

Recommendation 11. *The Welsh Government and End of Life Care Implementation Board should ensure that the funding of charitable hospices is regularly updated to ensure it is based on current local population need and prevalence data.*

Accept in Part - The funding formula was developed in 2009 and used as the basis for increased funding to provide an equitable platform on which to deliver palliative care throughout Wales. Funding at this time was allocated to voluntary hospices directly from the Welsh Government through the End of Life Care Board and also through service level agreements with Health Boards.

In June 2014, the First Minister confirmed in a statement that from 2015-16 all funding would be transferred to Health Boards for future allocation. The then Minister for Health and Social Services agreed to this funding being ring-fenced for three years, ending in 2017 and many voluntary hospices will have renegotiated funding with their individual Health Boards. Voluntary Hospices are also able to benefit from clinical support such as Palliative Medicine Consultants and Pharmacy Services teams employed within NHS Wales and other forms of statutory funding such as Wanless funding which is recurring. In addition, for patients who

meet continuing healthcare criteria, hospice at home providers are able to access this funding.

The current position is that funding for charitable hospices in all its forms has been devolved to health boards and we expect that they will develop their plans in line with the priorities of the end of life care delivery plan in place at the time. There are a number of variables that make need for charitable capacity different across health boards. These include the extent to which the NHS has specialist palliative care beds and community based services, the characteristics of the population in particular its age profile and the pattern of existing charitable provision.

We will work with the End of Life Care Board to review the way in which funding is allocated, in doing so moving away from the use of an arbitrary formula (which might work for one area and not another) to a system that is based on local determination of need.

Yours sincerely

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health and Social Services

Agenda Item 3.2

Cabinet Secretary for Health and Social Services
Welsh Government
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National Assembly for Wales Cross Party Group on Hospices and Palliative Care
C/o Hospice UK
City Hospice
Whitchurch
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10 October 2018

Dear Vaughan,

Cross Party Group on Hospices and Palliative Care Inquiry: response

Thank you for your letter dated 4 September 2018, which gave your detailed response on behalf of the Welsh Government to the Cross Party Group on Hospices and Palliative Care's Report 'Inequalities in access to hospice and palliative care: challenges and opportunities'.

Firstly, thank you for the time and consideration you gave the report and for accepting, either wholly or in part, each of the recommendations put forward. The Cross Party Group (the Group) will continue to monitor the implementation of the report's recommendations and value your willingness to work with us to improve access to hospice and palliative care in Wales.

The Group discussed your response during its meeting on 26 September 2018 and agreed our approach in taking forward our work in this area.

While the response was broadly welcomed, the Group noted that many recommendations were accepted on the basis that work in this area is already ongoing. I am pleased to see that the Welsh Government and End of Life Care Implementation Board are already taking steps to improve access to hospice and palliative care, and appreciate that developing services takes time. However, the evidence received by the Group during its inquiry was clear in demonstrating that progress in the areas we highlighted is too slow, or that information regarding progress is unavailable.

The Group further noted the lack of detail in relation to fulfilling recommendations to improve access to paediatric palliative care with disappointment. I trust that your officials and colleagues at the End of Life Care Implementation Board and health boards will be pursuing this agenda in line with the recommendations made by the Group. The Group will follow progress in this area with interest, including by targeted scrutiny of developments in the areas of 24/7 consultant and nurse cover and the availability of community paediatric nurses.

For your information, during the period until 2020, the Group will be prioritising scrutiny of:

- The provision of palliative care in care homes and the role of Regional Partnership Boards in delivering this.
- Out of hours care for people with palliative and end of life care needs, including the role of specialist 24/7 advice lines, and the equal coverage of out of hours care for children.
- The distribution and availability of community nursing services to deliver palliative care to people in their own homes or in the community, including district nurses and community paediatric nurses with palliative care skills.
- Sustainable, medium-term funding of charitable hospices and meaningful partnerships between charitable hospices and health boards.

I welcome your continued engagement with the Cross Party Group on Hospices and Palliative Care in taking forward these crucial areas, which will serve to improve equality of access for all who need it.

Yours sincerely,

Mark Isherwood AM
Chair, Cross Party Group on Hospices and Palliative Care

Agenda Item 3.3

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf / Our ref: MA-L/VG/0717/18

Dr Dai Lloyd AM
Chair
Health, Social Care and Sport Committee

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7 December 2018

Dear Dai,

In May 2018, I wrote to you regarding Welsh Government plans for the evaluation of the Public Health (Minimum Price for Alcohol) (Wales) Bill. Over the summer, my officials have undertaken work to further develop these plans – recognising the critical role of the evaluation in relation to the sunset and review clauses included in the legislation and any future decision on whether to continue its provisions on minimum pricing for alcohol in Wales.

I would also like to take this opportunity to update you regarding recently commissioned Welsh Government research on the possibility of switching from alcohol to other substances. I am aware that this is of particular interest to members of the Committee and was a specific recommendation included in the stage 1 report by the Health, Social Care and Sport Committee.

Plans for the Evaluation:

The Theory of Change diagram, outlining the possible sources of data has been updated and is attached. The independent evaluation will be commissioned through an open tender process over the next few months. The work will be commissioned as one contract, but will be divided into four lots as follows:

Lot 1: Contribution analysis

Overview of requirement: It is anticipated that the contribution analysis will look at the wider context of alcohol policy as well as bringing together the relevant data sets and the findings from the individual studies and evaluation work (including that undertaken in Scotland) to inform the assessment of the contribution that the introduction of minimum pricing has made to the policy objectives. The contractor will be required to provide an interim report after two years (2021). This will be a report that makes an initial assessment of the contribution that minimum pricing makes to the policy objective and outlines the additional data sources

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needed to improve the reliability of the contribution assessment. The 2021 interim report will inform the internal review of the level of the MUP which will be undertaken by Welsh Government officials, after two years of implementation. Draft final report intended to be provided by end November 2023.

Lot 2: Research into the impact on retailers

Overview of requirement: It is anticipated that this lot will utilise mixed methods to obtain feedback from retailers on implementation as well as the impact that the introduction of a minimum price has had on them. This will need to capture both the on and off trades, as well as small and large retailers. Baseline work will need to be completed before the end of August 2019. First follow-up will be undertaken around 18 months after implementation. It is anticipated that the final follow-up will take place after approximately three and a half years (around March 2023). The draft final report will be required to be submitted September 2023.

Lot 3: Qualitative work with services and service users

Overview of requirement: An initial piece of qualitative work has recently been commissioned and will work with service providers and users, looking at the potential for people switching substances as a consequence of the introduction of a minimum price for alcohol. This will also look at additional support required to help people prepare. That work has been commissioned as a standalone separate contract as the feedback on support needs is required during the implementation phase. This can, however, act as baseline work with this group. The requirement of this lot is to undertake further work with these groups post implementation. First follow-up will be undertaken around 18 months after implementation. It is anticipated that the final follow-up will take place after approximately three and a half years (around March 2023). The draft final report will required to be submitted September 2023.

Lot 4: Assessment of impact of introducing minimum price for alcohol on wider population of drinkers

Overview of requirement: This lot will explore the impacts of the legislation on the wider population of drinkers. This will include work with moderate, hazardous and harmful drinkers. It will also include an analysis of household expenditure. Baseline work will need to be completed before the end of August 2019. First follow-up will be undertaken around 18 months after implementation. It is anticipated that the final follow-up will take place after approximately three and a half years (around March 2023). The draft final report will be required to be submitted September 2023.

A Prior Information Notice outlining the above was published a couple of weeks ago, informing the market of the intention to commission this work.

Additional research work:

Questions were commissioned in the Beaufort Wales Omnibus Survey carried out in September 2018. The questions assessed awareness of and attitudes towards minimum pricing for alcohol. The data have recently been received and officials will prepare a report for publication early in the New Year.

Finally, as highlighted above, in response to one of the recommendations from the Health, Social Care and Sport Committee in your Stage 1 scrutiny report and the recommendation from the Welsh Government's Advisory Panel on Substance Misuse, research has been commissioned looking at the perception of service providers and service users of the

likelihood of individuals switching to other substances and what services are doing to help people prepare. The contract has been awarded to Figure 8 Consultancy Services Ltd, in partnership with University of South Wales and Glyndwr University.

I hope you find this update useful and I look forward to ongoing engagement with the Committee as we implement the Act.

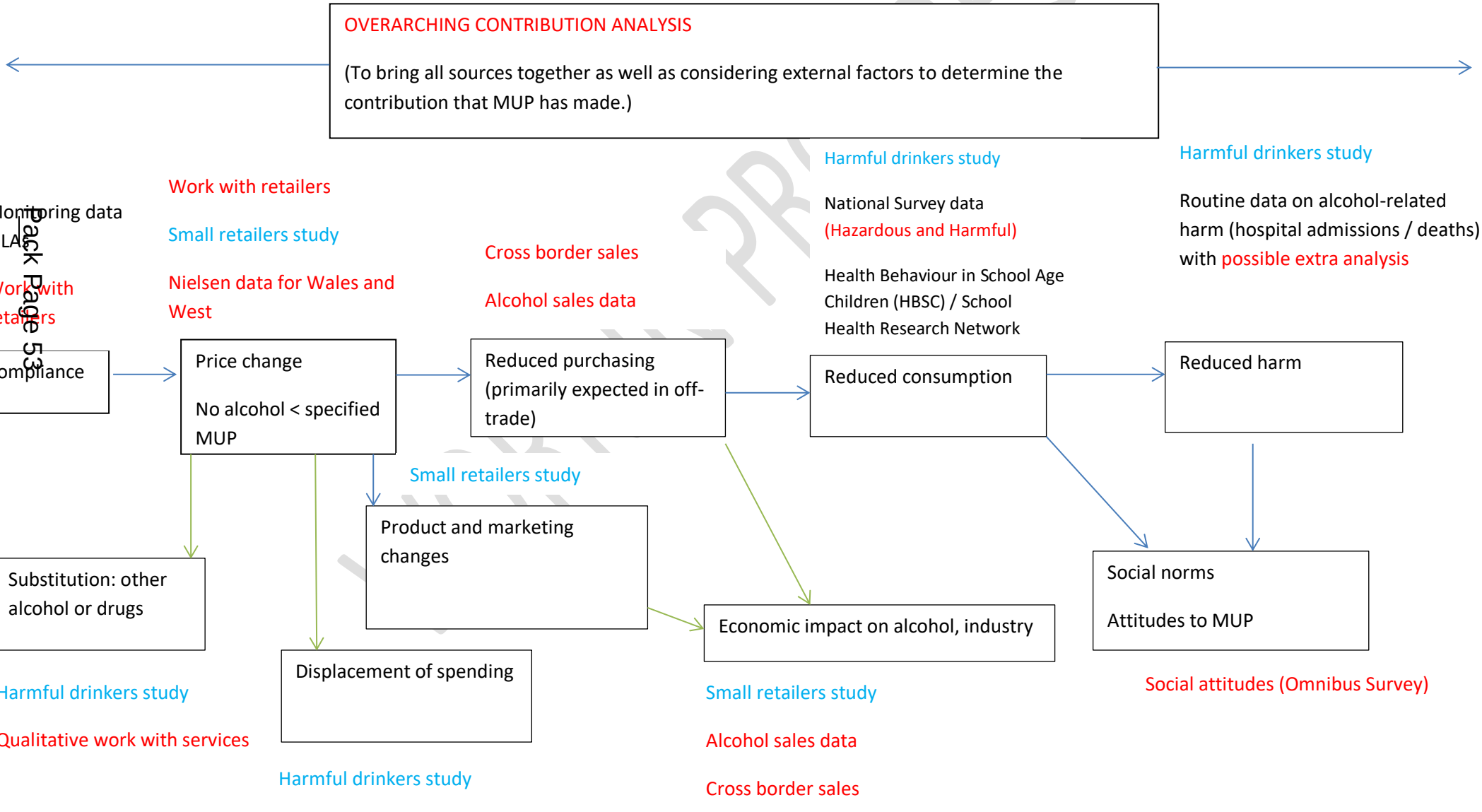
Yours sincerely,

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health and Social Services

Annex 1

Theory of Change - MUP Wales – showing existing studies elsewhere and possible additional studies to be commissioned.

NOTE: Text in red outlines work to consider commissioning. Text in blue is a Scottish study. Text in black signifies routine data.



Julie James AC/AM
Arweinydd y Tŷ a'r Prif Chwip
Leader of the House and Chief Whip

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: MA - L/JJ/0825/18

Mick Antoniw AM
Chair
Constitutional and Legislative Affairs Committee
National Assembly for Wales

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10 December 2018

Dear Mick,

Thank you for your letter dated 15 November 2018 in relation to the scrutiny of regulations arising from the European Union (Withdrawal) Act 2018. As you can appreciate, the UK's withdrawal from the European Union has created an unprecedented legislative programme across all the Governments in the UK and we are all working to ensure that we will be ready for exit day on 29 March 2019.

I am currently expecting 140-150 UK Government EU Exit SIs to legislate in areas devolved to Wales ahead of exit day, though this number is subject to change as SIs are merged or disaggregated and new ones emerge. Almost all of these will require the consent of the Welsh Ministers through the process set out in the Intergovernmental Agreement.

The Welsh Ministers have given formal consent to 71 SIs and have notified the National Assembly under Standing Order 30C of 51 SIs (the outstanding 20 are yet to be laid in Parliament). Of the 71, six have required a Statutory Instrument Consent Memorandum under Standing Order 3OA.2. Our current estimate is that around 20 will be subject to SO30A, though this figure is subject to change as officials consider the detail of the outstanding draft SIs which the UK Government will be sharing with us during the coming weeks.

The Welsh Ministers are expecting to lay around 50 Welsh EU Exit SIs in the National Assembly. There has been a delay in the Welsh SI programme, with several causes. In many cases, the Welsh SIs must follow the UK SIs and the UK SI programme has itself been delayed. Often the Welsh SIs must follow the UK SIs because the UK SIs are amending legislation to which the Welsh SIs are then making subsequent amendments. In some cases, the Welsh SIs will form part of a UK wide agreed approach to delivery that requires our SIs to co-ordinate with the SIs laid in Parliament.

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More generally, the Welsh Government has also had to prioritise work on the UK SI programme given the high volume of SIs that are being brought forward which are making provision on the Welsh Ministers' behalf. As I have explained above, the Welsh Ministers have already consented to 71 separate UK Government SIs. In order to reach a position where the Welsh Ministers have been able to consent to the final versions of these SIs, there have been extensive discussions with relevant UK Government departments on the proposed solutions and drafting approaches in order to ensure that each SI properly protects our devolved interests. The agreements that are being reached on UK SIs which make amendments to directly applicable EU law and provisions in UK legislation which are within the Assembly's competence to amend are vitally important to ensure that there is a properly functioning statute book on exit day.

As a result of the agreements that have been reached on UK SIs to date, we anticipate that our SI programme will be confined to SIs which amend Welsh domestic regulations and Welsh primary legislation. None of these Welsh SIs amend directly applicable EU law. We are anticipating that 77 UK EU Exit SIs will amend directly applicable EU law in areas devolved to Wales. These SIs are included in the figure of 140-150 UK EU Exit SIs which we estimate will legislate in devolved areas.

We anticipate that the UK SI programme will continue at the current pace until March. Providing there is no further slippage in the UK SI programme, we expect that the Welsh SIs will be laid from December to March. We are anticipating three SIs to be laid before the Christmas recess, all proposed negative procedure SIs for sifting. We are expecting the remaining SIs to be laid from the recess to March, of which around 5% are currently anticipated to be subject to the affirmative procedure. I fully expect that January will be particularly busy as the Welsh EU Exit SI programme will be operating in earnest and the UK SI programme will be continuing.

The bases on which the Welsh Ministers are consenting to the UK SIs are that there is no divergence on policy between Wales and the UK, and that the SIs are not politically sensitive. These SIs are for the purpose of making the corrections so that the statute book will be operable and are being made by the UK Government, with the consent of the Welsh Ministers, for reasons of administrative efficiency.

Officials in all four administrations are working closely together on the drafting of the SIs and the accompanying material for inclusion in the explanatory memorandums. Decisions on who should exercise powers currently conferred on EU entities after exit are being considered in the context of each SI, depending on the nature of the power in question, and whether factors exist that mean that it is not desirable for an administration to exercise that power without the involvement of another administration. Our default position is that where there is a function within an area devolved to Wales, the relevant function should be conferred on the Welsh Ministers or on an appropriate public body in Wales. However, there are a number of circumstances where the default position may not be appropriate or practical. These are likely to arise in the following cases:

- Where the cross-border nature of service provision requires close co-operation across both nations, for the benefit of citizens or to avoid placing unnecessary burdens on organisations. This could be due to the way people or goods travel across the border, or the particular geographical features of the border.
- Where the devolved and non-devolved aspects of policy delivery are so intertwined, that it is not workable for the devolved elements to be delivered without reference to the non-devolved elements, or vice versa.
- Where the operational delivery of the policy is constrained by international agreements that will apply beyond Brexit so there is limited flexibility in policy decisions.

In these cases, there are a range of options for how functions can be exercised, and Ministers are reaching a decision on each individual UK Government SI following a full consideration of all of the relevant issues.

In circumstances where consent is given to a UK Government SI, our position is that consent is provided for the entire SI, rather than consenting to specific parts of the SI. Where provision is made in relation to devolved and reserved matters in a single SI, the approach that is taken towards reserved matters will often have an impact on devolved matters. For that reason, we consider it appropriate that Welsh Ministers consider and consent to the SI as a whole, rather than confine their consideration to the devolved areas only.

Yours sincerely,

Julie James AC/AM
Arweinydd y Tŷ a'r Prif Chwip
Leader of the House and Chief Whip

Cynulliad Cenedlaethol Cymru
Y Pwyllgor Materion Allanol a Deddfwriaeth Ychwanegol

National Assembly for Wales
External Affairs and Additional Legislation Committee

Dai Lloyd AM
Chair of the Health, Social Care and Sport Committee

17 December 2018

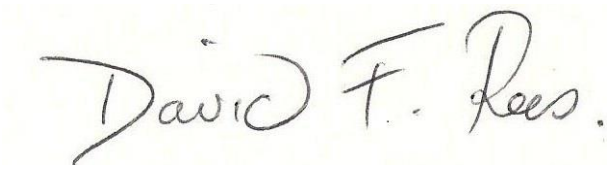
Dear Dai,

Preparing for Brexit – Report on the preparedness of the healthcare and medicines sector in Wales

Over the last term the External Affairs and Additional Legislation Committee has been considering issues relating to how various sectors have been preparing for Brexit.

In particular I would like to draw your attention to our report on the preparedness of the healthcare and medicines sector in Wales, published on 3 December 2018.

Yours sincerely,



David Rees AM

Chair of the External Affairs and Additional Legislation Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg.

We welcome correspondence in Welsh or English.

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Yr Ysgrifennydd Elis-Thomas AC/AM
Ein cyf/Our ref Deputy Minister for Culture, Sport and Tourism
Y Dirprwy Weinidog Diwylliant Chwareon a Thwristiaeth

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Ein cyf/Our ref: MA-(P) DET/4383/18

Dr Dai Lloyd AM
Chair
Health, Social Care and Sport Committee
National Assembly for Wales

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21 December 2018

Dear Dai,

Thank you for your letter of 27 November regarding the results from the Sport Wales State of the Nation 2018 survey. The survey involved over **118,000** pupils and over **1,000** teachers, who completed a School Sport Survey provision questionnaire. This was an increase on the numbers taking part in 2015, remaining the largest UK survey of young people and sport. Surveys of this size help to inform future policy and Sport Wales are to be congratulated.

As you state, the overall participation figure is static at **48%** which is disappointing. However, given the **20%** increase over the last two survey cycles (it went up 13% in 2013 and a further 8% in 2015) to have sustained the current level is a positive marker as Sport Wales move into their new Sport Strategy. In order to drive forward the participation agenda my officials are working with Sport Wales to ensure that their new delivery and investment models are aimed at increasing these participation levels.

I was very pleased to see the increase in participation rates amongst traditionally under-represented groups, including those with a disability/impairment and certain ethic groups (Asian/Asian-British have gone from 36% to 40%, while Arab/Other have increased by 7 percentage points from 39% to 46%). We now have no ethnic group below **40%** for the first time ever, which demonstrates that sporting opportunities are reaching all these parts of our communities.

The survey notes that female and older pupils take part less frequently in PE and Sport. PE is a statutory subject in the curriculum for learners, up to the age of 16, and the Programme of Study for PE requires schools to give **all learners** opportunities to participate in the four specified areas of learning which cover health, fitness and well-being, creative activities and competiveness.

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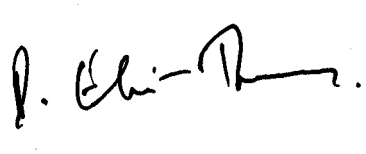
The Minister for Education is working with Pioneer schools and stakeholders, including Sport Wales, to develop a new curriculum for Wales, taking forward the recommendations of the *Successful Futures* report. One of the four key purposes of the new curriculum, which will incorporate a Health and Well-being Area of Learning and Experience, is that learners develop as **healthy, confident individuals** who take part in physical activity, and as such this is integral to the new curriculum. The new curriculum will be rolled out to all schools starting in September 2022 for primary schools and Year 7 pupils in secondary schools, with full roll-out to all pupils by 2026.

We acknowledge that more work needs to be done but we have made good progress over the last few years in terms of increasing rates of participation so to see sustained participation rates is positive. We will continue to target investment in socially deprived areas across Wales so young people irrespective of their social circumstances receive equality of opportunity and are able to take part in sport and physical activity.

Together with the Minister for Health and Social Services I have instituted a new Healthy and Active Fund which is a partnership between Welsh Government, Sport Wales and Public Health Wales involving investment of £5m over the next three years. This will focus on supporting projects which support active lifestyles, supporting community assets and also encourage interested partners working together and Sport Wales report that there has been strong interest shown by stakeholders and partners.

Sport Wales is also introducing a new model for Community Sport by establishing regional entities commencing with North Wales. Discussions are taking place with key partners and this approach will focus on working in collaboration to support our communities become hubs of activity.

Yours sincerely,



Yr Arglwydd Elis-Thomas AC/AM

Deputy Minister for Culture, Sport and Tourism - Y Dirprwy Weinidog Diwylliant, Chwaraeon a Thwristiaeth

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