

The key issues for health and social care organisations as the UK prepares to leave the European Union

Health and social care organisations from across Wales have come together through the Welsh NHS Confederation's Policy Forum to outline the key issues and priorities during the Brexit withdrawal process and beyond.

The Policy Forum does not take any stance on the merits or otherwise of Brexit. Its aim is to make sure that we are in the strongest possible position once the UK leaves the EU, and to this effect it advocates an implementation period that adequately reflects the time needed to achieve the following desired outcomes:

- A continued domestic and international pipeline of high calibre professionals and trainees in health and social care to deliver sustainable NHS, social care, and independent health services to ensure the best care for our communities and people who use our services.
- Continued recognition of professional qualifications for people trained in the EU27 and mechanisms to alert each other of health and social care professionals who are prohibited or restricted to practice.
- Protection of workers' employment rights and patients' rights post-Brexit.
- Health and social care organisations across the UK continuing to participate in EU collaborative programmes, and lead and contribute positively to European Reference Networks and other collaborative EU networks, such as those which support medical research, post-Brexit.
- Patients continue to benefit from early access to the wide range of innovative health technologies available on the EU market and not miss out on participation in EU clinical trials.
- Regulatory alignment for the benefit of patients and the public's health, so that UK patients continue to have early access to the wide range of innovative health technologies available.
- Reciprocal healthcare arrangements preserved.
- Robust co-ordination mechanisms on public health and wellbeing with the same or higher level of safety guaranteed through domestic standards and regulations.
- A strong funding commitment to the healthcare sector, promoting solutions to minimise any additional pressures which may result from Brexit, as well as advocating for any loss of EU funds to be offset by alternative funding.
- Continued engagement between the Welsh Government and the UK Government to ensure the interests of the health and social care sector in Wales are safeguarded during the withdrawal process and beyond.

Desired outcome: A continued domestic and international pipeline of high calibre professionals and trainees in health and social care to deliver sustainable NHS, social care, and independent health services to ensure the best care for our communities and people who use our services.

A total exit from the single market, as put forward by the UK Government, will leave the UK completely free to determine its own policies on immigration with possibly much greater implications for health and social care. Under this scenario we believe it is crucial to ensure that any future UK immigration rules recognise health and social care as priority sectors for overseas recruitment, from both inside and outside the EU.

According to the latest figures (April 2018), 1,462 individuals directly employed by the NHS in Wales identified themselves as EU nationals (1.6% of the total workforce) on the Electronic Staff Record. This might not seem much but it includes a significant number of trained, qualified and dedicated staff who could not be replaced in the short term — for example, 6.2% of medical and dental professionals working in the Welsh NHS identify as EU nationals.

Doctors from Europe make a vital contribution to the health services across the UK. Currently in Wales there are 104 GPs (4% of total) on the General Medical Council (GMC) register who gained their primary medical qualification from another country in the EEA. To date, the vote to leave the EU has not affected overall numbers of non-UK trained doctors registered to work in the UK.

In relation to the wider healthcare workforce there is still concern about the lack of robust data on the social care, independent and third sector workforce and what Brexit will mean for them. The number of EU nationals working in social care is far greater than those working in the NHS. Nearly one in five care workers were born outside of the UK (approximately 266,000 people across the UK), of whom 28% were born in the EU.

However there has been no risk assessments undertaken in relation to EU workers and the vulnerability in the social care and independent sector. If migrant workers are not able to be part of the social care workforce the outlook is worrying for the sector and for the elderly, the vulnerable, the disabled, carers, and the health and the social care workers who support them.

Clarification is also required around students and graduates. There were 5,424 EU students at Welsh universities in 2014/15, equivalent to 4% of the student population. It is unclear whether student mobility is on the UK Government's agenda.

Desired outcome: Continued recognition of professional qualifications for people trained in the EU27 and mechanisms to alert each other of health and social care professionals who are prohibited or restricted to practice.

We want to ensure that the EU27 and UK health and social care professionals, and the health and social care system, continues to benefit from training and education opportunities and automatic recognition of qualifications. We want continued recognition of professional qualifications of nurses, doctors, dentists, pharmacists, midwives and Allied Health Professionals trained in the EU27 and the UK before exit day and after the UK's departure from the EU.

Under a 'hard' Brexit scenario, all provisions deriving from the Recognition of Professional Qualifications Directive would be stripped out of the Medical Act 1983. The GMC would be legally required to treat an application from a doctor who had qualified within the EEA as an International Medical Graduate (IMG). This would have an important operational impact on the GMC and also place pressure on both the applicants and the Royal Colleges who work with the GMC to process applications. This could result in a delay of around 18 months between application and acceptance onto the register, which is likely to impact on professional mobility and workforce planning. The GMC also provides the Professional and Linguistic Assessments Board test (PLAB test) for doctors who have qualified abroad. PLAB testing is already at full capacity and would find it difficult to cope if they had to provide clinical assessment for EEA doctors as well.

We also need to agree a way forward on simplifying the movement of professionals, including improving the checks we put in place to ensure all professionals practising in the UK meet the same standards. It is important that the EU27 and UK competency authorities continue to use the Internal Market Information (IMI) System to alert each other of health professionals who are prohibited or restricted to practice.

The GMC has led the way in international information sharing. They led the campaign for the introduction of a legal duty at European level to share fitness to practise alerts using the European Commission's IMI system, which came into force in January 2016. Participation in this system is contingent on single market membership — a 'hard' Brexit will result in the UK's removal from the system. If this happens, the GMC will need to decide how to share information with European regulators and how they obtain similar information in return. This is particularly important as European regulators will continue to have access to the IMI system and may be unwilling to establish a separate system solely for UK health professional regulators.

Desired outcome: Protection of workers' employment rights and patients' rights post-Brexit.

A substantial proportion of UK employment law originates from the EU and provides important protections for social care and health staff. The UK Government has already stated its intention to protect workers' rights after Brexit and we very much welcome this.

The following are some areas that impact on health and social care:

- The **European Working Time Directive** outlines the number of hours an employee can work before taking a break and how many hours can be worked in a week. This is crucial for health and social care staff. Any legislation developed to replace this must not put pressure on employers to force workers into working longer hours.
- The **Directive on measures to improve safety and health at work** encourages improvements in occupational health and safety in all sectors of activity, both public and private; promotes workers' rights to make proposals relating to health and safety, to appeal to the competent authority and to stop work in the event of serious danger; and seeks to adequately protect workers and ensure that they return home in good health at the end of the working day.
- The **prevention from sharp injuries in the hospital and healthcare sector Directive** regulates the prevention of sharps injuries, for example injuries caused by needlesticks. Sharps injuries are especially prevalent in healthcare settings and are a major hazard and cause of sickness absence in the sector worldwide. Workers who have suffered a sharps injury can experience anxiety and distress and in the most serious cases the injury can result in infection with blood-borne pathogens such as HIV or hepatitis B or C.
- The **manual handling of loads Directive** lays down minimum health and safety requirements for manual handling where there is a risk particularly of back injury to workers, for example the implementation of hoists and other lifting equipment for health and social care staff. The Directive reduces the risks of musculoskeletal disorder, which is particularly prevalent in the nursing workforce and the main cause of sickness absence in the sector.
- The **Charter of Fundamental Rights** brings together all the personal, civic, political, economic and social rights enjoyed by people within the EU. The charter contains rights and freedoms under six titles, including Article 3 which protects the right to and respect for physical and mental integrity, requires free and informed consent from people, and prohibits making the human body a source of financial gain.
- **Article 19 of the Treaty on the Functioning of the European Union** provides protection to combat discrimination based on sex, racial or ethnic origin, religion or belief, disability, age or sexual orientation.

Changes to workers' rights could result in health and social care staff working longer hours, exacerbating the pressures they are under, and could lead to increased sickness and potentially pose risks to patient safety. In addition, already vulnerable people will be at increased risk without specific legal protection for patients and service users.

Desired outcome: Health and social care organisations across the UK continuing to participate in EU collaborative programmes, and lead and contribute positively to European Reference Networks and other collaborative EU networks, such as those which support medical research, post-Brexit.

Through co-operation spanning decades, European nations have created a world-leading location for research and innovation, and a world-class funding agency. The European Research Council has invested in unique research facilities, including CERN (the European Organization for Nuclear Research) and the European Laboratory of Molecular Biology.

Clinical research and innovation are key components of health and social care activity across the UK and healthcare organisations have a long tradition of EU collaborative research. The EU enables medical research collaboration by supporting the sharing of research staff and expertise, cross-border trials, and the development of research facilities. The EU provides funding through programmes such as Horizon 2020, and the European Investment Bank has invested in UK research facilities, including Swansea University and Bangor University.

Between 2008 and 2013, the UK received €8.8 billion of EU science funding. Access to funding and the formation of strategic partnerships are vital to the progression of medical research. But without access to EU funding and collaborative projects, Welsh science excellence risks falling behind, and organisations including the NHS will become less attractive to professionals wanting to undertake research.

We welcome the UK Government's commitment to underwrite Horizon 2020 funding beyond the date the UK leaves the EU for projects approved while the UK was an EU member. However, the future beyond 2020 is uncertain. The joint report from the EU and UK Brexit negotiators in December 2017 stated the UK "*may wish to participate in some Union budgetary programmes of the new MFF (Multiannual Financial Framework) post-2020 as a non-Member State*". Access to EU research and development funding could be retained by the UK gaining "*associate member*" status for Horizon 2020's successor, Horizon Europe, as achieved by Switzerland and Israel for Horizon 2020. This would also allow UK-based academics to lead and participate in EU-wide collaborations. However, the UK will not be able to sign an association agreement for Horizon Europe until the programme has been legislated, probably in late 2020. Given that the Brexit transition period ends on 31 December 2020 and the new framework programme is due to begin the day afterwards, timing is clearly critical to ensure a smooth transition.

The UK has one of the strongest science bases of all European countries. We welcome the UK Government's intention to continue a strong collaboration with European partners in science and innovation. For health research we need to ensure that UK patients, the public and organisations can take part in pan-European research, innovation networks and clinical trials and that these can be supported through UK involvement in EU funding programmes and the EU Health programme.

The UK should continue to contribute knowledge and take the lead in European Reference Networks which are a virtual space for collaboration across the EU on rare diseases. This will give patients in the UK and across Europe access to the best treatment and knowledge available and support clinicians in developing their knowledge of rare diseases.

We recommend that the UK continues to harmonise its data protection regulations with Europe. Data sharing between Europe and the UK is essential for public health, medical research and ensuring patient safety. The UK must retain the General Data Protection Regulation (GDPR) because it provides important protections for individuals, while also allowing data to be shared within the EU.

Desired outcome: Patients continue to benefit from early access to the wide range of innovative health technologies available on the EU market and not miss out on participation in EU clinical trials.

The UK is currently part of the EU's European Medicines Agency (EMA) network, which encompasses more than 500 million people. The EMA ensures that medicines are safe, effective and of a high quality. It supports cross-border collaboration and provides a common framework for assessing and monitoring drug safety and efficacy, and allows timely access to new therapies and technologies.

The EMA represents 25% of the global pharmaceutical sales market, compared to the UK's 3% share in isolation. If the UK leaves the EMA arrangements and develops its own drug approval system, it may lose its 'tier 1' status, which would lead to:

- Delayed access by up to 12 to 24 months to new medicines and medical devices. For example, in Switzerland and Canada where there are separate approval systems, medicines typically reach the market six months later than in the EU
- Weakened post-approval regulation and pharmacovigilance
- Loss of expertise.

It is therefore crucial that any potential risks are minimised and that the UK's Medicines and Healthcare products Regulatory Agency (MHRA) retains its valuable role as an authority in the field, protecting and supporting innovation through scientific research and development.

As a result of the UK's withdrawal from the EU, the EMA is moving from London to Amsterdam. This will have a considerable impact, not only because it is relocating headquarters and personnel, but also because the relationship with the UK MHRA will change. The MHRA is a significant contributor to EU regulatory systems and processes, both for medicines and medical technologies. This includes scientific and clinical assessments, surveillance and supervision of products, and reporting of adverse events. Delay and expense in accessing treatments could be caused by separating the MHRA from the close working relationship it maintains with the EMA, in terms of vigilance, licencing, assessing medicinal products, offering scientific support and providing regulatory advice.

It is important that NHS patients do not miss out on opportunities to participate in EU clinical trials. Multi-country clinical trials must continue post-Brexit, particularly for rare diseases and personalised medicine, as these trials provide researchers with access to the large population base required. Currently, there are 1,500 clinical trials being conducted in multiple EU member states that have a UK-based sponsor, and over half of these trials are scheduled to continue beyond March 2019. The UK has the highest number of phase I clinical trials (those testing a new drug or treatment for the first time) in the EU and the second highest number of phase II and phase III clinical trials. It also has the highest number of trials across the EU for both rare and childhood diseases, many of which are scheduled to continue beyond March 2019.

Clinical trials for new drugs are currently carried out on a national level but are subject to EU regulations, including for their registration. The revised EU clinical trials Directive which takes effect in 2019, will harmonise arrangements across the EU with the aim of creating a single-entry point for companies that wish to carry out trials of new drugs on participants in different countries. Some in the pharmaceutical industry have expressed concern that leaving the EU could result in the UK losing out on some trials that might otherwise benefit patients.

Desired outcome: Regulatory alignment for the benefit of patients and the public's health, so that UK patients continue to have early access to the wide range of innovative health technologies available.

Over 2,600 medicinal products have some stage of manufacture based in the UK. This equates, to 45 million patient packs of medicines supplied from the UK to other EU27 and EEA countries every month. Over 37 million patient packs of medicines come the other way, supplied from the EU27 and EEA to the UK. Securing continued co-operation and mutual recognition between the EU and UK regarding the authorisation, conformity assessments, and testing and surveillance of medicines and medical technologies should be a priority outcome of the Brexit negotiations.

If the UK establishes a separate regulatory framework to continue to trade with the EU block of countries, we would still need to abide by their principles. This would impact all those involved in innovative health technologies, the pharmaceutical industry, medical devices and medical technology manufacturers, distributors, suppliers, researchers, NHS Wales and most importantly, patients. In Wales, it would hurt the ambition to link the health and wealth of the nation. According to the Welsh Government website, the Life Sciences sector in Wales employs around 11,000 people in over 350 companies.

To avoid dangerous delays for patients and an impact on this important health and economic sector, all products used in healthcare should be exempt from any new customs, tariff or VAT arrangements, and afforded pre-shipping clearance and fast-track access across any new EU/UK borders.

Desired outcome: Reciprocal healthcare arrangements preserved.

The current arrangements for reciprocal healthcare work well for the mutual benefit of UK and EU citizens. We support the UK Government's proposal to continue reciprocal healthcare arrangements both for UK citizens currently living in the EU, and for EU citizens living in the UK, after the UK has left the EU. They give peace of mind to travellers who know that if they carry a European Health Insurance Card (EHIC) they will be covered for urgent treatment, regardless of any pre-existing conditions, and to expatriates who can access healthcare in their country of residence. The system is also relatively simple for healthcare systems to administer.

Many UK citizens currently rely on the EHIC exclusively, even though it may not cover all costs (for example repatriation). Loss of access to the card would mean all citizens travelling across the UK/EU border would have to take out private medical insurance, as they do now when visiting the USA. Some people with long-term conditions, poor health, or disabilities may be unable to afford the cost of private insurance and could therefore effectively be unable to travel. Those who travel uninsured and need urgent or emergency care could be faced with large bills.

There are about 53 million visits made to the EU from the UK each year, and 25 million visits from the EU to the UK. Only around 1% of these visits results in an EHIC claim. Every year the UK recoups about £70 million from other EU countries and spends about £150 million on EHIC reimbursements, plus the cost (approximately £500 million a year) of reimbursing other member states for healthcare provided to British pensioners.

The current schemes also work very well for UK or EU citizens who need planned treatment in another EU country because, for example, the relevant expertise or equipment is not available in the country in which they reside. This provision is especially valuable for patients with rare diseases as there may be only a few centres of excellence in the EU where specialist treatment can be provided or in border situations where the nearest suitable facilities may be in a different member state.

Pensioners residing abroad who currently benefit from "S1" arrangements could, if allowed to stay in the host country after Brexit, have to take out healthcare insurance to access local services. This could be expensive and bureaucratic. There are far more British pensioners living in the EU27 countries than vice-versa (190,000 as opposed to 5,800) who have the right to receive healthcare on the same terms as the local population thanks to EU reciprocal healthcare arrangements. If these arrangements were to be discontinued, it is reasonable to assume that a proportion of these pensioners, many of whom have chronic conditions or complex healthcare needs, would return to the UK. Planning and funding provisions would have to be made for them in the UK's health and care system.

New non-reciprocal arrangements would also increase the administrative and resource burden in the UK when providing health services to EU citizens. Currently, managing access to health services by non-EU citizens is bureaucratically more burdensome than managing access for EU nationals.

Desired outcome: Robust co-ordination mechanisms on public health and wellbeing with the same or higher level of safety guaranteed through domestic standards and regulations.

The EU has a significant impact on health and wellbeing in Wales, both directly and indirectly. Examples include supporting co-operation to protect against current and emerging infectious diseases, legislation to support food quality and environmental improvements, social policy and enabling research and development. The health of citizens across Europe, including the UK, needs to be protected from pan-European disease outbreak. Tackling these health risks effectively requires joined-up policies and action, and the UK and EU need to reach agreement on the best way of collaborating to fight these public health risks after the UK leaves the EU.

The EU has several agencies that are directly relevant to health and wellbeing:

- European Centre for Disease Prevention and Control (ECDC)
- European Food Safety Authority (EFSA)
- European Medicines Agency (EMA)
- European Food and Veterinary Office (EFVO)
- European Agency for Health and Safety at Work (EU-OSHA)
- European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

These agencies undertake monitoring, surveillance, trend analysis and risk assessments, as well as providing alerts to government and stakeholders. They also support shared learning across borders and provide a platform for co-ordinated responses to global threats.

A significant proportion of the domestic legislation in public health and consumer protection originates from the EU, including:

- **Environmental protection:** a range of EU policies relating to water, waste, air pollution and climate change have been transposed and implemented in the UK.
- **Food standards:** EU law on nutrition and food (Food Information for Consumers Regulation) is embedded in the principles of food law.
- **Health and nutrition:** since 2007, EU institutions have established rules on both health and nutrition claims that allow businesses to demonstrate potential benefits of a particular produce.
- **Tobacco and alcohol:** the EU has enabled a cross-border approach to anti-smoking measures through the Tobacco Products Directive.
- **Cost and availability of fresh food:** currently 30% of the UK's food is imported from the EU and predictions point to decreased availability and higher costs of fruit and vegetables after Brexit.

To ensure that public health for all EU and UK citizens is maintained post-Brexit, it is key that there is strong co-ordination between the EU and UK to deal with pandemics, communicable diseases, influenza outbreaks, infectious diseases and antimicrobial resistance. We must also seek the highest possible level of co-ordination on health promotion and disease prevention programmes.

Any reduced level of collaboration with the European Centre for Disease Prevention and Control (ECDC) could lead to delays in reporting and disease tracking, hampering outbreak response. It would also reduce the effectiveness of pandemic preparedness planning and co-ordinating appropriate responses.

We recommend that the UK Government negotiate an agreement to continue to share information, evidence and planning for pandemic preparedness with the ECDC. Maintaining the fullest possible access to the ECDC's emergency preparedness systems would enable the UK to continue sharing data and evidence with the EU, and vice-versa, to protect its citizens and ensure preparedness co-ordination.

Desired outcome: A strong funding commitment to the healthcare sector, promoting solutions to minimise any additional pressures which may result from Brexit, as well as advocating for any loss of EU funds to be offset by alternative funding.

The Health Foundation estimated that the Department of Health's budget could be £2.8 billion lower than currently planned by 2019-20 as a result of a fall in economic growth following the UK's decision to leave the EU. In the longer term, the analysis concluded that the NHS funding shortfall could be at least £19 billion by 2030-31 – equivalent to £365 million a week – assuming the UK is able to join the European Economic Area. If this is not the case, the shortfall will potentially be as high as £28 billion or £540 million a week. The repercussions will be felt by the NHS in Wales and any decline in the economy will see a rise in socio-economic inequalities, with a likely increase in health inequalities impacting on the most vulnerable in society, including at risk groups and people with disabilities.

In addition to the impact on the economy, EU structural funds have supported initiatives to reduce inequalities in health, tackle poverty and contribute to the promotion of wellbeing of the Welsh people. Wales is home to some of the poorest regions in the EU and so receives a disproportionately larger amount of EU funding compared with other parts of the UK. Unlike other areas of the UK, Wales is a net beneficiary of the EU, receiving £245 million more from the EU than it pays in. The net benefit to Wales from the EU equated to around £79 per head in 2014, compared to a net contribution of £151 per head for the UK as a whole. Any loss of funding could negatively impact on wellbeing and inequalities in Wales.

There is currently a great deal of uncertainty as to the availability of future replacement EU funding in Wales. EU funding that is currently administered on a Welsh level includes European Structural Funds; Rural Development Programme and CAP Pillar 1 support; and the Ireland Wales Cross Border Programme (jointly with Ireland).

Local government has been a key partner in delivering EU Funding in Wales over several programming periods. It is important in the delivery of EU-funded activity within regions through the direct delivery of capital and revenue schemes that support getting people back into employment. Local Authorities also play a strategic role in the delivery of these programmes on a local level. A key priority for Wales is to understand the rules of engagement for accessing any replacement funding after Brexit.

The period of uncertainty related to Brexit is likely to impact the mental health and wellbeing of the population and may disproportionately affect specific groups, such as farming communities, lower socio-economic groups and people with disabilities. We believe that it is important to understand the impacts on health and wellbeing during negotiation and transition.

Desired outcome: Continued engagement between the Welsh Government and the UK Government to ensure the interests of the health and social care sector in Wales are safeguarded during the withdrawal process and beyond.

Policy Forum members will continue to highlight the possible implications for the NHS in Wales of the UK exiting the EU with the Welsh Government and Assembly Members, as well as with the UK Government.

A number of Policy Forum members are UK-wide organisations so have been speaking directly with the Department of Health in England, the Scottish Parliament and with colleagues in Northern Ireland regarding the border issue. In addition a number of organisations are members of the Brexit Health Alliance and Cavendish Coalition. Through these groups we have ensured that any briefings produced or any submissions to the UK Government, House of Lords or Westminster Committees reflect the issues impacting on the health and care system in Wales.

The Brexit Health Alliance brings together the NHS, medical research, industry, patients and public health organisations. The Alliance seeks to make sure that healthcare research, access to technologies and treatment of patients are given the prominence and attention they deserve during the Brexit negotiations. It will argue that it is in both the EU's and the UK's interests to maintain co-operation in research and in handling public health issues.

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 is committed to working together to ensure a continued domestic and international pipeline of high calibre professionals and trainees in health and social care.

The following organisations have endorsed this



Bringing medicines to *life*
Dod a meddyginiath i *fywyd*

Cymru | Wales



Unedig Yn
Erbyn Dementia
United Against
Dementia



AMRCW
ACADEMY OF MEDICAL
ROYAL COLLEGES WALES
ACADEMI COLEGAU MEDDYGOL
BRENHINOL CYMRU



The Association
of UK Dietitians



BASW
Cymru



**British Heart
Foundation
Cymru**



BMA
Cymru Wales



**BOWEL
CANCER UK**



**BRITISH
LIVER
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CHARTERED SOCIETY
OF PHYSIOTHERAPY
CYMDEITHAS SIARTREDIG
FFISIOTHERAPI



**Children in Wales
Plant yng Nghymru**



**MACMILLAN
CANCER SUPPORT**



**CYMORTH CANCER
MACMILLAN**



MS Society
Cymru



**PROSTATE
CANCER UK**



RNIB
Cymru
Yn cefnogi pobl
â cholled golwg
Supporting people
with sight loss



ROYAL CYMDEITHAS
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**THE ROYAL COLLEGE
OF SURGEONS OF
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