Cynulliad Cenedlaethol Cymru | National Assembly for Wales
Y Pwyllgor Materion Allanol a Deddfwriaeth Ychwanegol | External Affairs and Additional Legislation Committee
Y goblygiadau i Gymru wrth i Brydain adael yr Undeb Ewropeaidd| Implications for Wales of Britain exiting the European Union
IOB 17
Ymateb gan Bwrdd Iechyd Prifysgol Hywel Dda
Evidence from Hywel Dda University Health Board

Introduction

1. The Welsh NHS Confederation, which represents the seven Health Boards and three NHS Trusts in Wales, welcomes the opportunity to provide information to the External Affairs and Additional Legislation Committee on the implications for Wales of Britain exiting the European Union. Our response predominately considers the impact that exiting the EU could have on health and social care in Wales and we recommend that the uncertainty and the issues raised in our response should be a top priority for Wales in advance of the UK Government triggering Article 50.

2. The Welsh NHS Confederation supports our members to improve health and well-being by working with them to deliver high standards of care for patients and best value for taxpayers' money. We act as a driving force for positive change through strong representation and our policy, influencing and engagement work.

3. The Welsh NHS Confederation and its members are committed to working with the Welsh Government and its partners to ensure there is a strong NHS which delivers high quality, person-centred services to the people of Wales.

Summary

4.

a. Many aspects of the UK's health and social care services have been influenced by European Union policies and legislation. Depending on the settlement, the UK's exit from the EU could have a profound impact on the UK economy, our workforce and the delivery of public services.
b. From an NHS perspective, possible implications on workforce, research and innovation, and health technology regulation are priority issues to be looked at during the withdrawal negotiations.
c. On workforce, our priority will be to ensure a continuing 'pipeline' of staff for the sector, including recognising health and social care as a priority sector for overseas recruitment. We have asked the UK Government to provide clarification as soon as possible that EU professionals who are already working for the NHS, or who will be recruited during the leave negotiations, will be allowed to remain after Brexit.

d. On research and innovation, our aim is that NHS organisations can continue to participate in EU collaborative programmes and are allowed to lead and be a member of European Reference Networks post-Brexit.
e. On health technology regulation, our priority is that NHS patients can continue to benefit from early access to the wide range of innovative health technologies available on the EU market and that they do not miss out on the opportunities offered by participation in EU clinical trials.
f. Alongside these priorities, we have identified public health, employment law and cross-border healthcare as other areas in which risks or opportunities emerging from Brexit should also be considered.

Most important issues during the withdrawal negotiations

5. As the UK Government has not outlined its detailed negotiating position and negotiations have not started yet, it is difficult to be very specific on the measures which should be put in place to mitigate risks and to take advantage of opportunities. While the implications of UK withdrawal from the European Union are anticipated to affect all parts of the health system, we have identified implications on workforce, research and innovation, and regulation of healthcare technologies as primary issues for the withdrawal negotiations at the outset.

Workforce

6. Across the UK, the NHS is heavily reliant on EU workers. In September 2015 there were 1,139 EU Nationals directly employed by the NHS (these numbers may have increased since this date).

7. The current percentage of doctors who are recorded on the Electronic staff record as being from the European Union is **8%** (compared to 10% in England).

Nationality (March 16)	**UK**	**EU**	**Non EU**
Consultant	74%	7%	19%
SAS	43%	13%	43%
Training Grades	74%	7%	20%
Other M&D	87%	5%	8%
Grand Total	**70%**	**8%**	**22%**

8. Further analysis was also carried out on GMC numbers to identify the place of qualification to provide an additional perspective.

Country of Qualification (March 16)	**UK**	**EU**	**Non EU**
Consultant	65%	5%	30%
SAS	30%	11%	59%
Training Grades	74%	5%	22%
Other M&D	84%	4%	12%
Grand Total	**65%**	**6%**	**30%**

9. While the figures for the whole NHS works are relatively small there are some points to note:
   - Irish staff form by far the largest group and in particular there are significant numbers in the professional/medical staff groups;
   - Staffing levels in the service operate on very fine margins as can be seen by the need to use high levels of agency and locum staff. Any decrease in staffing numbers will exacerbate the problem;
   - One of the solutions to the current staffing shortages since September 2015 has been to recruit from the EU, so these numbers may have increased since then; and
   - The current uncertainty as to the timetable for leaving the EU may potentially lead to staff looking for opportunities outside of the UK and for potential applicants to be deterred from applying. In addition, the incidents of harassment of foreign workers and feeling that they are may no longer be welcome may have an impact on EU/EEA workers' willingness to remain in the UK, even if permanent freedom to remain is granted.

10. Our reliance on EU workforce has increased in the last few years, probably due to tightening of UK immigration policy on non-EU workers. The priority should be to ensure that the UK can continue to recruit and retain much needed health and social care staff from the EU and beyond, whilst increasing the domestic supply, through robust workforce planning.

11. While we welcome the recent announcement that more healthcare professionals will be trained domestically from now on, we are also aware that workforce planning is an inexact science and that it is extremely difficult to predict the number of professionals needed to ensure the smooth and safe operation of a health and care system in continuous change. Shortages in specific areas can take only 2-3 years to develop, but may need 10-15 years for the UK trained workforce to respond, by which time other solutions have usually been found and different workforce shortages may have emerged. It is to be expected, therefore, that our sector will need to continue to recruit

overseas trained professionals, including from within the European single market, to operate smoothly and to offer safe and high quality services to patients in the future.

12. The freedom of movement provisions of the EU single market make it possible for healthcare professionals qualified in other parts of the EEA to access the employment market in the UK without having to obtain visas and work permits, unlike citizens from non-EU countries. This makes it quicker and easier for the NHS to recruit staff from the EU, especially into shortage areas and specialties. The UK benefits enormously from the single market in this respect, as we are a net importer of healthcare professionals qualified in other parts of the EU.

13. In addition the EU legislation on mutual recognition of qualifications means that currently many EU healthcare professionals are "fast-tracked" for registration with the General Medical Council, the Nursing Midwifery Council or other relevant regulatory bodies. EU rules mean the process for professional registration and the right to practise legally in the UK is different to non-EEA trained practitioners, for example it does not systematically require pre-registration competency and language testing by the regulator. These arrangements are reciprocal so that UK-qualified practitioners can also practise relatively easily elsewhere in the EU, although the outbound flow is less.

14. Our priority will be to ensure a continuing 'pipeline' of staff for the sector. The immigration system that is in place after the UK leaves the EU will need to ensure that, alongside our domestic workforce strategy, it supports the ability of our sector to provide the best care to our communities and people who use our services.

15. If the UK continues to have full access to the single market in future, entailing freedom of movement for EU citizens to live and work in the UK and vice-versa, not much would change in terms of our ability to recruit from the EU. At the other extreme, a total exit from the single market would leave the UK completely free to determine its own policies on immigration, with possibly much greater implications for the NHS. Under this latter scenario, it would be crucial to ensure that any future UK immigration rules recognise health and social care as a priority sector for overseas recruitment, from both within and outside the EU.

Research and innovation

16. Clinical research and innovation are key components of NHS activity and the NHS has a long tradition of EU collaborative research. Subsequent EU Research and Innovation funding programmes have acted as catalysts for this collaborative work, filling gaps in the research pipeline, and allowing researchers across Europe to gather forces to find responses to common challenges, both at clinical and operational levels, that confront health systems in Europe.

17. European programmes have, for example, supported research into health economics and the resilience of healthcare systems, for the public good. At the bottom line, the

NHS wants to access research which brings affordable innovation and, most importantly, benefits to NHS patients. This is not possible, at least to the same extent, through participation in collaborative research with other regions of the world, such as the USA, where commercial interests are often the key driver of research.

18. EU research grants have also been crucial for the NHS' ability to attract and retain some of the most renowned clinicians in the world, who often decide to work for the NHS due to its reputation in leading EU collaborative medical research initiatives.

19. Collaboration at EU level has helped the NHS to develop new treatments, adopt innovation more quickly, and improve the quality of healthcare it provides. We would like to ensure that the NHS can continue to participate in EU collaborative research programmes post-Brexit.

Regulation of health technologies

20. The EU has competence to regulate health technologies, such as pharmaceuticals and medical devices, but also products of human origin such as blood, tissues and cells. This is because these products circulate in the EU single market and therefore a set of common standards and rules are needed to ensure their safety and quality.

21. In Wales the life sciences sector employs around 11,000 people[i] based at more than 350 companies and delivers a turnover of circa £2bn per year. These include companies in the ground-breaking fields of medical technology – biopharmaceuticals, regenerative medicine, diagnostics, e-health and biotechnology. Recognising this inherent strength and potential, the Welsh Government has established initiatives such as the Life Sciences Hub[ii] and Life Sciences Research Network Wales[iii] to ensure ongoing development of the sector in Wales, which is expected to deliver significant (over £1bn) economic impact by 2022.

22. Having a single EU regulatory framework has allowed new health technologies to be brought more quickly to the market for the benefit of patients. For example, pharmaceutical companies can make new medicines available everywhere in the EU through the single centralised marketing authorisation procedure provided by the European Medicine Agency, instead of having to apply for authorisation in each individual member state. Maintaining access to this centralised authorisation procedure is the main priority for the UK pharmaceutical/life sciences industry.

23. A single EU system has also allowed a higher level of patient safety and public health protection to be achieved through a close-knit network of competent authorities in member states and the European Medicines Agency, collaborating, exchanging information, and bringing their expertise to the table in a way that adds value, whilst avoiding duplication of effort.

24. The EU regulatory framework spans the full process needed to bring new health technologies to the market, starting from the clinical research phase. It is for this reason that the authorisation and conduct of clinical trials are also regulated by the EU. This is particularly relevant from an NHS perspective, given the vast amount of clinical studies conducted by the NHS.

25. In the event that the UK continues to have full access to the single market in the future, the EU medical regulatory framework will continue to apply and thus not much would change. At the other extreme, an exit from the single market would leave the UK free to determine its own medical regulation, with possibly much greater implications for the NHS. Under such a 'hard Brexit' scenario, it will be essential to ensure that our patients can continue to benefit from early access to the wide range of innovative health technologies which are available on the EU market. Similarly, it will be crucial that NHS patients do not miss out on the opportunities offered by participation in EU clinical trials.

Other risks and opportunities

26. In addition to the areas mentioned above, potential risks and opportunities of leaving the EU in other areas of health policy should also be highlighted:

Public health

27. A significant proportion of the domestic legislation in public health and consumer protection originates from the EU, as the EU has legislative competence in these areas. If EU rules were no longer enforceable in the UK after we leave the EU, we would recommend to ensure that the same or higher level of safety is guaranteed through domestic standards and rules in the future.

28. Furthermore, the EU has several mechanisms to respond to and combat major cross-border health threats, including communicable disease outbreaks. This has allowed considerable improvement in the degree of information sharing and response coordination at EU level in cases such as Ebola, or swine flu pandemics. Continued access to these EU coordination mechanisms and networks, such as the European Centre for Disease Prevention and Control (ECDC)[iv] should be sought during the negotiations, as it would be more difficult for the UK to tackle in isolation what are inherently transnational threats.

Employment law

29. A substantial proportion of UK employment law originates from the EU and provides important protections for nurses, social care and health staff, in particular, rules on health and safety at work, information and consultation on collective redundancies and safeguarding employment rights in the event of transfers of undertakings (TUPE).

30. The Government has already stated its intention to protect workers' rights after Brexit and, as the largest employer in the country, we very much welcome this. The EU's key

health and safety related directives provide a legal framework for employers to reduce the risks of stress, violence, musculoskeletal disorders (MSDs), biological hazards, stress and violence to health and social care staff. MSDs and stress are particularly prevalent in the nursing workforce and the main cause of sickness absence in the sector and, arguably, without the directives the situation would be worse. The implementation of hoists and other lifting equipment, as required by the Manual Handling Directive, has been proven to significantly reduce the risks for social care and health staff and the people they care for.[vvi]

31. In the event of the UK no longer being bound by EU employment law in the future, we believe however that there are very **specific elements of EU law which could be looked at and reconsidered**. For example, we believe that while the European Working Time Directive has helped to protect staff from fatigue due to excessive working hours, and that therefore its founding principles should remain, the opportunity to change the rules on the timing of rest breaks and working patterns could permit greater flexibility to support seven-day working and integrated care, create better work-life balance for our workforce and potentially improve both training and staffing in healthcare settings.

Cross-border healthcare

32. As the right to receive healthcare in another EU country is regulated by the EU, leaving the EU may have consequences for NHS patients in terms of their ability to access cross-border healthcare. This could mean that, in the future, British citizens on holiday in Europe might no longer be able to use the European Health Insurance Card, which allows them to receive emergency or immediately necessary healthcare on the same terms as the residents of that country.

33. EU law also allows Britons who are abroad for a longer period of time – such as pensioners living abroad, or UK citizens who work in another EU country – to be entitled to receive healthcare in the country where they live on the same basis as the local population. It should be stressed that these EU rules are reciprocal and therefore uncertainty also exists on whether EU citizens will be entitled to receive healthcare in the UK following Brexit.

34. If the UK were to leave the EU single market, these systems would in principle no longer apply in the future, unless bilateral agreements were negotiated. Consideration should be given by negotiators to possible implications for patients and how to ensure that a **fair alternative system is put in place,** either with the EU as a whole, or with those EU countries, such as Spain, which have high numbers of UK nationals living there.

How to mitigate risks and take advantage of opportunities

35. The risks and opportunities will largely depend on whether the UK will continue to have access to the EU single market, or not, in the future. As the UK Government has not outlined its detailed negotiating position and negotiations have not started yet, it is difficult to be specific on the measures which should be put in place to mitigate risks and to take advantage of opportunities. Nevertheless, we have the following main recommendations at this stage:
    a. In the event that the UK were no longer part of the EU Customs Union and could therefore embark in the negotiation of trade deals with different economic regions across the globe, particular care will have to be paid to respective public health policies and standards applied, as other trade blocks will be pushing for mutual recognition of their standards, which could be set at a lower level of safety compared to the EU's. International free trade deals are very complex and long to negotiate. While we recognise the UK Government may wish to agree deals quickly, for each trade pact it will also be crucial to ensure a high level of public health protection by conducting an in depth analysis of the standards applicable to each individual economic sector and ensuring that, whenever deemed necessary, reservations are agreed with our counterpart.
    b. Given the complexity of negotiations and the variety of policy areas that will be covered, we strongly recommend that organisations with specific expertise and knowledge in these respective areas are consulted by Government when drawing up the detailed approach to particular issues. This will allow a well-informed negotiating position to be shaped and avoid the risk that some of the implications could be overlooked.
    c. To reduce uncertainty in the run up and during the negotiations, whenever possible clarification should be provided by the Government. For example, the clarification given by HMT on EU funding programmes has been extremely helpful in reassuring our EU funding partners that it is safe to involve UK organisations in new funding bids. Similar clarification in other areas will be very welcome. In particular, reassurance by Government as soon as possible that EU healthcare professionals who are already working for the NHS, or who will be recruited during the leave negotiations, will be allowed to remain after Brexit, would be extremely helpful. Given the workforce shortages that the health service already faces, such reassurance is vital to enable us to recruit and retain EU staff, who could otherwise be discouraged from coming/staying in the UK due to uncertainty over their employment rights after Brexit.

Conclusion

36. The Welsh NHS Confederation will continue to highlight the possible implications for NHS in Wales of Britain exiting the European Union both with Assembly Members but also to the UK Government as part of the Cavendish Coalition.[vii] The Cavendish Coalition is a group of health and social care organisations united in their commitment to provide the best care to their communities, patients and residents. The coalition recognise that the talented and diverse group of people we all employ and represent are central to the

success of that commitment, and that these individuals from the UK, Europe and across the world make a vital contribution to delivering care to the UK's population. We are committed to working together to ensure a continued domestic and international pipeline of high calibre professionals and trainees in health and social care in the future.

---

[i] http://gov.wales/topics/businessandeconomy/sectors/life-sciences-sector/?lang=en

[ii] https://www.lifescienceshubwales.com/

[iii] http://www.lsrnw.ac.uk/

[iv] http://ecdc.europa.eu/en/Pages/home.aspx

[v] Health and Safety Executive (2002) Second Evaluation of the Manual Handling Regulations (1992) and Guidance. HSE Books: Sudbury

[vi] Health and Safety Executive (2003) Evaluation of the implementation of the use of work equipment directive and the amending directive to the use of work equipment in the UK. HSE Books: Sudbury

[vii] http://www.nhsemployers.org/your-workforce/need-to-know/brexit-and-the-nhs-eu-workforce/the-cavendish-coalition