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Health and Social Care after Brexit

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This paper will look at the

implications of leaving the EU on

Health and Social Care to date.

Facts - How did it happen?

After a year of campaigning

The vote on the 24th June 2016 came as a surprise to our then-Prime Minister David Cameron.

The actual results from Brexit were that England voted strongly for Brexit, by 53.4% to 46.6%, as did Wales, with Leave getting 52.5% of the vote and Remain 47.5%.

Scotland and Northern Ireland both backed staying in the EU. Scotland backed Remain by 62% to 38%, while 55.8% in Northern Ireland voted Remain and 44.2% Leave.

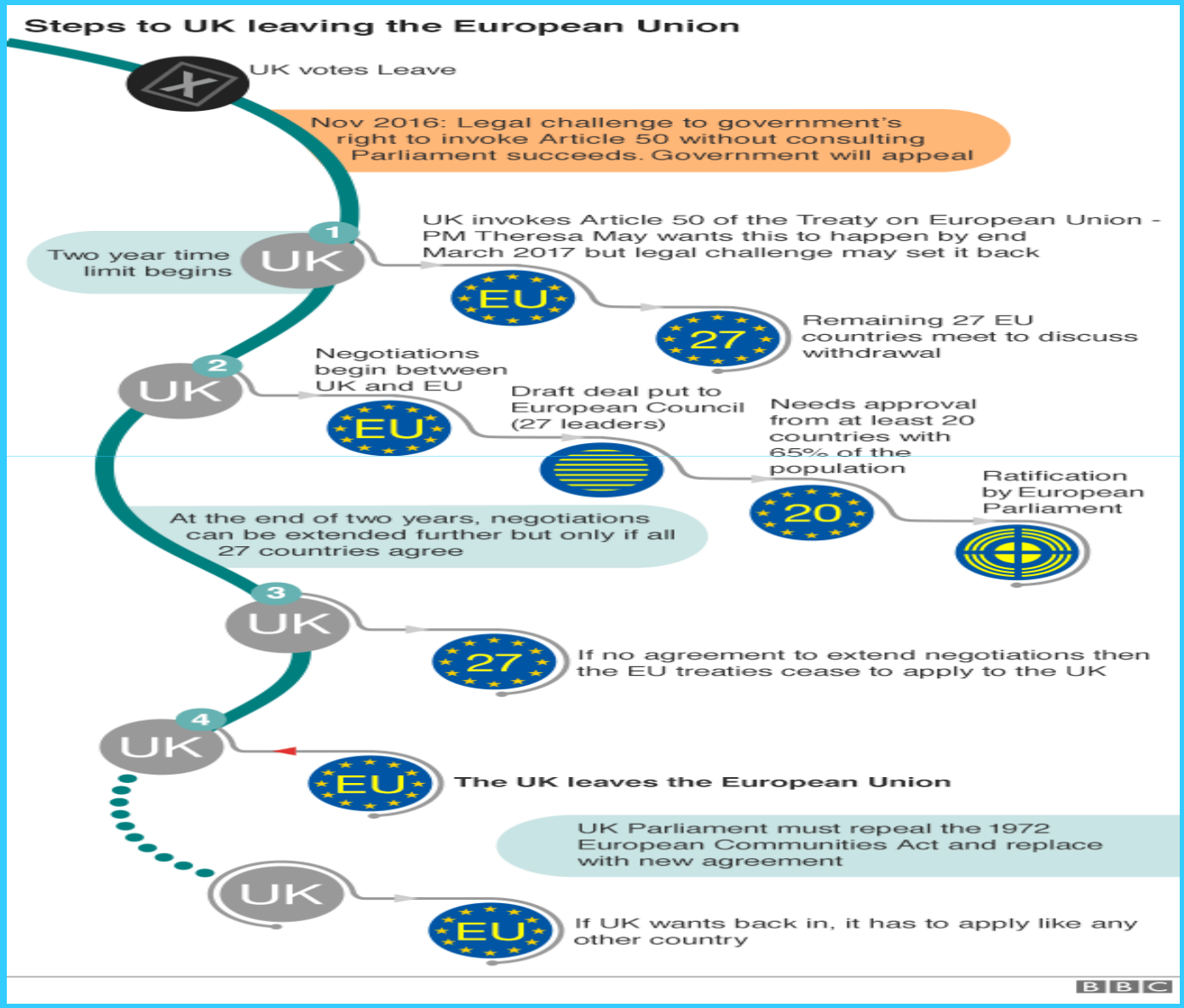
What happened next:

Scotland's First Minister, Nicola Sturgeon, declared that if Scotland was not able to stay in the single market she would call a second referendum to enable Scotland to be a separate country.

On 14th March 2017, she announced that it would take place in the Autumn of 2018 or the Spring of 2019.

EU inclusion is likely to be vetoed by the Spanish Parliament, which is fighting off Catalan plans and is supported by Italy, Greece, Belgium, Cyprus and Slovaka; these countries face separatist challenges and have concerns regarding independence

The Times of 20th March 2017 suggested a possible time line:



In November the High Court ruled that Mrs. May and her Government had no right to trigger the formal two-year process of leaving the EU without there being a vote in Parliament.

The Government appealed against the decision; however, the ruling meant that Members of Parliament and the House of Lords would have to accept that the Act would gain consent.

29th March 2017 : Article 50 was trigger at 12.25 Donal Tuck the President of the EU received the document form Sir. Tim Barrow Britain's permanent representative to the EU.

31st March: the European Commission draws up guidelines for the divorce focusing on the EU's red lines these set out the guidelines.

27th April: EU 27 summit to agree on the guidelines.

Eight days after the 8th June: Divorce terms will be presented at the first meeting between British and EU negotiators after the election.

The United Kingdom will exit the European Union (EU) by the middle of 2019 and will need to unpick forty years of laws and regulations (*approximate 53,000 acts).*

Initially they will be kept and as they need to be renewed they will be altered.

The concerns the **Kings Fund** brought to the Government's attention to be considered by the Health Service Select Committee were:

•The UK's Health and Social Care workforce, both those here and those working in the EU/EEA.

•Reciprocal health care and cross border access (E11 – the European Health Card).

•Regulations, market function and networking to enable wider research/projects.

•Cross border co-operation in public health and environmental protection, including communicable disease.

•Finance, medicines and medical devices, including drugs.

On 30th June, Helen McKenna wrote:

"Health is not an area of significant EU competence; its role is by and large limited to supporting member states in their health endeavour".

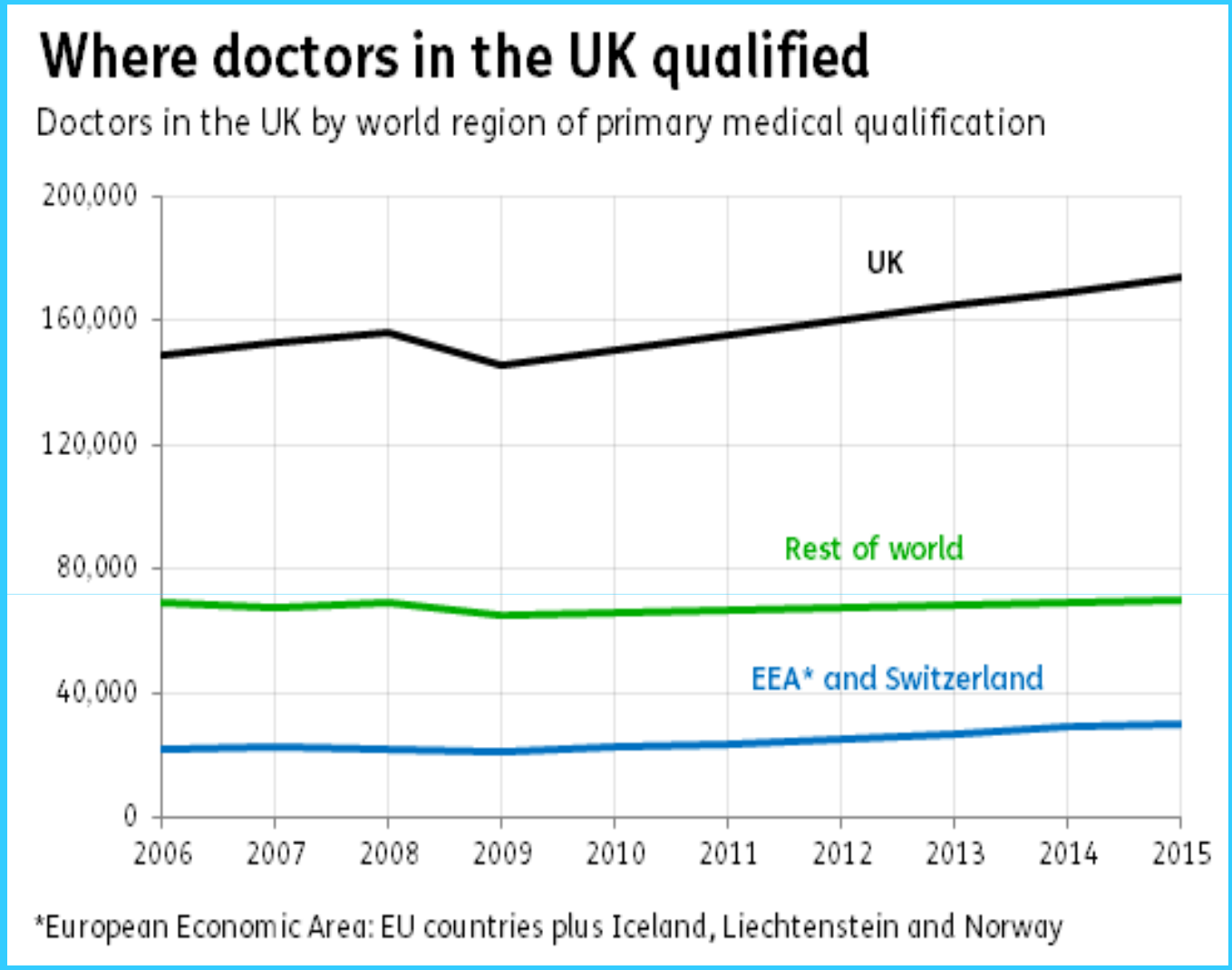
"While the impact on health and social care services of leaving the EU is impossible to forecast, it is clear that a number of important issues will need to be resolved".

The Workforce

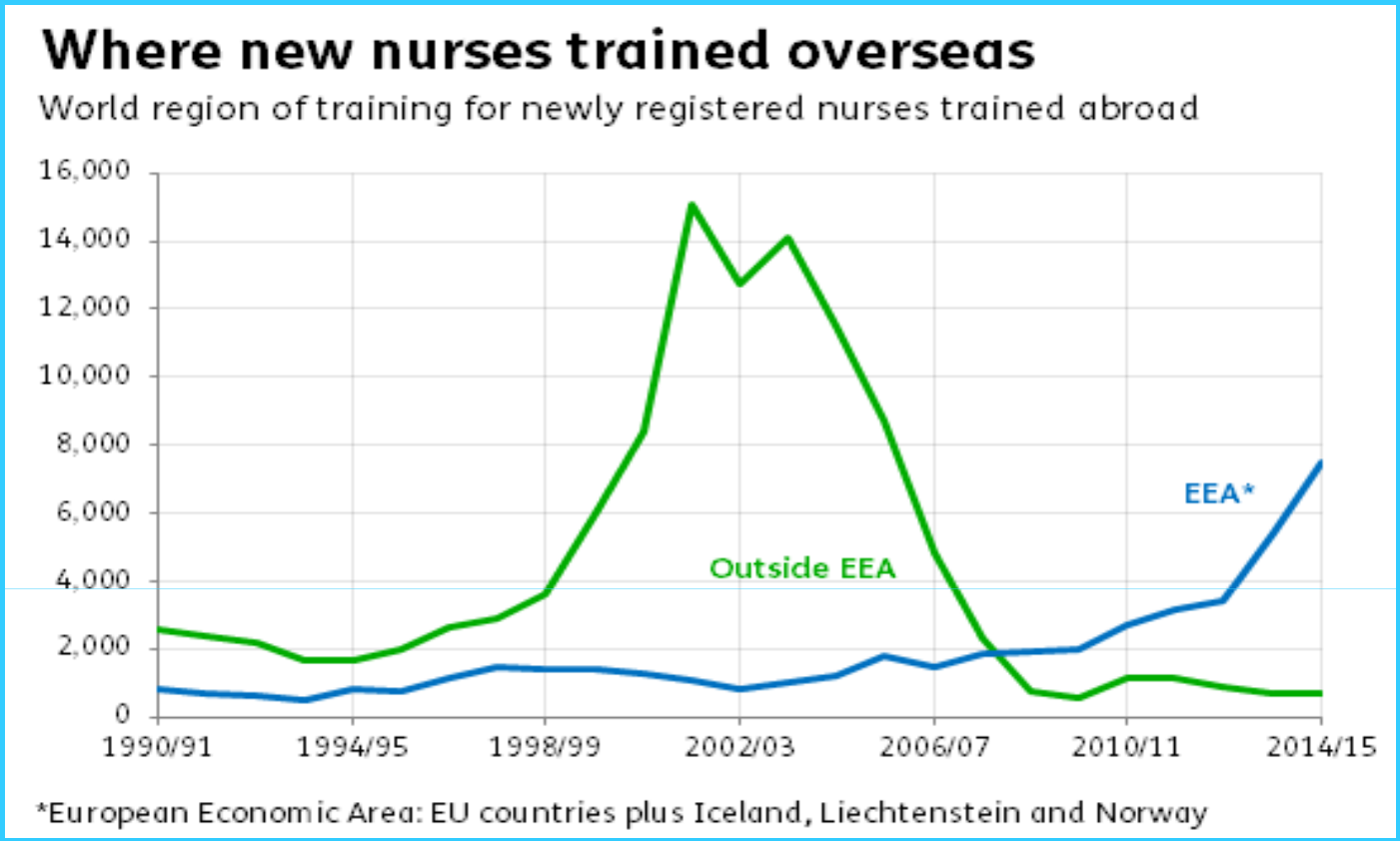
We have about 130,000 EU and EEA (Iceland, Norway and Liechtenstein) nurses, doctors and care workers in the NHS and Social Care.

Since 2000, there has been a deficit in staffing, possibly due to the cutback in student numbers by the Government.

So if we look at the numbers, it can be seen that 10% of medical staff come from the EU/EEA and 4% of nurses, and it is thought another 4% in social care.



GMC figures 2016 EU immigration and NHS staff



NMC figures 2015 EU immigration and NHS staff

Historically, the NHS has relied on staff from overseas.

Philippine, Irish, Australian, and New Zealand nurses.

Over the last 20 years more have come from the Southern part of Africa.

Mrs May's is hoping that they will be able to negotiate a continuation of this practice, as the few Polish nurses that we employ have already lobbied their Government.

This will be essential for the number of registered doctors, nurses and midwives, and social works, who work in the EU/EEA.

How might a staffing shortage be addressed if staff are not allowed to stay in the UK?

Many professionals have been in the country a long time and might have married but not had the need to change to UK citizenship; they might have expected to live the rest of their lives as nationals of an EU/EEA country.

This group feels more threatened than the more recent immigrants from Poland and Romania, particularly as they might have UK children who have not lived in their parents' countries.

Bedford, which had a small long term population of Italians which number about 2,000.

They have remained Italians and have the right to vote in Italian elections.

However, over the past five years they have also received nearly 4,000 Polish citizens, a number which has increased year on year (Bedford Council, 2017).

According to their records, this group is fluid, in that the people tend to stay about five years and then return to Poland.

The Government's Health Secretary, Jeremy Hunt, announced on 30th November 2016 that he has asked the Nursing and Midwifery Council to consider regulation for the new Nursing Associate qualification.

Over 1,000 Nursing Associates will begin training in September 2017 in eleven hospitals.

The new role will sit alongside existing nursing care support workers and fully-qualified registered nurses to deliver hands-on care for patients.

The demand for this type of course has risen over many years, which was a reaction to the EU's rejection of our Enrolled Nurse Training.

Another change co-terminus with the NA course will also happen this coming September: nurses' training will happen through an apprenticeship scheme where they will be paid while they train to complete a graduate route.

They will be released by their employers to study part time and can join the course anywhere according to their prior qualifications.

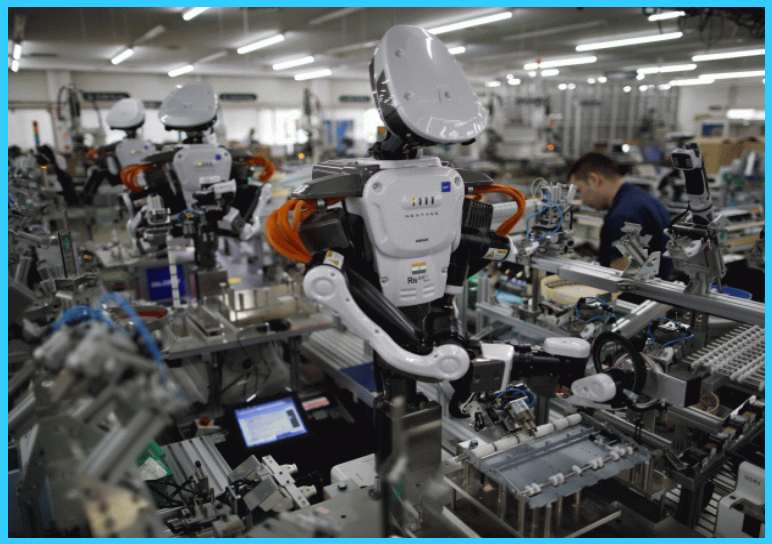
A Trust will be given £200,000 to release these trainees for study.

Similarly the Government has increased the number of medical students and allowed them to APEL in if they have prior qualifications.

So a gap may occur but it will be short term.

If we look at the top five overseas suppliers of doctors to the UK, we see India (25,005 doctors), Pakistan (9,770), South Africa (5,282), Nigeria (4,169) and Ireland (4,046); there is no reason to consider that these trends will change.

NB. APEL stands for the accreditation of prior experiential learning. It is the award of credit towards a university award in respect of skills and knowledge acquired through life, work experience, and/or study elsewhere.



The Independent - UK workers are more worried about losing their jobs to machines or because of the falling value of the pound than they are concerned about being squeezed out of work by immigration and globalisation, according to a new study. (http://www.independent.co.uk/topic/brexit)

The Working Time Directive

Since the EU's introduction of these directives, problems have been encountered, and many members of the medical staff have asked for their profession to be exempted.

The hours are stipulated so that junior doctors cannot be allowed to continue a patient's care to gain experience if there they have completed their specified hours, so instead the missing out.

Lintern (2016) wrote protection of working hours for more than one million NHS staff could be in jeopardy in the wake of Britain's decision to leave the EU, many difficulties could occur if these directives were removed.

Finance, Medicines and Medical Devices (including drugs);

We would lose the European Medicines Agency, which is based in London. The EMA's work is to evaluate drugs and other medications that have been developed by pharmaceutical companies, making recommendations to the EU.

However, the UK has always had its own regulation agency which authorises medicines for general use.

Our agency links with the European Centre for Disease Prevention and Control give early warnings of communicable diseases and how surveillance can be more effectively coupled with the need to look for drugs that will be ready for use if we have a further epidemic of (for example) Ebola or SARS.

There is concern that Public Health collaboration will be weakened, however this is doubtful as most countries feed into the World Health Organisation and collective findings are disseminated back to all countries.

Selby et.al. wrote*:*

"Research funding streams from the EU are open to non-EU countries under a variety of negotiations and conditions.

It is possible that the UK would be able to remain part of these and even conceivable that it would remain possible for the UK to 'punch above its weight' in terms of capturing the EU funding" (Selby, et. al. 2017).

Reciprocal Health Care

(E11 – the European Health Card).

At present, all EU/EEA people can use there E11.

It is hoped that one of the aspects of the discussions will consider the future of the E11.

It is hoped that some sort of reciprocal policy will be achieved.

However many tourist will be aware that outside that holidaying or working outside Europe they need health insurance.

It would be much more effective if this aspect of the treaty could be retained as it would prevent and extraordinary amount of time taken by various agency to reclaim the moneys due.

Regulations

There are many regulations which all EU/EEA members adhere too, some of which the UK wish to remove themselves from and over the next two years these will be examined critically.

The ones they will want to keep are those regarding competence and skills of any person wishing to work in the UK as a doctor, nurse, midwifery and in social care.

The UK would always which to maintain the language test so that all staff obtain a standard of 7.5 in the International English Language Testing System (IELTS).

Social Care

Are the people who work in social care any different from those who work in the NHS sector, yes?

When we are considering the social care sector we are looking at various levels of care that is offered by the Local Authorities.

The local authorities care supports:

Home care:

Personal care is needed so person can stay at home for example disabled, elderly, terminal care.

Temporary care following illness or surgery or accidents.

Supporting mentally ill, adults with educational problems, recovering addicts.

An approximation is that at least 4% are from the EU/EAU

It is still an estimate because it is not easy to find out the numbers from some of the agencies despite all agencies and care home are covered by the quality care commission.

So following Brexit there was concern that if this level of staff leaving or are asked to leave there would be a gap in the possible care cover.

Conclusion

At present we are only just on the brink of change however having two years has enabled a useful time in which to address some of the possible problems that lie ahead.

These cannot be take alone but as part of the reorganisation on health and social care in the UK, as the population is aging and there is far more demand on the all health facilities.

Fifty two countries are members of the Commonwealth. Our countries span Africa, Asia, the Americas, Europe and the Pacific and are diverse

Africa	Asia	Caribbean and Americas	Pacific
Botswana	Bangladesh	Antigua and Barbuda	Australia
Cameroon	Brunei Darussalam	Bahamas, The	Fiji
Ghana	India	Barbados	Kiribati
Kenya	Malaysia	Belize	Nauru
Lesotho	Pakistan	Canada	New Zealand
Malawi	Singapore	Dominica	Papua New Guinea
Mauritius	Sri Lanka	Grenada	Samoa
Mozambique		Guyana	Solomon Islands
Namibia	Europe	Jamaica	Tonga
Nigeria	Cyprus	Saint Lucia	Tuvalu
Rwanda	Malta	St Kitts and Nevis	Vanuatu
Seychelles	United Kingdom	St Vincent and The Grenadines	
Sierra Leone		Trinidad and Tobago	
South Africa			
Swaziland			
Uganda			
United Republic of Tanzania			
Zambia			

Thank you for listening.

Any Questions