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 25
Ymateb gan Coleg Brenhinol yr Anesthetyddion (RCoA)
Evidence from Royal College of Anaesthetists (RCoA)

Below is a response sent by the Royal College of Anaesthetists (RCoA) to the Commons Health Committee inquiry on the impact of Brexit. With regard to Wales, the vast majority of the issues are identical. The Welsh Board of the RCoA has considered the issue and would add that many hospitals in Wales are even more reliant on anaesthetic staff (particularly at middle grade) from Europe. Any effect Brexit may have on that source of staffing either in retention or on-going recruitment would have detrimental effects on delivery of a service already experiencing recruitment challenges.

Submission to the Commons Health Committee inquiry on the impact of Brexit on health and social care

27 October 2017

Introduction

The Royal College of Anaesthetists (RCoA) is the professional body responsible for the specialty throughout the UK, and represents a combined membership of 21,000 doctors who work in the NHS. The RCoA is committed to improving patients' safety, wellbeing and outcomes through the maintenance and advancement of standards in anaesthesia, critical care and pain medicine. Through our services, anaesthetists will be well trained and supported, and we continue to uphold a central role in the development and delivery of high quality healthcare.

Anaesthesia is the UK's largest secondary care specialty; 16% of all hospital consultants are anaesthetists and over two-thirds of in-patients will see an anaesthetist during their stay in hospital. Moreover anaesthetists play a vital role in the delivery of pre-hospital emergency medicine.

The recent RCoA members' survey reveals that 6.5% of our members originate from the European Economic Area (EEA)[1] and we believe that the NHS could not deliver a safe and sustainable anaesthetic, pain medicine and intensive care service without the pivotal contribution of EEA colleagues.

We therefore welcome this important inquiry and the opportunity to provide views on the implications of Brexit for the NHS.

Summary of key points

We recommend that the following Issues and priorities are addressed by Government in the negotiations for Brexit

1. **Free movement of and access to EU healthcare workers** (from nurses to doctors) to fill gaps in NHS workforce
2. Implications of losing the **European Working Time Directive (EWTD)**
3. **Risk of economic recession** when the UK formally leaves the EU and consequent reduction in public spending and healthcare
4. **Cross border access to healthcare**
5. Limits on **sharing and collaborating within the medical community** brought by constraints on freedom of movement
6. **Loss of EU funding for UK medical research**
7. **Possible relocation of the European Medicines Agency (EMA)** (currently based in London) and consequent decline in the UK's influence on medical research and innovation
8. Ability to sign up to the **new EU Clinical Trials regulations** (managed by the EMA) to come into operation in 2018
9. Potential **weakening of current regulations** around public health, health and safety and workers' rights.

Issues the Government should consider in the negotiations for Brexit and why we feel these should be priorities for health and social care

1. **Free movement of and access to EU healthcare workers (skilled and unskilled) to fill gaps in NHS workforce**
   1.1 The UK is currently heavily dependent on the invaluable contribution that EU migrants make to staffing the NHS and social care sectors. 130,000 people from the EU work for the NHS or in social care, including 10% of doctors, 5% of nurses and 5% of the social care workforce. In addition UK hospitals rely heavily on free movement with Europe to recruit non-clinical staff, such as porters, cleaners and technicians. Restriction of free movement would affect all areas of patient care.
   1.2 The RCoA's 2016 membership survey[1] of our anaesthetic workforce showed that 70% received their Primary Medical Qualification in the UK, and 23% from a non-EEA country and 7% from an EAA country (this figure may actually be considerably higher as not all European doctors are affiliated with Medical Royal Colleges). Whilst Brexit (and potential changes to visa arrangements with EU countries) may result in better access to qualified doctors from other continents, the Government should not underestimate the crucial contribution of EEA colleagues to the NHS during Brexit negotiations.
   1.3 The House of Commons Public Accounts Committee estimate that the NHS is short of at least 50,000 staff and the College's recent workforce census[2] estimates a current 7% shortfall in anaesthetic workforce provision.

Even with the recent Government plans to increase medical school places, we are mindful that the increased cohort of medical students will not graduate until 2023 and are anticipated to complete specialist training in anaesthesia in 2032. In the meantime the acute workforce shortage still needs to be addressed and the contribution of doctors from overseas will remain invaluable. Therefore the NHS will still need to recruit staff from overseas in the foreseeable future.

1.4 The Government will also need to consider the demoralising effect that the debate around immigration control and free movement is having on EEA doctors and nurses currently employed by the NHS. If Brexit negotiations cause further uncertainty and fail to value the contribution of the EEA migrant workforce, the current acute NHS staffing problems could be exacerbated by a sudden departure of EEA colleagues from NHS hospitals and patients' safety could be compromised.

1.5 Implications on the Common Travel Area, (an open borders area comprising Ireland, the United Kingdom of Great Britain and Northern Ireland, the Isle of Man, and the Channel Islands) on the free movement of patients, doctors and healthcare workers between Ireland, which will remain in the EU, and the UK. It is unclear how the Common Travel Area might continue to operate once the UK leaves the EU.

2. Implications on the Working Time Regulations (WTR) and other employees rights

2.1 The Working Time Regulations (1998) implement the European Working Time Directive (EWTD) into UK law. The EWTD has been a controversial issue in healthcare and for the medical profession for many years. Although it has been welcomed for the protection it brings for doctors and their patients from working excessively long hours, some have expressed concern that it denies doctors in training the opportunity to gain valuable clinical experience and hinders continuity of patient care.

2.2 The Government will need to balance carefully the risks and benefits of any amendments to existing UK regulations derived from EU law and the impact these changes might have on both the rights of healthcare employees and patient safety.

3. Risk of economic recession when the UK formally leaves the EU and consequent reduction in public spending and healthcare

3.1 Post referendum, there has been the predicted volatility in the money markets and foreign exchange rates, with some economic experts predicting a 'high disruption scenario' of a 6% fall in GDP by 2020. We are concerned that overall public spending, including that for the NHS, will soon start to come under pressure and even more so post Brexit.

3.2 NHS organisations currently have to abide by EU procurement rules when they purchase goods and services from the market. Whether procurement rules will continue to apply as now, or might be amended post-Brexit, will once again depend primarily on the type of deal which the UK negotiates with the EU. In

considering procurement issues post Brexit the Government will also need to bear in mind the implications on NHS procurement of Lord Carter of Cole's 'Review of Operational Productivity in NHS Providers'. The NHS will need to try and retain budgetary control in light of all these changes.

4. **Continued access to healthcare systems by British citizens living and travelling in Europe**

   4.1 Over 27 million Britons have European Health Insurance Cards facilitating access to the host European country's public healthcare system on the same basis as the indigenous population. More worryingly there are approximately 2 million UK citizens currently living, working and travelling in the EU, with 380,000 living in Spain alone. Although admittedly the current system is open to abuse by 'health tourists', changes to the current reciprocal agreements between the UK and EU countries for access to healthcare could be detrimental to British ex-pats, who may be forced to return to the UK, many elderly and with complex medical needs, for medical treatment. This would no doubt put pressure on already stretched NHS resources.

5. **Limits on sharing and collaborating in the medical community brought by constraints on freedom of movement**

   5.1 The prospect of Brexit is causing considerable anxiety amongst the medical and wider scientific research communities. With 23% of research scientists and 5% of undergraduates in our universities from the EU, constraints on freedom of movement would potentially limit the opportunities to travel, collaborate and share ideas. This could hinder the ability of the UK to be part of important conversations about medical research, innovation and public health matters, such as disease prevention and antimicrobial resistance to name a few.

6. **Loss of EU funding for UK medical research**

   6.1 Financially, the UK receives 16% of all its research funding from the EU – £8 billion between 2006-2015. In fact according to the NHS European Office UK organisations are the largest beneficiary of EU health research funds. Projects funded by the EU or those planned under the umbrella of EU regulation may be jeopardised and with that the ability to translate medical discoveries in treatments for British patients.

7. **Possible relocation of the European Medicines Agency (EMA) and consequent decline in the UK's sphere of influence on medical research and innovation**

   7.1 The EMA, which is at the heart of pharmaceutical research and medical innovation, is currently based in London and employs over 800 people. The UK is the leading player in European pharma development, with 15% of the EMA budget invested in UK-led projects. Leaving the EU risks downgrading the UK's pre-eminent position as, although access to funding may still be possible, it would not have the same influence on research policy that it currently enjoys.

8. **Ability to sign up to the new EU Clinical Trials regulations (managed by the EMA) to come into operation in 2018**

   8.1 **The way** clinical trials **are conducted in the EU will undergo a major change when the new EU** Clinical Trial **Regulation comes into operation in 2018 and replaces the current Clinical Trials Directive. The Regulation harmonises the assessment and supervision processes for** clinical trials **throughout the EU, via an EU portal and database.** This will **increase the efficiency of all trials** in Europe with the greatest benefit for those conducted in multiple Member States. It aims to foster innovation and research, while helping **avoid unnecessary duplication** of clinical trials or repetition of unsuccessful trials. **The European Medicines Agency (EMA) will set up and maintain the portal and database, in collaboration with the Member States and the European Commission.**

   It would be extremely beneficial for UK medical research to remain part of the EMA and the new Clinical Trials Regulation.

9. **Potential weakening of current regulations around public health, health and safety and workers' rights**

   9.1 There are over 80,000 pages of EU regulations related to public health matters. These range from use of tobacco products to food regulation, from water and air quality to coordinated responses to pandemics. There is no doubt that these regulations have brought considerable benefits to the UK and its citizens, and the Government will need to devote considerable resources to ensuring that these important safeguards remain in place post Brexit.

We would be happy to supplement this written evidence with oral evidence, or answer any further questions, comments or queries in writing.
For further information please contact Elena Fabbrani, Business Co-ordinator, Royal College of Anaesthetists. Email: efabbrani@rcoa.ac.uk Tel: 0207 092 1694.

References

1. Royal College of Anaesthetists 2016 Membership Survey. Results to be published in October 2016 www.rcoa.ac.uk

2. Royal College of Anaesthetists 2015 Medical Workforce Census. http://www.rcoa.ac.uk/census2015

Chair RCoA Advisory Board in Wales

25/11/2016