

KENT AND MEDWAY: HEALTH AND SOCIAL CARE A BREXIT IMPACT ASSESSMENT

March 2018



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CONTENTS

ABOUT THE AUTHORS	5
SPECIAL THANKS	5
HOST: ROSIE DUFFIELD, MP	6
CEFEUS HEALTH AND SOCIAL CARE STEERING GROUP CO-CHAIR: ALICE CHAPMAN-HATCHETT	8
CEFEUS HEALTH AND SOCIAL CARE STEERING GROUP CO-CHAIR: DR ROBERT STEWART	9
INTRODUCTION	10
CONTEXT: WHERE ARE WE NOW?	12
MEDIA COVERAGE OF HEALTH AND SOCIAL CARE IN KENT AND MEDWAY	18
WORKFORCE AND SKILLS	19
SOCIAL CARE	27
MEDICINES AND MEDICAL INDUSTRY	32
PUBLIC HEALTH	36
LIFE SCIENCES, RESEARCH AND DEVELOPMENT	38
REGULATORY REGIMES	41
RECIPROCAL HEALTHCARE	46
TRANSPORT AND INFRASTRUCTURE	49
KENT IMPERATIVES: RECOMMENDATIONS FOR 2018-2021	50
CASE STUDIES	56
REFERENCES	62

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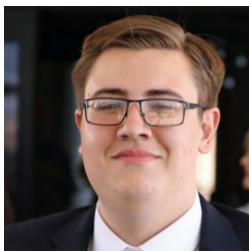
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KENT AND MEDWAY: HEALTH AND SOCIAL CARE: A BREXIT IMPACT ASSESSMENT

HOST: ROSIE DUFFIELD, MP

Since winning my seat in June 2017, I have been campaigning hard on East Kent health and social care provision issues. I am delighted to host the launch of this report, and to work once again with Canterbury Christ Church University, the Centre for European Studies (CEFEUS) and their excellent research team.

When I speak to doctors, nurses, administrators and other healthcare professionals across the region, it is clear that a steady and continued skilled workforce for the Kent and Medway health and social care sector post-Brexit, is of utmost importance. We must remember that 22% of doctors currently working in our NHS are from outside the UK. Indeed, as this report highlights, Kent and Medway is reliant on EU citizens right across its healthcare sector, with 8% coming from the EU: a higher proportion than most parts of England.

Clarification on the Government's post-Brexit proposed immigration system is therefore needed swiftly in order to reassure and affirm that valuable staff will not leave the healthcare sector in the UK, looking for security and long-term employment prospects elsewhere. As the British Medical Association suggest, and as CEFEUS have examined, these reassurances on immigration policy will be fundamental in maintaining the stability of Kent's NHS workforce.

The valuable data contained in this impact assessment makes this an excellent resource for healthcare professionals in Kent and Medway, and indeed for politicians – both local and national – across our district. Demography is an important part of informed policy-making. As the report notes, there is in Kent a 'disproportionately greater number of 65+ year olds in the population than in the rest of the country'. As such, we need a more active health service and there will be more pressures and more demand on social care services than many other parts of the UK.

Are we ready to face these pressures post-Brexit? Certainly not yet. Thank you to Alice Chapman-Hatchett, Dr Robert Stewart, Professor Amelia Hadfield, Professor Mark Hammond, Noora Virtanen, Christian Turner and their respective teams for completing this report, and putting together its launch.

A handwritten signature in black ink that reads "Rosie Duffield". The signature is written in a cursive, flowing style.

Rosie Duffield is the Labour MP for Canterbury, Whitstable, and the Villages. Before getting into politics, Rosie mainly worked as a Teaching Assistant, but also with local charities, churches, parents' groups, arts events and schools in the area.

Rosie is heavily involved in women's issues. She was a 'graduate' of the first year of the Jo Cox Women in Leadership Programme; she is also an active supporter of 50:50 Parliament, and is Parliamentary Private Secretary (PPS) to Dawn Butler MP, Shadow Secretary of State for Women & Equalities.



CEFEUS HEALTH AND SOCIAL CARE STEERING GROUP CO-CHAIR:

ALICE CHAPMAN-HATCHETT

This impact assessment of health and social care in Kent and Medway comes at a critical time in the Brexit journey, as the country approaches the agreement of a transition period and the government lays out its vision for the UK's relationship with the EU post transition.

Three issues are particularly clear from the report: workforce issues, funding options, and the future of the UK's regulatory regime. All three are key issues for the Kent and Medway health and social care sector, and need to be addressed with clarity in the short to medium term. In addition, the many organisations and individuals interviewed for this report have highlighted the vital importance of ensuring that good working relations remain between Kent and Medway, and our various European neighbours and sectoral partners, and that this ambition be more fully realised and reflected at the highest levels of government and industry.

These issues – and indeed the many related challenges flagged up within this report – may require amended, or entirely new government policy to reflect these changes. The recommendations found in the 'asks' of this report are particularly helpful and timely for this reason, and are commended to local, national and regional decision-makers accordingly.

A. Chapman - Hatchett

Alice Chapman-Hatchett is the Director of the Health and Europe Centre, a post she has held since 2009. The Centre's speciality is EU project development and support for the health and social care sectors in Kent and Medway, having a unique and profound understanding of how health and social care systems operate in Europe and how innovation can be transferred and implemented between countries. Alice has extensive European and public sector experience and focuses on promoting co-operation with health and social care experts in other EU countries to develop EU funded projects, explore evidence of good practice and create links for exchanges and shared learning. Under her leadership, the Centre has successfully bid for and is now managing EU funded health and social care projects worth in excess of €25m.



CEFEUS HEALTH AND SOCIAL CARE STEERING GROUP CO-CHAIR:

DR ROBERT STEWART

This 2018 appraisal of health and social care in Kent and Medway comes at a time when health and social care services across our county and the country as a whole are under great pressure to meet the changing and increasing needs of an ageing population. We are very concerned about a potential market failure of the health and care sector in Kent and Medway as a result of current difficulties in recruiting and retaining medical, nursing, therapy and care staff, as well as anticipated workforce problems. There is a real need to address workforce and sectoral issues at national and European levels, as well as working with local SMEs and care organisations to address this issue.

In addition, we recognise a 'Kent imperative' in remaining at the forefront of innovation in order to create the workforce of the future, and to maintain the range of vital collaborative connections in key parts of the health and social care realm. As this report highlights, Kent and Medway has had great success in both attracting European funding and establishing a host of new collaborative efforts with European partners. From my perspective, one of the best and most recent examples of this is our current partnering with Sweden in adopting the ESTHER philosophy of care, which highlights the focus individual-led care. With Kent operating as the UK's 'gateway to Europe' it is key that we retaining connections with both European and international partners to maintain joint co-operation of critical issues from the infection risk management to radioisotope access.

Dr Robert Stewart is the Clinical Design Director of the Design and Learning Centre for Clinical and Social Innovation which is designing Better, Safer and Cheaper Care for the 1.8 million residents of Kent and Medway. He has had significant experience as a Medical Director and over 30 years GP experience. He has always had a mission to innovate, integrate and transform health and social care with a focus on technology to empower the citizen to be more in control of their health and wellbeing.

INTRODUCTION

1 Since we published our third Brexit impact assessment in July 2017 focusing in joint fashion on Small and Medium Sized Enterprises and the Rural Economy, there have been few days when Brexit has been out of the news. The issues were central to the General Election and continue to dominate political and economic life in the UK. The Phase One agreement in December 2017 saw the foundation of the 'divorce' terms made and allowed for the negotiations to move onto Phase Two, which covers the future relationship between the EU and UK. This includes any potential transition period necessary to implementing the agreement and the terms of a new trade agreement.

2 Clearly the length of the transition and the terms under which it takes place will be key elements to determine the potential impact on Health and Social Care. This report can only be a snapshot and as we did with our previous reports we have tried to reflect the best state of knowledge and avoid speculation. We have always sought to maintain the two essential criteria from previous reports, namely that the issues are directly related to Brexit, and that they affect Kent and Medway in particular. Taken together, these represent the 'Kent imperatives', i.e. the list of issues vital to the strategic integrity of the county that are necessary for national and local decision-makers to tackle in the short-term, and pressing challenges facing the county as a whole in the medium and long-term.

3 It does now seem likely that though the UK will leave the EU on March 29 2019, there will be a **transition phase** lasting up to, or possibly beyond, two years. Although negotiations taking place during the very month of this report completion may see changes to the form or timing of this assumption, Britain will likely remain a part of the Single Market and the Customs Union during this period, which in turn will see little immediate change for those currently operating within the UK, and/or between the UK and the rest of the EU.

4 This suggests a working assumption that temporary arrangements – largely on the same basis as now – will be put in place with minimum change in order to prevent organisations from having to adapt to two stages of regulations, as well as having to deal with the 'double-handling' of possible changes that could begin from 2021. This has increasingly been seen as important to reduce the potential costs to the economy and any potential adverse disruption to economic activity.

5 During this anticipated transition phase, EU rules and regulations will continue to apply to the UK, while the UK itself in political terms will likely lose its seat on the EU Council and representation in the European Parliament.

6 Equally, during this period, there is clearly an enormous amount of work still to do. Given the very real shortness of available time, we feel that the government is best advised to divide its efforts into the vital issues to be dealt with in the short-term (i.e. between 2018 and the end of the transition period in c. 2021), medium-term issues arising from the first wave of post-Brexit challenges (2021-2025) and issues that could characterise the long-term for Britain in its key sectors (2025-2035).

7 This report is focused for the most part on the ‘**Kent imperatives**’ arising in the short and medium term (2019-2021) in the health and social care sector. However, as indicated below, and in the recommendations, further research will clearly be needed to assist decision-makers and stakeholders in making decisions that are both sensible to and sensitive of the specific conditions of Kent and Medway.

8 Guided by its strategic steering group, assisted by its co-chairs, and on the basis of a mixed methods approach combining qualitative and quantitative evaluation, as well as intensive use of group and individual interviews, surveys, and primary and secondary documentary analysis, CEFEUS staff have worked since mid-2017 to produce a balanced, coherent and ultimately practical report identifying the range of thematic impacts, opportunities and asks that are key to Kent and Medway’s health and social care sector arising from the anticipated impact of Brexit.

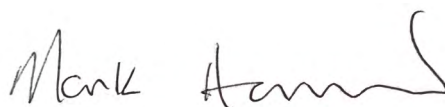
9 Short-term issues have almost always boiled down to ensuring minimal adverse impacts on services to patients and the public in terms of workforce and skills, while medium-term challenges generally indicated a need to think strategically about retaining or reframing regulatory and collaborative structures, and reworking funding issues. Impacts of a potentially negative kind are a very real feature of the report and ought to be taken seriously and acted upon expeditiously by public and private sector decision-makers. Equally, opportunities are on offer, suggesting new modes of tackling the not uncomplicated structure of health and social care at the county level, in order to encourage both synergies and efficiencies. Such opportunities are outlined in the forms of best practice featured in the concluding two Case Studies.

10 Ultimately, the recommendations that make up our list of ‘asks’ illustrate the **relevant and fundamentally requisite requirements** from the most important actors in the health and social care industry in the county. We commend them to all those in relevant positions of authority, on behalf of the citizens of Kent and Medway.

Professor Amelia Hadfield,
Director of the Centre for European Studies (CEFEUS),
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Visiting Professor, Public Policy,
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With the assistance of Noora Virtanen, CEFEUS Postgraduate Coordinator, Christian Turner, CEFEUS Undergraduate Coordinator and Sam Cairns, CEFEUS Undergraduate Research Assistant.

March, 2018

WHERE ARE WE NOW?

Research focus

11 It should be pointed out here that the potential impact of the UK's 2016 Referendum upon health and social care has not yet been felt in its entirety, either at a national or local level.

12 This is due to three reasons. First, we are as yet in the interim period of the UK's negotiations with the EU, the ultimate outcome of which remains unclear as of March 2018. Second, the UK government itself has neither produced an emphatically clear picture of its desired 'Brexit endpoint', nor its preferred mode of arriving at it. Third, and in consequence, it is not yet possible to accurately identify either direct or indirect impacts upon key aspects of health and social care, whether in terms of labour or funding, regulations or research.

13 Nevertheless, as indicated below, some data is now available, indicating a range of emerging impacts on the current state of British healthcare at national and local level. Whatever the various attitudes to the outcome of the Referendum, the data and insights gathered suggests that the historically overstretched condition of public health and social care prevalent in most areas of Britain is likely to be impacted negatively as a result of the envisaged repercussions of detaching from the EU, whether directly and in the short-term (e.g. workforce) or more indirectly and in the medium to long-term (e.g. reciprocal healthcare and funding).

14 Areas and sectors that are more robust may equally present with fewer negative impacts. This is not a political statement but rather a data-driven observation: systems and sectors under strain domestically will inevitably be impacted both directly and indirectly, in the short and medium term, as a result of major shifts to its administrative, budgetary, personnel, and legal composition, all of which are highly likely in terms of Brexit-induced changes, whether those changes themselves are regarded as positive or negative.

Reports and surveys

15 Health and Social Care is a multi-actor, cross-sectoral area involving thousands of various employees across a spectrum of skills, all of whom have a primary goal in common: the provision of high-quality, appropriate and timely care to patients of all ages, in all stages of need, in order to facilitate healing, protect and promote life, and to provide comfort. A huge number of primary documents from various public sector actors examining the potential impact of Brexit upon the health and social care sectors across the UK is now available, a critical mass of which this report has endeavoured to appraise in what follows (readers are encouraged to consult the list of references which conclude this report).

16 Rather fewer reports however have emerged from local actors, whether public and private; thus region and county-specific analyses on health and social care assessing the impacts and opportunities of Brexit – and the cross-sectoral data that generally accompanies them – remain comparatively rare. To fill out these gaps, CEFUS undertook a survey in February 2018 of key health care providers across the Kent and Medway region. While some of the most salient observations are included in the analysis that follows, the outcome was not as clear-cut empirically as previous surveys, for a number of reasons.

17 First, key individuals with access to / knowledge of data requested in these organisations appeared to be under such serious professional pressure that they were unable and/or unwilling to participate fully in the survey work. Thus, however large Brexit looms for some, for many others in health and social care in Kent and Medway – even those in key positions of authority – immediate pressures are simply more important at this point. Until a clearer Brexit picture emerges, filling current foundation trust vacancies and preventing the drift of county-based staff to London remain more pressing issues.

18 Second, those individuals who responded by and large conceded that ongoing uncertainty about what Brexit means in practice for their organisation largely prevented them from identifying areas of change, or defining these changes as positive or negative. Third, of the issues raised, workforce supply dominated, both in terms of pre-Brexit pressures, as well as post-Brexit impacts. Fourth, specific issues relating to regulatory arrangements – most notably the supply of medical isotopes – alongside reciprocal healthcare, and R&D were raised as a concern. Finally, and encouragingly for those scrutinising the sector for shared knowledge, most respondents felt that national NHS bodies and local providers had undertaken considerable work on ensuring their preliminary Brexit analysis is shared across all NHS local organisations.

19 The next step is to ensure these same observations are genuinely considered by those taking decisions with respect to the UK's future relations with the EU. As such, in examining the range of work published since early 2017, as well as key public statements, a number of clear themes have emerged, including labour (workforce, training, etc.), medicines and the medical industry, public health issues, funding, life sciences research and development, reciprocal (UK-EU) healthcare, regulatory regimes, as well as cross-sectoral issues of transport and infrastructure. Each of these we felt were variously pertinent to Kent and Medway, and comprise the key themes that make up the subsequent report.

Sectoral issues raised at national level

20 As this report is intended to influence the decisions of national and local decision-makers in both public and private sectors, referencing the most recent series of issues raised at the national level in terms of health and social care is a necessary first step, before refining our observations to the county level. In this respect, the points raised by Dr Sarah Wollaston MP, **House of Commons Health Committee Chair** to Jeremy Hunt, Secretary of State for Health and Social Care are especially instructive.

21 Writing to “stress the pressing need for clarify on the details of a transitional period after the UK Exit day” as well as the Government’s “contingency planning to protect patients, NHS services and the UK’s life science industry”, Dr Wollaston on **15 February 2018** raised the following points:

- The need for certainty amongst businesses and healthcare services “to avoid any disruption to the supply of **medical products...** including those **manufacturing and distributing medicines**”, and to minimise the broader risk of compromising **patient care** both in the UK and Europe.
- That business and healthcare services “must not be forced to transition twice” between and after the envisaged transition period. Instead, the government “should seek to agree an implementation period wherein the **current regulatory status quo is maintained** to avoid imposing unnecessary burdens on the life science sector.”
- That failure to agree with the EU “on other sectors of the economy could jeopardise an agreement on medicines, devices and substances of human origin would **put patient care at risk**”.
- Ensuring that the UK “maintains access to medical radioisotopes after Brexit, in the event that the desired close association with Euratom is not achieved”.
- In terms of transparency, those areas involving “complex supply chains, **extensive public scrutiny of any contingency planning** will ensure that all relevant aspects are covered to guarantee the health of UK patients regardless of the Brexit outcome”.

Kent and Medway: resources and community

22 It is clear from these specific focal points that labour and workforce, as well as regulatory status of much of the 'hardware' and 'software' of the medical industry need urgent attention. Workforce issues however, continue to dominate.

23 As the 2017 House of Commons Health Committee made clear, the first phase must be "addressing the **immediate issues faced by people**, whether they are workers in health and social care or patients who rely on reciprocal healthcare arrangements" (Brexit and health and social care – people and process, p.3). With 60,000 people from EU member states currently working in the NHS in England, and 90,000 in adult social care, it is clear that "post-Brexit we will continue to need, and benefit from the presence of EU staff in health and social care" (p.3). Failure to address workforce issues impinges on the current overstretch of the NHS, its ability to provide further services for an ageing population (particularly in Kent), as well as exacerbating the overall professional and personal uncertainty of British and EU.

24 As our interviews with key health and social care stakeholders across Kent and Medway revealed, sectors like health and social care function on the basis of an employment parallelism in which both high-paid and high-skilled are as key as low-paid and low-skilled employees. For various reasons, both these categories are hard to recruit, and as such, rely heavily on immigration. It is key that government decision-makers and stakeholders of all stripes think rationally and objectively about this issue, moving beyond the toxic nature this issue has taken on since the 2016 Referendum, and focus instead upon the very real needs of citizens in terms of patient care.

25 There is arguably 'support for 'low-skilled workers' in key sectors such as health and social care and in those sectors in which the public do not typically wish to work, such as seasonal farm work' but this needs to support a swift process of examining immigration, employment, skills spectrum from the perspective of the requirements of Britain's health service (House of Commons, Home Office delivery of Brexit: immigration, 2018, p.31). From the perspective of public services in Kent and Medway, labour patterns are "as much a local issue as a national one" (p.40). This requires a dual approach. Not merely the much-needed focus on staffing the required health and social care services in our area, but doing so in a way sympathetic to the wider needs of the communities in which these services are located and to whom they are responsible.

26 As the Commons report itself made clear on the basis of its own evidence, the Royal College of Nursing had demonstrated "the significant contribution made by nursing staff from outside the UK to providing healthcare to local communities. They pointed out that between 2001 and 2012, the percentage share of non-UK nationals within the practising nursing workforce grew from 15% to 22%." (p.33)

27 Gathering together people in terms of their needs and the skilled workforce required to address those needs across a county like Kent and Medway means working with community providers and local government, just as much as working to guide the strategic decisions being taken at national level. To that end, the multi-stakeholder evidence-led approach undertaken by this report focuses on the health and social care needs of Kent and Medway, and the best methods of meeting those needs, short and long-term.

Sectoral viewpoints

28 In addition to primary government statements (both national and local) regarding the impact of Brexit on health and social care, this report also drew upon the Brexit Position Statements of key healthcare institutions and associations. **The Academy of Medical Royal Colleges** for instance identified in July 2017 the following key issues that must be addressed within Brexit discussions on healthcare:

- **Workforce supply:** the retention and continued recruitment of EU staff.
- **Medical regulation/retention of qualifications:** clear agreement on replacing the automatic recognition of medical qualifications for EU doctors.
- **Medical science and research:** ensuring funding streams remain open and are maintained as a part of a competitive programme in healthcare and economic terms.
- **Regulatory alignment for health technology (medicines and devices):** alternative arrangements subsequent to the relocation from London to Amsterdam of the European Medicines Agency regarding UK regulation and registration of medicines and devices (patient safety and technology and innovation).
- **Public health issues.**
- **Reciprocal health arrangements.**
- **Funding and sustainability of the NHS.**
- **Non-healthcare specific issues.**

NHS Brexit bulletin

29 As part of our comprehensive data gathering exercise, we have since November 2017, reviewed the monthly Brexit Bulletin published by the NHS European Office.¹ The bulletins are helpful digests sent in a form of an email containing a wide variety of topical issues that touch on the NHS. In tandem with the work of the Health and Social Care sub-sector group, these monthly roundups have proved valuable to our report, and the table below is collated from topics that were featured in the bulletin and are important for the report.

NHS issue	Pros	Cons
Innovations and medical supplies ²	A successful exit deal would secure access to these in the future and new markets could be explored post-Brexit.	New markets could be more expensive or harder to import from/export to. A potential for increased frequency of medicines shortages due to administrative burden, customs delays and tariff measures. ³
Drug safety information ⁴	The UK has more say over this post-Brexit and can design them according to the UK's interests.	The sharing of important drug safety information or information relating to adverse medical events could face a five month delay post-Brexit.
Public health regulation and competition rules	Brexit allows faster public health regulation and enables the removal of rules on competition that are currently inhibiting further integration and collaboration between health services. ⁵	Europe's management of large-scale emerging public health concerns or crises – such as the Zika virus – could be at risk. ⁶
Regulations ⁷	A chance for the UK to design its own regulations that benefit the NHS.	Regulatory alignment post-Brexit would bring most certain benefits.
Working Time Directive (WTD) ⁸	Post-Brexit the NHS staff could work longer weeks and would not be limited to 48 hours a week.	Returning to allowing staff to work 90 hours a week, could harm not only the staff but lower the quality of care and lead to more accidents (e.g. doctors driving home tired).

1 <http://www.nhsconfed.org/regions-and-eu/nhs-european-office>

2 <https://www.nuffieldtrust.org.uk/research/brexit-relationship-eu-shape-nhs#key-points>

3 <http://www.abpi.org.uk/media-centre/news/2017/december/safeguarding-public-health-must-be-number-one-priority-for-eu27-and-uk-government-in-phase-two-of-brexit-talks>

4 <http://www.abpi.org.uk/media-centre/news/2017/december/safeguarding-public-health-must-be-number-one-priority-for-eu27-and-uk-government-in-phase-two-of-brexit-talks>

5 https://www.kingsfund.org.uk/publications/articles/brexit-implications-health-social-care?utm_source=The%20King%27s%20Fund%20newsletters&utm_medium=email&utm_campaign=8983222_NEWSL_Weekly%20update%202017-12-13&utm_content=brexitbutton&dm_i=21A8,5CJHY,FMB860,KNU1X,1

6 <http://www.abpi.org.uk/media-centre/news/2017/december/safeguarding-public-health-must-be-number-one-priority-for-eu27-and-uk-government-in-phase-two-of-brexit-talks>

7 <https://www.nuffieldtrust.org.uk/research/brexit-relationship-eu-shape-nhs#key-points>

8 <https://www.rcplondon.ac.uk/news/rcp-calls-government-retain-working-time-regulations-directive-after-brexit>

MEDIA COVERAGE OF HEALTH AND SOCIAL CARE IN KENT AND MEDWAY

30 Turning to Kent and Medway, the following key topics, most of which are related to the issue of NHS workforce, and the consequential direct and indirect impact of Brexit, were recently reported in national and local media. As with the NHS Brexit Bulletin, these assist in providing a snapshot of the issues of which the public themselves are increasingly aware.

Topic	Source, date	Details
Darent Valley Hospital warns of staff shortages as Brexit hits.	KentOnline July 2017[1]	The hospital is unable to recruit enough registered nurses locally and anticipates that it will become harder to recruit staff from abroad. They continue to welcome new recruits into the organisation regardless of nationality.
Medway Maritime Hospital has close to 400 nursing jobs vacant which are mainly being filled by temporary staff.	KentOnline August 2017[2]	The number is more than Kent's other trusts, with East Kent Hospitals Trust having 298; Maidstone and the Weald reporting 209 and Dartford and Gravesham with the lowest vacancy rate at 162. The Medway NHS trust has also disclosed that 122 EU nationals left jobs at the hospital in the run up to the Brexit referendum and in the immediate aftermath.
Iwade Health Centre put in special measures after CQC found there were not enough staff to keep patients safe.	KentOnline August 2017[3]	The clinical team had resigned and the practice was reliant on locum GPs and nurses. Substantial and frequent staff shortages and poor management of agency or locum staff increased the risk of harm to people who used the service. Inspectors also found that staff were unsure who had responsibility for the running of the service, and that appropriate recruitment checks had not been undertaken prior to staff being employed including Data and Barring service checks.
East Kent NHS Trust recruits more emergency doctors.	KentOnline September 2017[4]	Patients have reported long waiting hours at both the William Harvey Hospital in Ashford and the Queen Elizabeth the Queen Mother (QEQM) Hospital in Margate as staff struggle to cope with the high demand. Health chiefs say they have drafted in more emergency doctors and plan to expand A&E wards at crisis hit hospitals.

[1] <http://www.kentonline.co.uk/dartford/news/hospital-warns-of-staff-shortages-129128>

[2] <http://www.kentonline.co.uk/medway/news/nearly-400-nursing-vacancies-at-130639>

[3] <http://www.kentonline.co.uk/sittingbourne/news/health-centre-placed-in-special-measures-130307>

[4] <http://www.kentonline.co.uk/ashford/news/more-doctors-for-crisis-nhs-132132>

WORKFORCE AND SKILLS

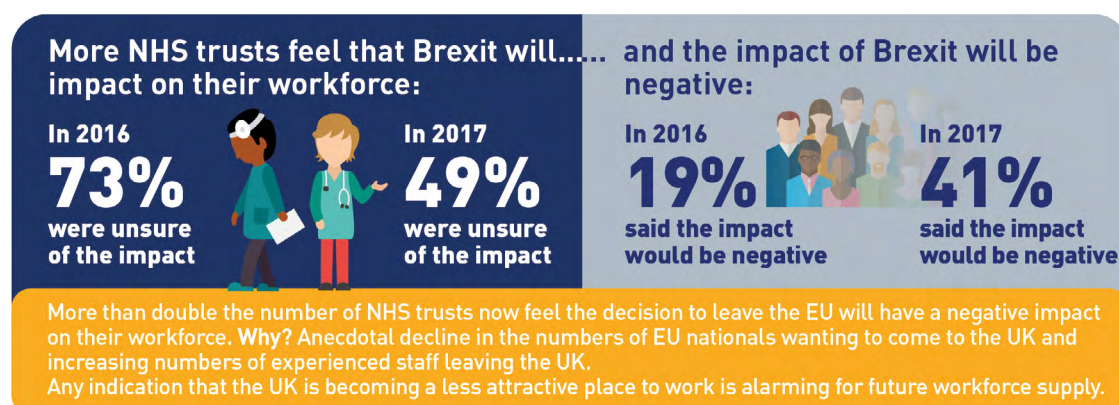
NATIONAL WORKFORCE PATTERNS

31 The importance of other EU nationals in the NHS workforce nationally and locally will be a key issue in the coming period. Whilst it could be possible to replace other EU nationals with UK trained staff or medical staff from other countries over time, as the NHS is already trying to do with GPS, this process will take time and there will be short term pressures.

- Approximately 22% of all doctors currently working in the NHS in England are from countries other than the UK.⁹
- Of that, 7.7% are from the EEA, with the remaining 14.6% from other countries.
- A study by the British Medical Association found that 45% of EEA doctors were consider leaving the United Kingdom, with 39.1% of those intending to leave having already made plans to do so.
- The primary reason expressed for leaving was the UK's decision to leave the European Union, in addition to negative attitudes towards EU workers in the country, uncertainty over future immigration status and how the UK Government treats EU workers (BMA, November 2017).

32 At a national level, there have been indications of a shift in the recruitment strategies over the last year. Whereas 73% of NHS Trusts were unsure of the impact that Brexit would bring to their workforce in 2016, that uncertainty has decreased to 49% in 2017.¹⁰ It would appear that the uncertainty has changed to negativity, with 41% of Trusts now believing Brexit will have a negative impact on their workforce in comparison to 19% a year earlier.

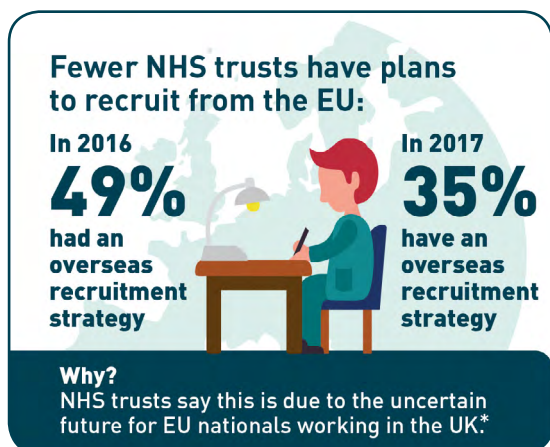
33 Nationally, nursing vacancies have increased in the NHS due to a variety of factors. Consequently, the reliance on EU labour to fulfil these roles has increased. There have been clear signs of a shift away from Commonwealth nations to EU states filling the workforce. Since 2009, there are 53% fewer South African nurses, 46% fewer Malaysians nurses and 39% fewer Australian nurses. In turn, there has been a substantial increase in Portuguese, Italian and Spanish nurses filling the roles; with 3,338 Portuguese nurses working in the NHS in comparison to just 209 eight years earlier.



⁹ <https://www.bma.org.uk/collective-voice/influence/europe/brexit/bma-brexit-briefings/workforce-and-future-immigration-policy>

¹⁰ Illustrations found at: <http://www.nhsememployers.org/case-studies-and-resources/2018/02/brexit-one-year-on>

34 Despite the agreements emerging in December 2017 as part of the conclusion of Phase 1 of the UK's negotiations with the EU, there is continued uncertainty regarding the civil and working rights of EU citizens in the UK, including the issue of both EU non-EU citizens confronting Home Office restrictions or requirements. Taken together, this unclear climate appears to have affected the recruitment plans of NHS Trusts, diminishing their overall strategies of hiring, with only 35% of Trusts in possession of such a strategy in comparison to 49% the previous year.



Results are based on data collected from two surveys of NHS trusts, covering the period July – September 2016 (response rate of 79 employers) and April – June 2017 (response rate of 80 employers).

80 trusts responded to the survey last quarter representing over a third of total NHS trusts (34%).

* Figure is based on the comparison between October – December 2016 versus April – June 2017.

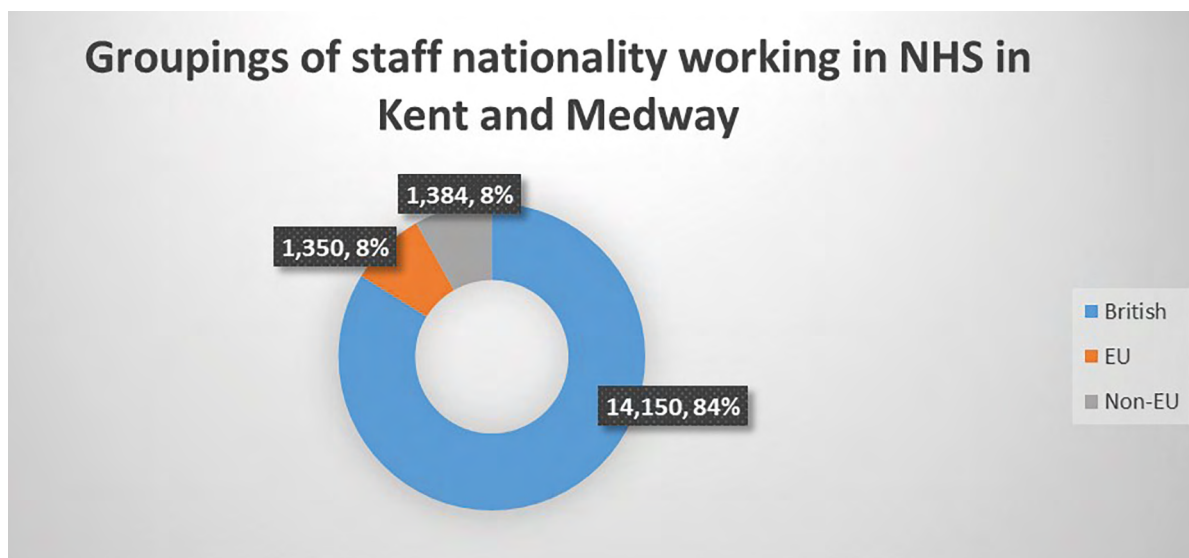
Illustrations found at: <http://www.nhsemployers.org/case-studies-and-resources/2018/02/brexit-one-year-on>

35 In addition, the perceived likelihood in the change of status for EU citizens has seen an increase in NHS Trusts altering their recruitment plans, with 18% changing their recruitment plans in 2017 in comparison to just 6% in 2016.

KENT AND MEDWAY WORKFORCE PATTERNS

36 As of 31st October 2017, there are 20,844 workers within the National Health Service (NHS) in Kent and Medway. From that, approximately 14,150 identify as British, with 1,350 as EU and 1,384 as non-EU respectively. Finally, 3,990 chose not to give their nationality. Based on the data of known nationalities in the NHS in Kent and Medway, 84% of the workforce is British. 8% of workers are from the EU and the remaining 8% are from the rest of the world. A recent House of Commons Library papers revealed that after London, the combined South East counties of Kent, Surrey and Sussex had the third highest EU labour force in the NHS at 8.1%.

Table 1¹¹



37 The factors affecting the future of Brexit on the NHS staffing in Kent and Medway will include:

- the number of other EU nationals who choose to leave and whether these numbers increase;
- the numbers of other EU nationals who continue to come to work in the NHS and whether these numbers increase or decrease;
- the composition of a new structure for managing immigration, post-Brexit and how this impacts on medical staff.

38 In Kent and Medway, there is evidence that the numbers of other EU nationals who have left or who are considering leaving after Brexit will increase pressure on staffing. For example, a survey of 2,000 doctors from other EU countries showed some **60%** were considering leaving and of those **90%** cited Brexit as the main rationale for their views.

¹¹ Tables 1-5 are drawn from data available from NHS Digital and compiled by CEFEUS (<https://digital.nhs.uk>)

39 However only half of those considering leaving said they might leave in the next two years, suggesting there remains scope to stem the potential loss of valuable staff. There is also evidence that the numbers of other EU nationals applying for nursing places in the UK has fallen very sharply, one survey suggested by over **90%**. This would be a significant loss to the NHS. As illustrated, there is a higher proportion of non-EU staff working in the NHS than EU. In particular, of the 20,844 workforce, 399 (**1.9%**) are Indian nationals and a further 257 (**1.2%**) are Philippine nationals. However, six of the remaining eight nationalities are indeed EU nationals, primarily from Mediterranean states.¹²

Table 2

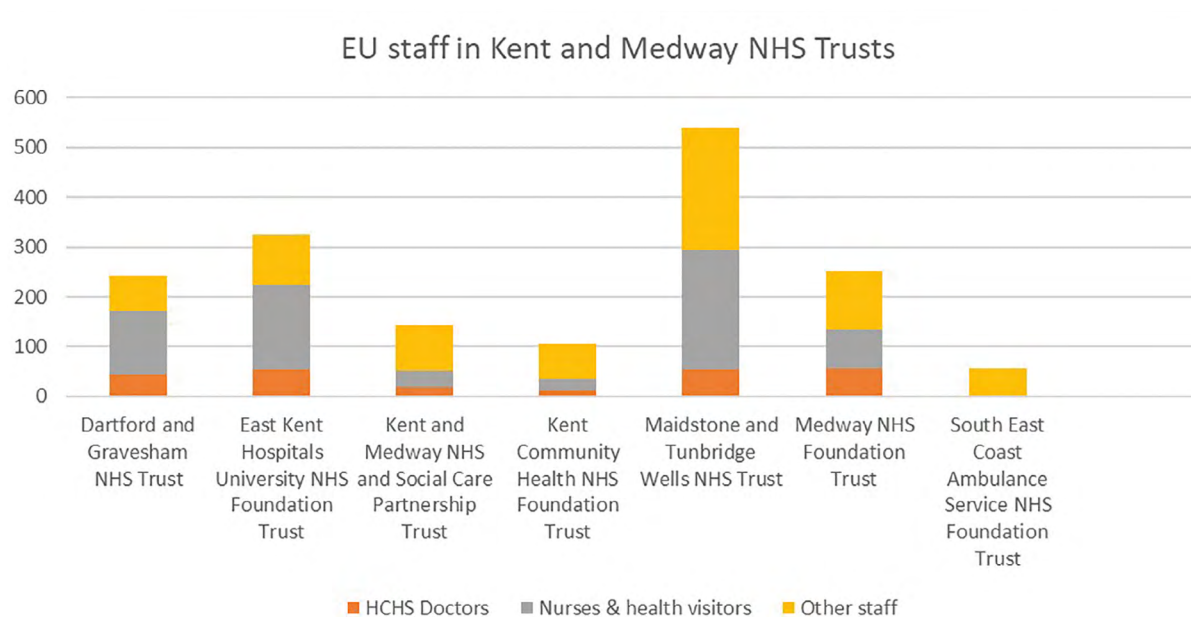


40 Based on 30th April 2017 data, 1,605 staff from the EU were working across the five primary NHS Trust employment providers, with a further 56 employed by the South East Coast Ambulance Service NHS Foundation Trust.¹³ The largest employer of EU labour is the **Maidstone and Tunbridge Wells NHS Trust**, with 540 EU employees. More than half of the nurse and health visitor workforce at the East Kent Hospitals University NHS Foundation Trust is EU-derived, as examined in Table 3.

¹² While this report has primarily focused on Brexit-specific impacts for Kent and Medway, in terms of workforce both EU and non-EU staff need to be taken into account.

¹³ An NHS Trust is defined as an organisation, and is a legal entity, set up by order of the Secretary of State, with the goal of providing goods and services for the purposes of the health service. NHS Trusts may act as Health Care Providers and provide hospital services, community services and/or other aspects of patient care, such as patient transport facilities. They may also act as commissioners when sub-contracting patient care services to other providers of health care. (NHS, 2018)

Table 3



“For many, changes to the workforce are happening anyway. For others, Brexit is regarded as a key factor. At present, every NHS trust in Kent and Medway has a problem recruiting and retaining nurses. Some are beginning to turn a corner; but these are trusts who generally see overseas and EU nurses as part of their long-term workforce solution.

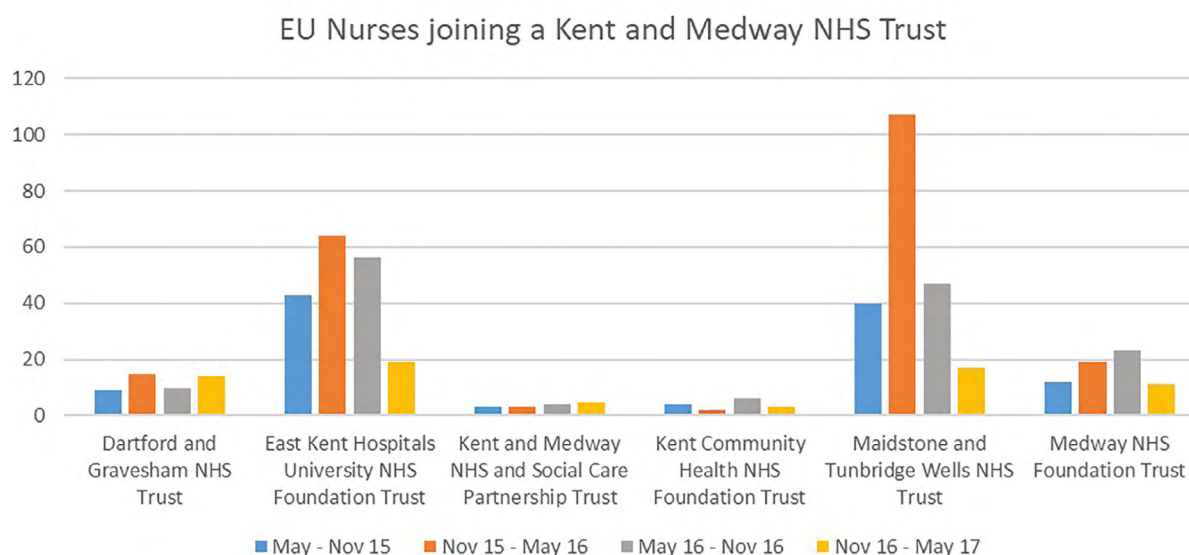
Equally, trained EU nurses will come to Kent, and some Kent trusts have been successful in recruiting them from a single area, such as Portugal. Sometimes nurses move here as a group, and work in the same trust or foundation, which creates a small community which in turn benefits the trust they work for. This is key, because London is admittedly a draw and generally brings more money. So, keeping new arrivals local is a priority.

Bear in mind that it takes three full years to train a nurse. Here at Canterbury Christ Church University, we recruited 220 students onto our nursing programme last year. Ideally, we want it to grow to 270 this year; but capacity issues may prevent that.”

Debra Teasdale, Dean of Faculty of Health and Wellbeing,
Canterbury Christ Church University

41 In Kent and Medway, these indications of a drop-off in EU nurses are particularly prevalent. For instance, the Maidstone and Tunbridge Wells NHS Trust recruited only 17 nurses and health visitors from November 2016 to May 2017, in comparison to a total of 107 in November 2015 to May 2016. East Kent Hospitals University NHS Foundation Trust has also reported a similar drop-off, with just 19 nurses joining in comparison to 64 during the same period. Dartford and Gravesham NHS Trust, and Medway NHS Foundation Trust, November 2016 to May 2017 represented similar recruitment to May to November 2015, with perceptible drop-offs. Indeed, as Table 4 indicates, of the four largest NHS Trust employers in the county, all have reported substantial drop-offs in recruitment of EU nurses in comparison to the six months that led up to the EU Referendum.

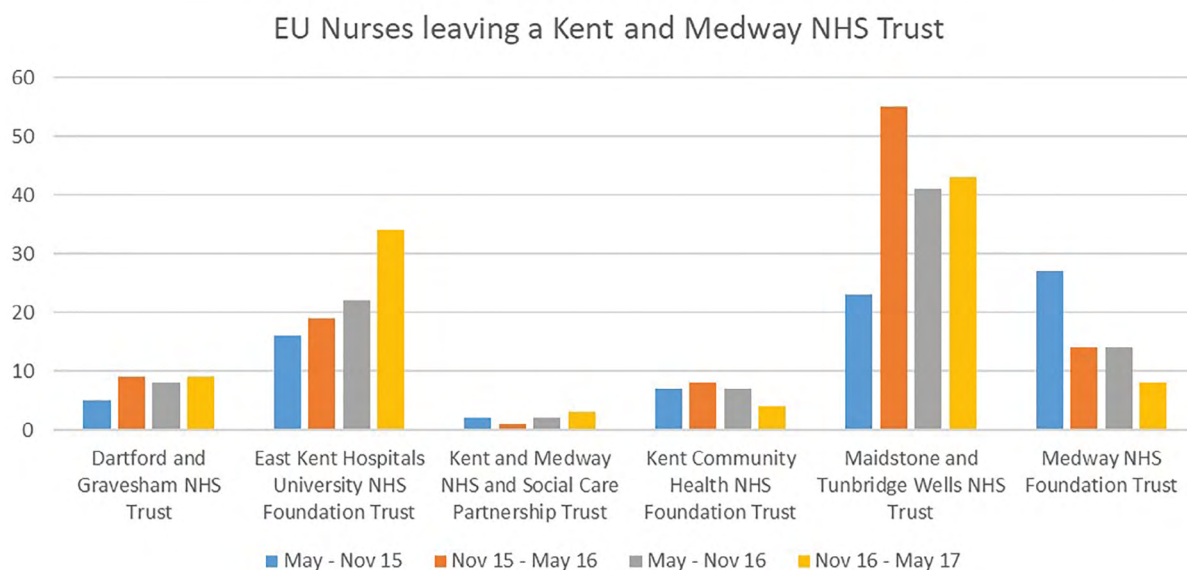
Table 4



“We would like to continue to recruit from within the EU, rather than from outside it. It is unlikely that we will ever be able to recruit sufficient numbers of local UK staff, so the EU is the next nearest option... we would like to be able to continue to recruit staff from the EU and to be competitive with Germany as a place to work.”

Kent and Medway Social Care Provider, 2018

Table 5



42 Since the Referendum, the number of EU nurses leaving a Kent and Medway NHS Trust has increased. Quantitatively, this has been led by Maidstone and Tunbridge Wells NHS Foundation Trust, who saw 43 nurses depart in November 2016 to May 2017 whilst just 23 EU nurses left the trust in May to November 2015. East Kent Hospitals University NHS Foundation Trust has seen an increase in each quarter in EU nurses departing, with November 2016 to May 2017 seeing 34 nurses depart in comparison to just 16 in May to November 2015. Similarly, Dartford and Gravesham NHS Trust, and Kent and Medway NHS and Social Care Partnership Trust have seen increases when the same periods are compared. Medway NHS Foundation Trust have also seen the number of EU nurses departing decrease over the same four periods, with a high of 27 EU nurses leaving in May to November 2015 compared to a low of 8 in November 2016 to May 2017. Similarly, Kent Community NHS Foundation Trust has reported a similar decrease in EU nurses departing.

43 This pattern, whilst not yet definitive, suggests that there is a connection emerging between the uncertain labour environment caused by Brexit affecting the majority of sectors in the UK, the current ability of health and social care trusts to retain and attract, and the specific numbers of departures of healthcare professionals exhibited across the majority of trusts and foundations in Kent and Medway.

ANALYSIS

44 In terms of short-term responses between now and the end of the envisaged transition period, the rights of current EU citizens in the UK, and those who may arrive after March 2019, are significant issues in the negotiations. The UK Government has made several announcements encouraging EU nationals to remain and continue to work e.g. in the NHS.

“The 90,000 staff from the EU who work in the social care system and the 58,000 who work in the NHS do a brilliant job. Frankly, we would fall over without their help. That is why it is a very early priority for us to secure, as quickly as we can, agreement for their right to remain in the UK and continue their great work.”

Jeremy Hunt, Secretary of State for
Health and Social Care, Health Committee, 2017

45 In addition, the Government has commissioned work on a new immigration system after Brexit. However, at this stage, no specific proposals are expected until autumn 2018. Within a wider context, it should be noted that the current system for managing migration from non-EU countries is based on income thresholds. In recent weeks, reports have emerged that the Home Office quota system has been fully subscribed. As of late February 2018, the UK has therefore for the third month in a row, hit the maximum limit in the number of people it can bring in from non-EEA states on **skilled visas** (also known as Tier 2 visas). This in turn has seen the salary threshold increase to £50,000 (from £30,000), impairing the ability of NHS Trusts to bring in medical personnel for vacant roles. At issue here is whether this current structure will form the basis for EU nationals as well as non-EU nationals after Brexit, potentially producing an even greater barrier to the recruitment of medical staff to the NHS.

46 It is clear that principles for a new immigration system need to be clarified as ‘a very early priority’, rather than at the tail-end of the transition period, ensuring that national and local healthcare providers can both recruit and retain the staff it needs both from the EU, and beyond. While a number of key asks feature at the end of this report, the **British Medical Association** have set out instructive key labour recommendations, including:

- Permanent residence for EEA doctors and medical academics who are currently working in the UK, and their family members, whether they have been living here for five years or not, to give reassurance and protection to them and to maintain the stability of the NHS workforce;
- Sufficient stay for EEA medical students currently studying in the UK to allow them to complete their courses and continue to foundation training and training posts;
- The maintenance of a system of mutual recognition of professional qualifications (MRPQ);
- Be responsive to individuals and organisations using it, easy to understand and navigate, transparent, predictable and affordable: keep it simple.
- Recognise the wider value to society and the economy of certain skills and roles, beyond using salary levels as a determinant of entry to the UK.

SOCIAL CARE

47 Social care is a key part of the broader healthcare environment across Kent and Medway and the country as a whole. It is sufficiently different from healthcare in terms of objectives, regulation and management to be treated separately here, though still an area that in the next 2-5 years could see changes as a result of the sectoral impact of Brexit.

48 Across the UK, local authorities spent £14.8 billion in 2016-2017 on social care, and further supported with an additional £2 billion from a pooled budget through the Better Care Fund. Public funding is essential for the care sector as local authorities commission most care from the private and voluntary sector, with 65% of providers' income derived from this source (National Audit Office, 2018, p.5). The social care market in Kent and Medway is currently 80-85% owned and operated by the private sector, whose providers – particularly the larger companies – rely on attracting both high and low skilled workers from the EU, and internationally (Skills for Care, August 2017).

49 The social care sector is a critical intermediary, located between both public sector actors like Kent County Council who commission social care services and entities like NHS trusts who similarly require these services within their own healthcare system (i.e. post-hospital domiciled care, domestic assistance, residential care homes, personal care). Our interviews with key social care actors providers suggest that “intelligently run providers can work alongside, and even reduce the burden on the NHS, particularly in the areas of GPs, clinics, and hospitals, across the entire spectrum of diagnosis, treatment, and recovery” (2018). Conversely, poor social care can “pile up the pressures on the NHS system and worsen the overall standard of living for citizens dependent upon key social care services”.

50 Social care is also an important indicator of the overall health prospects in a given region in demographic terms. Regions featuring numerous or endemic areas of deprivation, with associated characteristics including above-average mortality rates require intervention and assistance from social care providers. Equally, areas featuring average or above-average attributes but with recent changes to lifespan (e.g. increasing numbers of 65+ years) place other strains on the social system of a given region. These and other demographics indicate that demand for social care will increase both quantitatively and qualitatively over time, and that care needs will themselves become more complex. This in turn places a foreseen burden on the number of available staff, the range of their skills (high and low) and the quality of their training. To stay ahead of such trends, national and local care workforces need to both grow and transform in terms of numbers and quality (National Audit Office, 2018, p.5).

51 As illustrated in Table 6, the demographics in Kent and Medway are changing steadily. The population of 65-85 year olds across the county is expected to increase by 20.5% from 2015 and 2025, while the percentage of 85+ will rise 43.5% by 2025. Further, men across Kent reaching the age of 65 are expected to live for 18.9 more years, and women for 21.3 years, with the majority reaching the next 85+ age bracket. These various increases will in turn boost the need for health, but especially social care significantly.

Table 6

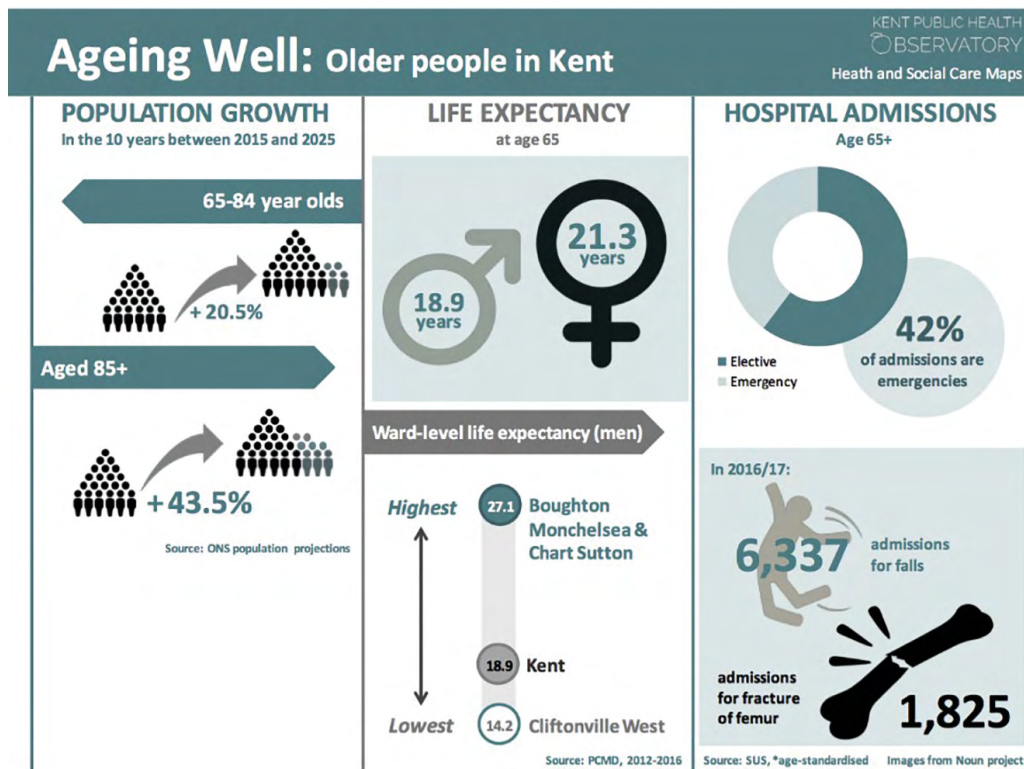
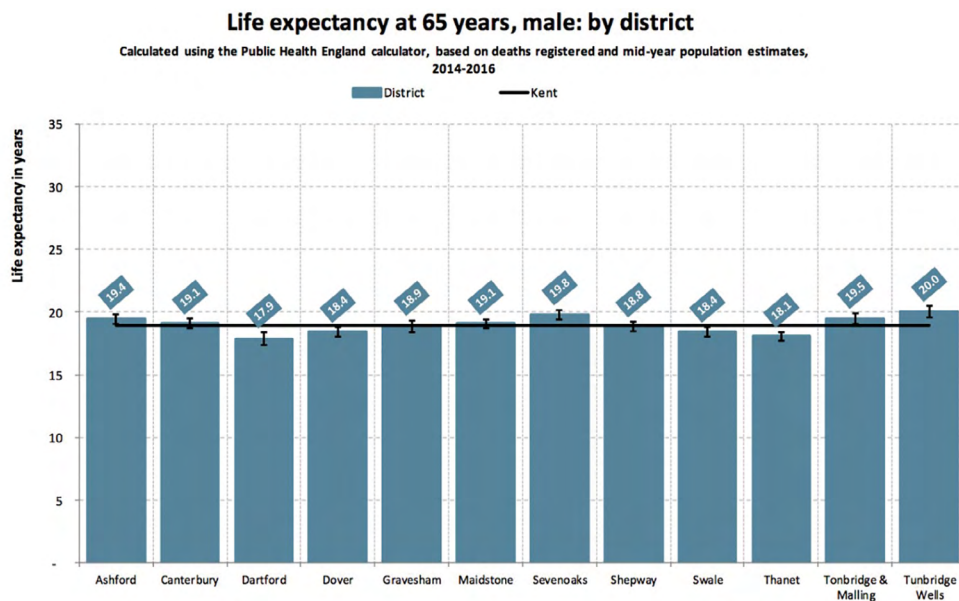


Illustration: Kent Public Health Observatory

52 Table 7 further illustrates the life expectancy of men ages 65 years in Kent on the basis of district, between 2014 and 2016. Tunbridge Wells and Sevenoaks currently have the highest life expectancy, while Thanet and Dartford have the lowest. The difference between the highest (20 years in Tunbridge Wells) and the lowest (17.9 in Dartford) is 2.1 years.

Table 7

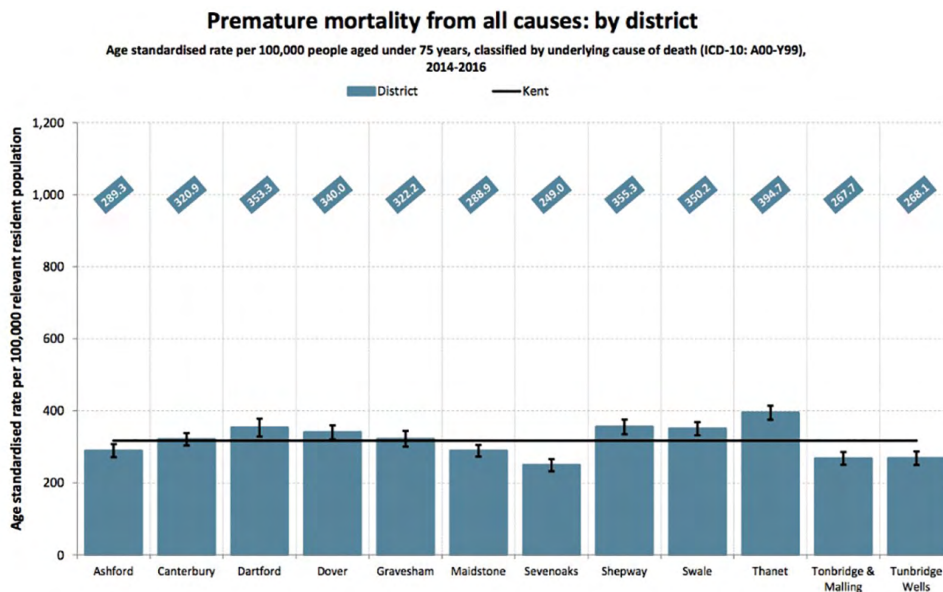


Source: ONS, NHS Digital, PHE, prepared by KPHO (TG), Nov-17

Table 7: Ageing Well: Older people in Kent (Districts)

Table 8 meanwhile illustrates the premature mortality rates in Kent of citizens aged below 75. Here, this particular rate is the lowest in Sevenoaks, but highest in Thanet. The rate of difference between these two is 145.7 per 100,000 people.

Table 8



Source: PCMD, prepared by KPHO (TG), Nov-17

Table 8: Starting Well: in Kent (Districts)

53 Our interviewees stated that the ideal picture of successful social care provision in Kent and Medway relied on “steady workforce numbers, appropriate training and synergistic public-private sector links.” As one decision-maker from within the Kent and Medway social care system suggested, “despite the generally low numbers of EU/EEA staff currently working within our social care system at the present time, any perceptible drop off in EU nationals – however small – especially when combined with the continued downturn in EU nationals joining our system now still creates a disproportionately heavy impact on us. We’re overstretched as it is. Losing anyone, whatever their citizenship, ultimately counts as a loss” (CEFEUS interview, 2018). Taken together with projections on the basis of Kent’s above-mentioned demographic features, workforce shortfalls clearly paint “a bleak picture in terms of social care provision and associated quality of life for key groups in across Kent and Medway.”

54 Arguably, as the demand for jobs in social care will increase, models based on 2014 data found that the number of full-time equivalent jobs would also need to increase by around 2.6% per year until 2035 to meet the increased demand. In terms of demographic-oriented responses, Age UK “estimated that 1.2 million people over the age of 65 had some level of unmet care needs in 2016-17, up from 1 million in 2015-16” (National Audit Office, 2018, p.7).

ANALYSIS

55 As with healthcare, the chief concern regarding changes as a result of Brexit is that of labour and skills. According to National Audit Office, 7% of the care workforce in 2016-17 were non-British EEA nationals, with nursing having the highest proportion of non-British EEA workers. However, these percentages vary in different regions. For example, only 2% of care workers were non-British EEA nationals in the North East whereas, the number was 13% in London.

56 While the numbers of EU/EEAs nationals in Kent and Medway are also comparatively low, it is clear that there are already very real issues within the county’s social care sector in recruiting, employing and retaining care workers, particularly personal care workers, and domiciliary care providers. Both these categories “are key in being able to care for people in their own homes, which in turn has a direct impact on the pressures associated with hospital discharge times, and hospital waiting times” (Robert Stewart, 2018).

57 Further, social care providers and commissioners alike have commented that Kent currently struggles with the ‘London-effect’ in which social care job opportunities in London act as a magnet for Kent and Medway-based employees, who consequently move to London and leave vacancies that remain unfilled in the region, increasing the overall strain on the social, and by extension – the health care system in the county.

58 From this perspective, it appears that often the funding is available in crises but not the workforce. A key short-term Brexit issue must therefore be not only to look at labour force as a whole in large urban areas like London, and the likelihood of EU/EEA citizens themselves leaving, but the likelihood of those increased vacancies being filled at a disproportionately higher rate by current and newly-qualified staff from Kent and Medway, creating further pressures that the regional system can ill-afford.

Skills and training

59 In addition to staffing and workforce issues is the issue of skills. Many social care jobs are categorised as low-skilled, and consequently operate at the low end of wages (often at minimum wage). Such jobs are unlikely to be given a high priority in the new immigration management system; as such, the impacts on social care may actually be more adverse than for healthcare where doctors and nurses attract higher salaries and are more likely to be seen favourably for visas. This in turn will pose serious challenges for counties like **Kent and Medway** in the long term.

In terms of positives and opportunities going forward, the work undertaken by **Skills for Care** is instructive. To help counteract misconceptions about working in adult social care, in May 2017, the Skills for Care launched a toolkit to promote the rewards and increase general interest. The toolkit was a part of a project with Ambition London, funded by JP Morgan Chase Foundation. According to the chief executive at Learning and Work Institute, which runs Ambition London, Stephen Evans, the sector is under enormous pressure financially, exacerbated by growing shortages in skilled workers, a trend he feels will worsen after Brexit unless urgent action is taken. This makes it even more important to promote the career opportunities that are available in social care and “help those who work with jobseekers to enter and progress in the profession”.¹⁵

¹⁵ <http://www.skillsforcare.org.uk/About/News/News-Archive/Building-an-attractive-career-pathway-for-new-recruits-new-toolkit-to-explore-careers-in-adult-social-care.aspx> Medicines and Medical Industry

MEDICINES AND MEDICAL INDUSTRY

60 As a result of EU integration, a number of areas have become steadily more interconnected, including medicines and chemicals, with uniform standards for medicines and chemicals harmonised across 28 Member States. As illustrated in Table 9, the **pharmaceutical and medicinal chemicals** sectors play a crucial role within the UK economy, ranking 2nd and 3rd respectively in the top 5 manufacturing export and import industries, with an estimated total export value of \$28.8 billion and import value of \$32.7 billion (UKTPO, pg.2, 2018).

Table 9

ISIC4 Code	Industry name	Value of Trade (bn USD)
Top 5 manufacturing export industries		
2910	Motor vehicles	47.4
2100	Pharmaceuticals and medicinal chemicals	28.8
3030	Air and spacecraft and related machinery	28.1
2420	Basic precious and other non-ferrous metals	23.2
2011	Basic chemicals	12.7
Top 5 manufacturing import industries		
2420	Basic precious and other non-ferrous metals	67.7
2910	Motor vehicles	60.6
2100	Pharmaceuticals and medicinal chemicals	32.7
3030	Air and spacecraft and related machinery	22.8
1410	Wearing apparel, except fur apparel	21.2

Illustration: UKTPO, 2018

61 Furthermore, as indicated in Table 10, even on the basis of the UK's 'softest' departure from the EU, namely remaining a member of the European Economic Area (EEA), would register a 2% increase on the price of chemicals and pharmaceuticals in the UK, with a no-deal outcome potentially increases prices by 7.5% (UKTPO, pg.7, 2018).

Table 10

	Scenario 1: EEA	Scenario 2: FTAs with EU and FTA67	Scenario 3: FTA with EU	Scenario 4: No Deals	Scenario 5: FTAs with FTA67 and ROW
Percentage change in prices					
Food processing	0.6	2.3	2.5	3.7	2.9
Textiles, apparel and footwear	1.2	2.5	3.2	6.1	1.3
Wood, paper and printing	0.4	0.8	0.8	1.0	0.8
Chemicals and pharmaceuticals	2.0	4.9	5.2	7.5	6.1
Rubber and plastic	0.9	2.1	2.3	3.7	2.7
Metals and non-metallic minerals	0.7	1.4	2.1	2.7	1.2
Electronic and scientific	1.4	3.3	3.5	4.3	3.3
Electrical	1.4	3.1	3.4	4.7	3.3
Machinery	1.7	4.0	4.1	5.6	4.5
Transport	1.8	5.5	5.9	9.8	8.4
Other	1.1	2.6	2.7	3.3	2.6

Illustration: UKTPO, 2018

A no-deal scenario is spelled out in Table 11, with the severest impact resulting in exports dropping by 21.3% with the medicinal manufacturing industry.

Table 11

	Scenario 1: EEA	Scenario 2: FTAs with EU and FTA67	Scenario 3: FTA with EU	Scenario 4: No Deals	Scenario 5: FTAs with FTA67 and ROW
Percentage change in the value of exports					
Food processing	-6.9	-24.7	-26.2	-38.4	-33.7
Textiles, apparel and footwear	-8.4	-16.5	-17.8	-33.5	-29.7
Wood, paper and printing	-9.2	-14.8	-17.1	-20.2	-13.0
Chemicals and pharmaceuticals	-6.6	-14.4	-15.8	-21.3	-14.6
Rubber and plastic	-4.4	-9.9	-10.8	-17.4	-13.4
Metals and non-metallic minerals	-6.7	-12.6	-21.2	-25.5	-7.1
Electronic and scientific	-4.0	-9.2	-9.8	-11.9	-9.1
Electrical	-5.3	-11.6	-12.6	-16.7	-11.0
Machinery	-3.3	-7.3	-8.3	-10.7	-6.0
Transport	-3.0	-8.7	-9.8	-14.2	-9.1
Other	-3.7	-8.3	-9.0	-11.1	-8.2

Illustration: UKTPO, 2018

ANALYSIS

62 The economic factors bear thinking about in a universal healthcare system such as the UK. Much has been made in recent years over the ongoing underfunding of the NHS. Any increase in pricing of key components that both directly and indirectly impact its overall cost structure, including pharmaceutical and medicinal chemicals, would untimely increase the overall costs of health services and strain on already-tight public finances. Further increases in public funding for the NHS could become necessary to ensure that its ability to purchase and use pharmaceutical and medicinal chemicals in primary care continues as standard.

“In terms of changes to the European medicine market – this must be approached as a transition. It would be difficult to make such changes both entirely domestically and suddenly. There are many key products that the UK has to import as a matter of routine. If we cannot purchase them, or if there is a delay in receiving them, this will inevitably have a profound effect on NHS, their cost in particular. The investment is phenomenal when it comes to creating a new drug.”

Debra Teasdale, Dean of Faculty of Health and Wellbeing,
Canterbury Christ Church University

CASE STUDY: MEDICAL RADIOISOTOPES

63 One area where the United Kingdom is highly reliant upon EU export and collaboration is in the production of medical radioisotopes. Medical radioisotopes are used for both the diagnostics and treatment of cancer, heart, kidney and bone disease. Official figures estimate that 700,000 patients a year are reliant on isotopes for their care, whilst the BNMS suggest that this could be closer to 1 million patients. The EU regulatory oversight body on civilian nuclear power is Euratom, currently oversees the distribution of medical radioisotopes.¹⁶ 80% of diagnostic nuclear medicine procedures are made by the isotope technetium-99m, which in turn is derived from the isotope molybdenum-99. Only a handful of reactors around the world currently produce it. Overall, the UK imports approximately 80% of its medical radioisotopes, almost entirely from the EU (France, Belgium and the Netherlands).

¹⁶ Founded in 1957, Euratom was created with the purpose of creating a nuclear power market in Europe; developing nuclear energy for European states and selling any surplus to 3rd party states. More recently, following on from the severe supply chain crisis in 2008-10 that saw many EU member states impact by the shortage of medical radioisotopes, Euratom was empowered to oversee the production and distribution of isotopes fairly across the member states. Whilst legally distinctive from the European Union, it is governed by many of its institution and judicially by the ECJ. The UK's departure from the organisation would mean that it will be considered a 3rd party state, falling behind the distribution list of all EU member states and Switzerland.

Kent focus

64 Kent is home to a number of key producers and providers of pharmaceuticals and medical chemicals, including Pfizer and Kent Pharmaceuticals. Brief snapshots of each are provided as an aide memoire to both national and local decision-makers when looking at Kent in terms of these key industries and the regulatory and market-based frameworks that necessarily underwrite them.

Pfizer established a facility in Sandwich, Kent in 1954 to enable the expansion of its Kent-based activities. The main functions of Pfizer's Sandwich site include pharmatherapeutics, pharmaceutical sciences, focusing on primary care. Its key technologies are Active Pharmaceutical Ingredient (API) Route Design, Development and Manufacturing, Analytical Science Drug Product Design and Development, Drug Product Manufacture, Regulatory Chemistry Manufacturing and Control (CMC) Strategy, Good Manufacturing Process (GMP) Quality Assurance and Materials Science (Pfizer, 2018).

Historically the Sandwich site has an excellent track record of discovering new medicines to improve the health and quality of life of people suffering from critical diseases. Some of Pfizer's most important medicines were discovered at Sandwich. They include Celsentri® (maraviroc); Revatio® (sildenafil); Diflucan (fluconazole) and Vfend® (voriconazole); Istin (amlodipine) and Cardura (doxazosin); and Viagra® (sildenafil)' (Pfizer, 2018).

Kent Pharmaceuticals is based in Willesborough, Ashford, and it was established in 1986 as a small family-run business. It is now one of the UK's leading generic pharmaceutical companies. In 2013, it was sold to Development Capital Corporation. The company offers more than 100 own label products, with a manufacturing plant in Ireland supplying the UK with some 60% of the total penicillin antibiotics sold.

The **Kent Science Park** is based in Sittingbourne, Swale and currently home to over 60 companies that include public and private healthcare, pharmaceuticals, life sciences and ICT. It is considered Swale's most important economic hub, with 1,650 staff currently based on the 65-acre site. In addition, the **Discovery Park** in Sandwich, Dover is a leading developer in pharmaceuticals, in particular in the area of cancer research. Initially established in 1954 by Pfizer, it transitioned to a business science campus in 2012. It is currently home to approximately 150 companies employing 3,000 staff. Canterbury Christ Church University established an industry liaison laboratory in 2015, seeking to link academic with R&D.

PUBLIC HEALTH

65 The issues involved in public health are wide ranging. It is beyond the scope of this report to tackle specific issues such as smoking and obesity prevention or other health and lifestyle issues which are often covered under public health. Instead, bearing in mind Kent's geographical proximity to Europe, the placement and role of key UK ports within Kent and Medway, and Kent's role as a conduit to and through both the UK and the EU, this section focuses on three main concerns:

- the management of public health crises and emergencies which affect more than one country and where Brexit will have a significant impact;
- the structures and levels of cooperation which currently takes place on non-urgent but important public health threats;
- the potential impacts on public health protections which have been driven by EU law.

66 Cooperation on public health issues between the UK and its European neighbours pre-dates the creation of the EU and can and indeed must continue after the UK departs. However, over recent decades a considerable infrastructure has arisen to facilitate individual Member States in managing public health concerns both individually and collectively. These collaborative structures and their protocols are centred on the **European Centre for Disease Prevention and Control**, which is an agency of the EU.¹⁷ Established in 2005, and based in Stockholm, Sweden the ECDC works with Member States to strengthen Europe's defences against infectious diseases and provides data-based evidence for effective and efficient decision-making, strengthening public health systems across Europe, as well as supporting a continental response to public health threats.

67 It is reasonable to assume that as such the UK will leave the ECDC in March 2019 as it exits the EU, and that new arrangements will be needed to either replicate its functions within the UK and or to associate with the Centre in some form to continue to ensure European (as opposed to explicitly EU) cooperation on disease controls which of course do not respect boundaries. Currently, Norway and Switzerland are members of the ECDC (though absent from key decision-making rights); the UK should too be disposed to retaining membership. In addition to the work of the ECDC, the EU has over the decades created a substantial body of law for Member States which protects the public's health in various ways. These include food standards, air quality and clean water standards, and issues as diverse as protecting children from certain food advertising and limiting trans-fatty acid content in processed foods.

Changes and opportunities

68 Going forward, and operating as a potential opportunity of Brexit change, the UK's anticipated reform act will likely in the short-term simply incorporate the majority of EU standards into UK law as per its announced intention. Equally, the Government has also suggested in key sectors that Brexit will not mean a lowering of standards generally (the environment in particular). Public health could be an emerging area in which to examine the suitability and appropriateness of key EU regulations. Some changes for example might well support public health goals.

¹⁷ Information on the European Centre for Disease Prevention and Control can be found online at: <https://ecdc.europa.eu/en/home>. The ECDC's core functions cover a wide spectrum of activities: surveillance, epidemic intelligence, response, scientific advice, microbiology, preparedness, public health training, international relations, health communication, and the scientific journal *Eurosurveillance*. In total, ECDC monitors 52 communicable diseases.

For example the Scottish Government's announced intention to introduce minimum unit pricing on alcohol has been delayed for years while challenges are heard in the European Court of Justice as to whether such a regulation would breach EU laws. After Brexit, the UK and developed administrations could be free to take such decisions for themselves.

Critical collaboration

69 However, it is clear that unpicking cross-border operations in which the UK visibly benefits from critical collaboration on key areas of public health would be injurious to the health and wellbeing of citizens across the length and breadth of the UK. These operations include the pooling of national surveillance data, reporting on high profile public health issues such as swine flu, avian flu and other pandemics, as well as participation in ECDC itself to ensure coverage and participation in research on antimicrobial resistance and healthcare-associated infections; emerging and vector-borne diseases; food- and water-borne diseases and zoonoses; HIV, sexually transmitted infections and viral hepatitis; influenza and other respiratory viruses; tuberculosis; and vaccine-preventable diseases.

70 Based on our group and individual interviews, the majority of perspective from across Kent and Medway suggest it "unlikely that the UK would want to significantly or substantively reduce its own access to such cooperation, or place itself in a position of increased demographic risk to cross-border health issues" (2018).

71 Supporting such perspectives is the **Association of the British Pharmaceutical Industry** and the **BioIndustry Association** who recently commissioned a report which concluded that "delays in communication around crisis management or divergence in standards and procedures" between Europe and the UK "are likely to lead to delays in action". ABPI research also noted that if cooperation ended without a replacement structure, there could be delays in sharing information about drug safety or adverse medical events. Their Chief Executive further stated that "swift co-operation agreement between the EU and the UK on medicines is the only way to ensure there is no disruption to patients accessing the best possible healthcare and getting the medicines they need."¹⁸

ANALYSIS

72 The key priority for public health for March 2019 must be to ensure there is no gap in the cooperation between the UK and the EU on planning for, and if needed, tackling pandemics and related public health emergencies. This would need to be delivered through a new membership / association agreement between the UK and the European Centre for Disease Prevention and Control. In the period after the transition we will need to consider a very wide range of public health measures and standards which originate in EU law and which will have been translated into UK law at least for the time being. This is an opportunity to consider any advances in public health protections which EU law currently restricts and to ensure that we are setting the highest possible standards for public health protection in post Brexit UK.

¹⁸ ABPI, December 2017: <https://www.abpi.org.uk/media-centre/news/2017/december/safeguarding-public-health-must-be-number-one-priority-for-eu27-and-uk-government-in-phase-two-of-brexit-talks>

LIFE SCIENCES, RESEARCH AND DEVELOPMENT

73 The Health and Life Sciences sector is a great British success story. It has a turnover of over £60 billion and exports of around £30 billion. There are a number of reasons for this success, the strength of research in universities and pharmaceutical companies, the role of the NHS, access to finance and of course the current open access to the markets of the EU28. As with other sectors, much of the current regulatory system is set for the EU as a whole. This includes medicines testing and trials, licensing and drug safety regimes, and the current movement of products to and from the UK.

74 Currently, companies developing new drugs know that securing regulatory approval from the EU wide medicines agency will mean they can sell their product across all 28 countries. Once the UK leaves the EU, the UK will need to create a new system for licensing the use of medicines and medical products in the UK. Since a company would only gain access to the UK market by dealing with the new UK system, and any attendant changes that this new structure brings, the risk is that a repositioned British market would be ultimately less attractive than retaining or securing access to the EU market. This in turn may inhibit UK access to new medical products.

75 There are also important agreements between third countries and the EU, such as Switzerland, which will materially affect the future success of the UK life sciences sector. Access to markets and current research collaboration are important under these agreements. Brexit may however provide an opportunity to re-examine some issues. For example, the UK government could in future be able to directly fund or support life sciences companies in ways which are not currently permitted under EU state aid rules.

Medical research and development

76 The sector currently depends on talented scientists and researchers who come to the UK from many countries, and a future immigration system will need to consider how to ensure that this crucial flow of talent is maintained after Brexit. Collaboration – specifically cross-border collaboration – is the name of the game. As pointed out in May 2017 by the Technopolis Group, “scientists have greater impact when they collaborate internationally. EU programmes have helped to foster and strengthen scientific cooperation and the UK has been a major contributor to this, especially in medical research” (p.2).

77 As the UK develops new structures of collaboration with the EU from 2018 onwards, it is vital that negotiations produce the best possible outcome for upstream research and development, and for downstream patient care across the UK and its European partners. The UK Government must bear in mind that while some collaboration may continue after Brexit, any serious limitations on the ability of UK scientific research, development, HEIs, clinics and institutes to work together with European and indeed international partners could seriously diminish the quality of science, and positive impact on patient care and the overall collaborative structure as a whole. Equally, it will be important to ensure there is no loss of UK talent to other European research and development centres (including the European Medicines Agency).

78 Framework Programmes (FPs) are the main EU funding mechanism for research, development and innovation, accounting for 78% of EU research funding received by the UK between 2007 and 2013 or 3% of UK’s expenditure on R&D over the same period. As a result of FPs and structural funds for research and innovation activities, the UK secured €8.8 billion in funding from the EU between 2007 and 2013, earning €3.4 billion more than contributed. **Horizon 2020** meanwhile is the biggest of the EE’s research and innovation programmes, sponsoring around £80 billion over seven years up to 2020 across the EU. This amount is distributed based on criteria of scientific excellence, alignment with a number of strategic objectives, geographical and disciplinary diversity, and potential for commercialisation.¹⁹

79 At present, **the UK leads more medical research projects than any other EU country**, with great benefit for the sector both nationally and regionally. However, the role of UK research bodies (public and private alike) in future European and global projects still urgently requires resolution. While HM Treasury has committed to underwrite funding for approved Horizon 2020 projects applied for before the UK leaves the EU, providing short-term reassurance and long-term strategies to the UK’s own research and innovation base as well as its current and prospective European partners is absolutely vital.

80 Particularly worrying to the HEI and researchers that we interviewed across the county was the ambiguous status of EU funding in the medium term. As a local government decision-maker suggested, “because the future collaborative funding options like Interreg or Horizon 2020 remain unknown, we are struggling to get a clear picture of the projects that we can and ought to be pulling together with long-standing European consortium partners. This is having a knock-on effect on our ability for those projects planned within the areas of collaborative health and training, and life sciences more broadly” (CEFEUS interview, 2018). This trend is particularly worrying in across the entire health, medicines, pharmaceuticals and life sciences sectors, where projects require extended periods of time to construct, operate and conclude.

Kent and Medway

81 Within Kent and Medway, leading universities like Canterbury Christ Church University, and the University of Kent, as well as major public bodies like Kent County Council have benefited from a wide range of EU funding, and collaborative research and development structures. Funding and collaborative R&D together “have helped delivery key benefits in medical science for the county as a whole, improving the health of patients locally, while increasing knowledge of and access to our research across the UK and the EU” (CEFEUS interview, 2017).

ANALYSIS

82 Britain’s departure from the European Union brings with it both challenges and opportunities for the Life sciences, research and development sector, itself dependent on key decisions the UK Government makes over the coming year. As illustrated, a key strength of Britain’s medical research sector is the sheer diversity of organisations involved in both funding activity and policy dialogue, from medical research and charities to patient organisations. As attested by the Technopolis Group (2017), ‘the UK is an important partner in the EU research landscape, contributing to almost 20% of the total research work carried out within EU health programmes between 2007 and 2016’ (p.3).

83 Collaboration boosts scientific impact, keeps the UK at the forefront of evidence-based ground-breaking medical research, promotes the UK’s role within the architecture of European medical research (including its own facilities), allows the country to develop new therapies and medical technologies and provides an attractive training environments for early-career researchers.

84 As our interviewees raised time and time again, “labour mobility, education, research and funding are all deeply woven into these mechanics as well as a clear and predictably regulatory framework that allows R&D to develop in the short term and plan for the long term” (CEFEUS interviews, 2018). Impacts and opportunities here are thus finely balanced. As outlined once again in the recommendations below, the UK needs to prevent a series disruption to its hard-won role at the forefront of collaborative European R&D. Equally, British life sciences sectors could afford to think internationally as well as European, in terms of consortium building, scientific counterparts and innovative funding.

REGULATORY REGIMES

85 It is difficult to assess the extent to which the UK's medical and pharmaceutical industry will continue to be regulated by EU laws once the UK leaves the EU. A large part of this depends on whether the UK will continue to be part of the European single market and support free movement of medicinal products, a decision for both the UK and remaining EU member states to reach. The most likely outcome is that companies seeking to launch new products will have to apply separately for regulatory approval in the UK and in the EU. This will introduce delays to the system and may be detrimental to drug launches in the UK, as companies may prioritise applying for regulatory approval in the considerably larger EU market.

European Medicines Agency

86 A key issue of course is the appeal of London as an environment for the development of medical chemicals and pharmaceuticals, not least because it hosts the European Medicines Agency (EMA). Britain has hosted the EMA since it was established in 1995 in Canary Wharf, London. It currently employs approximately 900 staff members within the Secretariat, whilst an additional 36,000 national regulators and scientists visit London each year to make judgements on medicines.²⁰

87 Following Britain's decision to leave the European Union, the EU announced it would seek to relocate the EMA to another member state. 23 member states expressed interest in head-quartering the agency, with Amsterdam selected as the new host city at the end of 2017. Whilst neither the EU nor the UK has directly stated their stance on Britain's membership of the EMA, it is expected that the UK will leave the agency. In 2017, Jeremy Hunt, Secretary of State for Health and Social Care, stated that he does not expect us to remain within the EMA, but I am very hopeful that we will continue to work very closely with the EMA (Health Select Committee, 2017).

88 Britain will likely detach itself from EMA protocols at the end of the transition period, if not before. However, this decision raises the prospect of falling behind other nations in the development of new medicines, and their practical implementation. For instance, the delay in submitting for approval to a non-EU state is 2-3 months after an application is made to the EMA. Approximately 5-15% of applications are submitted after more than a year after initially being submitted to the EMA, whilst finally, 45% of applications currently submitted to the EMA as of January 2018 have not been submitted for approval in Australia, Canada and Switzerland (Brexit Health Alliance, pg.3, 2018). Out of the 1,500 registered clinical trials that currently include multiple EU states with an UK sponsor lead, 50% are expected to be ongoing as of March 2019 (Brexit Health Alliance, pg.5, 2018). Unless a similar regulatory framework is agreed to continue during the transition phase, there is a prospect that the trials could stop, or be forced to begin again within the EU27 member states.

²⁰ Financial Times, October 2017:
<https://www.ft.com/content/e816f0e4-a9a7-11e7-ab55-27219df83c97>

ANALYSIS

89 However, these problems could be circumvented by various administrative streamlining measures such as those used by EFTA states. For example, Liechtenstein uses processes that automatically approve medicines authorised by the EMA, whilst Norway and Iceland remain under the EMA's umbrella. In April 2014, a new Clinical Trials Regulation (CTR), Regulation EU No. 536/2014, was adopted by the EU with the aim of full implementation by 2018. This CTR focuses on the simplification of current rules, streamlining applications for the conduction of clinical trials and their authorisation, and aiming to increase the transparency of the data produced. Should the UK not adhere to Regulation EU No. 536/2014, innovation could be hindered as opportunities for doctors and academics to conduct clinical trials will be restricted and companies will begin to look elsewhere to carry out theirs.

Procurement Directive and health

90 The EU has developed public procurement rules that govern the way in which public bodies purchase goods, services and works, and seek to guarantee equal access to and fair competition for public contracts within the EU market.²¹ The regime for health service contracts, for example, is set at €750,000 which means that "health service contracts below this value are considered to have no cross-border interest" whereas contracts of a value equal or above €750,000 are required to:

- Ex-ante advertisement in OJEU (using contract notices or prior information notices) as well as publication of ex-post award notices
- Compliance with national rules ensuring that the key EU principles of anti-discrimination and equality are respected
- Award criteria can be based on principles other than price. In particular, quality, continuity, accessibility, comprehensiveness of services and innovation can be taken into account (NHS European Office, 2016).

These regulations enable NHS bodies to broaden "the possibilities for NHS bodies to conduct negotiations with bidders during the procurement process, in addition to clarifying how to conduct market consultation prior to the launch of the tender. These changes will help NHS bodies to buy products and services better adapted to their needs and to achieve better commercial outcomes" (NHS European Office, 2016).

²¹ NHS European Office, 2016:
<http://www.nhsconfed.org/regions-and-eu/nhs-european-office/influencing-eu-policy/public-procurement>

Procurement: mixed perspectives

91 However, the EU has stated that after 30th March 2019, the EU rules on public procurement will no longer apply to the UK.²² For some within the NHS in Kent that we spoke to, the opportunity to look again at profoundly streamlining procurement in the medical industry “is timely, necessary and if well-handled, a boon to streamlining one of the least efficient parts of our healthcare system”; for others, the “equal access to and fair competition for public contracts has little to do with internal problems of the NHS that exist independent of both procurement and its post-Brexit changes” (CEFEUS, 2017 and 2018).

92 Discussing regulatory options with the CEFEUS steering committee on health and social care, the general consensus was that the above-mentioned changes will have “profound consequences for EU public procurement procedures, including those producers and operators based in Kent and Medway” (2018). This is because economic operators from the United Kingdom will have the same status as all other economic operators based in a third country with which the EU does not have any agreement providing for the opening of the EU procurement market. As the committee pointed out, this renders UK economic operators across the entire spectrum of health, medicines and pharmaceuticals “subject to the same rules as any third country tenderer.”²³

Professional qualifications

93 Our discussions with Kent and Medway trusts, foundations, as well as with HEIs providing cross-spectrum health and social care training also raised the important point of retaining cross-border recognition of professional medical qualifications. While concerns continue to exist about competency, the broad consensus is that the UK must swiftly find a structure by which it can continue to accept the principle of mutual recognition within the wider European area to ensure labour, at least in the short term.

94 “It’s key that clinicians show relevant language, skills and knowledge competence: that’s a minimum. But in Kent and Medway – and I assume the country as a whole – regulations shouldn’t throw up a host of unnecessary bureaucratic barriers which will prevent us from hiring skilled clinicians locally” (CEFEUS, 2018). Other perspectives from within Kent and Medway hospital trusts suggested that “in some cases, automatic recognition of some qualifications should not be excluded from possible future regulatory arrangements with the EU. Why would we reinvent the wheel in this respect, particularly at a time when we’re under so much pressure simply to provide basic patient care?” (CEFEUS, 2018).

²² This is subject to any transitional agreement contained in a withdrawal agreement.

²³ European Commission, 2018:

<https://ec.europa.eu/docsroom/documents/27347/attachments/1/translations/en/renditions/native>

95 Further information on professional qualifications is also helpful at this point. Directive 2005/36/EC (amended by Directive 2013/55/EC)²⁴ recognises professional qualifications, therefore enabling the free movement of professionals within the EU. The professions recognised by this directive are:

- Doctors (general practitioners and specialists);
- Nurses;
- Midwives;
- Dental practitioners;
- Pharmacists;
- Architects;
- Veterinary surgeons.

This Directive sets the rules allowing these professionals to:

- Work in another Member State on the basis of a declaration made in advance
- Establish themselves as employed or self-employed, on a permanent basis, in a country where they did not obtain their professional qualification
- Get their qualification recognised under three different systems: automatic recognition, general system, recognition on the basis of professional experience
- Knowledge of languages and professional academic titles.

Key to the facilitation of the recognition of professional qualifications is the role of the European Professional Card.

The European Professional Card

96 The European Commission introduced the European Professional Card (EPC) on 18th January 2016 which allows EU-wide online digital procedure for the recognition of professional qualifications. This is available for general care nurses, physiotherapists, pharmacists, real estate agents and mountain guides, and might be extended to other professions in the future. The aim of the EPC is to contribute to completing all aspects of the Single Market in terms of professional equivalence and recognition. It is based within the Internal Market Information System (IMI) which itself allows communication and cooperation of the relevant authorities inside a secure network. The EPC does not therefore replace the procedures highlighted in the Directive 2005/36/EC but is an option for professionals who want to work in another EU country.

²⁴ European Commission, 2018:

<http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A32005L0036>

Working Time Directive

97 The Working Time Directive (WTD) will have an important influence on future workforce developments.²⁵ The WTD was implemented into UK law in 1998 and says that 'a worker's working time, including overtime, in any reference period which is applicable in his case shall not exceed an average of 48 hours for each seven days'. The working time regulations started to apply to junior doctors from 1 August 2004 onwards.

98 The European Court of Justice (ECJ) has ruled that any on-call duties at the workplace, which is common among medical professionals, must be subject to the norms of the WTD. Overall, the rationale of the ECJ ruling was that any on-call doctor remains more constrained by his employer than a doctor on stand-by (Séné, 2014). The WTD does, however, allow for individual opt-outs from the 48-hour week limit which was imposed by the UK in 1993. Until the Brexit result of 2016, the European Parliament discussed the removal of the opt-out clause as it was perceived that the UK had acquired an unfair trade advantage because of it (Royal College of Surgeons, 2018). To illustrate, the European Commission as early as 2003, reported that the UK was making widespread use of this derogation as 16% of the UK's workforce was working more than 48 hours per week, an increase from 15% in the early 1990s (Séné, 2014). In fact, data published by the ONS shows that more recently this derogation has become more pronounced as 18% of people were working 48+ hours per week in the second quarter of 2008 (Séné, 2014).

99 British workers can refuse to work more than 48 hours a week, however, many workers, particularly junior doctors see more working hours as the only way to advance their careers and working knowledge. However, they must have the ability to opt-in again. Where derogation is applied, the limit becomes 52 hours (NHS Employers, 2009). However, in a letter to the Prime Minister in December 2017, 12 national representatives of doctors, nursing staff and midwives in the UK stressed their concerns regarding to the removal of the WTD, arguing that excessive working has wide consequences and occupational hazards not only to the individuals and their families, but also to patient safety.

ANALYSIS

100 The current WTD rules will be translated into UK law under the Great Reform Bill and it would be for Parliament to decide subsequently whether and when to make any changes to the rules. Although in the past the WTD has been cited as a reason for pressures on the NHS it does not seem likely that Parliament will want to simply allow junior doctors to work longer hours with all the issues this would raise for patient safety.

101 Equally, a possible decrease in EU labour could further increase pressure on professionals that choose to remain in the NHS, and in turn bring an expectation that they opt out of the WTD to ensure patient care. As such, it may be necessary for Parliament to legislate a new WTD bill that will ensure patient safety is not placed at risk and that NHS workers remain rested and competent.

²⁵ European Commission, 2018:

https://ec.europa.eu/growth/single-market/services/free-movement-professionals/european-professional-card_en

RECIPROCAL HEALTHCARE

102 The ability to access healthcare when we are in other EU countries has become a right we all take for granted whether travelling on business or pleasure. Directive 2011/24/EU defines the conditions under which an EU/EEA patient may travel to another EU/EEA country to receive medical care and apply for reimbursement of its cost from their home country. The reimbursement of successful applicants is managed by the health authorities in each UK nation, not by central government (BMA, 2017). The Directive covers healthcare costs, as well as the prescription and delivery of medications and medical devices (European Commission, 2018). As such, British citizens have become acclimatised to the freedom of mobility associated with living and working in another EU country and in parallel, obtaining easy and generally low-cost access to healthcare.

103 Under EU laws, all 28 EU Member States are obliged to provide reciprocal healthcare to EU citizens under three broad categories: temporary visits (EHIC, see below), residency (S1) and those receiving healthcare (S2).²⁶ Under the temporary healthcare category for example, the approximately 27 million UK citizens currently in possession of a European Health Insurance Card are able to receive emergency healthcare for free or minor cost across the EU, Switzerland and the European Economic Area (Iceland, Liechtenstein and Norway).

104 European Health Insurance Card

First issued in 2004, to formally cover the medical insurance costs of Europeans when abroad in another EU member state, the European Health Insurance Card (EHIC) is issued free of charge to anyone who was covered by a statutory social security scheme of the EEA countries and Switzerland to receive medical treatment in another member state free or at a reduced cost, if that treatment becomes necessary during their visit. The EHIC gives access to state-provided medical treatment only, allowing EU/EEA citizens to be treated on the same basis as an insured person living in the country they are visiting. EHIC covers treatment for a pre-existing chronic disease or illness (kidney dialysis or oxygen therapy, requires arrangements made in advance of travelling), providing eligible insurance cover in the event of succumbing to illness whilst travelling.²⁷

105 The EU guarantees the right of **residency** for all EU citizens in all member states; which brings with it the right to reciprocal healthcare. Specifically, all EU citizens are afforded the same rights as domestic citizens in healthcare, meaning that no discrimination can take place in terms of financing or access. Approximately 3 million EU citizens reside in the UK, whereas around 1.2 million UK citizens reside in the EU27. In addition, an EU citizen receiving a pension from a EU member state is entitled to receive healthcare in the country they reside. The member states subsequently reimburse each other for the cost of the healthcare received.

²⁶ There is also a 4th category (S3), which covers the access of healthcare in a country of previous employment.

²⁷ <https://www.nhs.uk/NHSEngland/Healthcareabroad/countryguide/NonEEAcountries/Pages/Non-EEAcountries.aspx>
<http://www.nhsconfed.org/media/Confederation/Files/Publications/Maintaining-reciprocal-healthcare-for-patients-after-Brexit.pdf>

<https://www.which.co.uk/money/insurance/travel-insurance/guides/the-ehic-explained>

106 Finally, EU citizens are able to **receive healthcare** from another member state in special circumstances, such as treatment for a medical condition that is not available in their country of residency under the S2 system. Whilst the process can be complex, including prior authorisation from the local healthcare system, the country of residency will ultimately cover the cost of treatment. This is of particular importance in smaller member states such as Luxembourg and Bulgaria, where they might not have the structure in place to adequately treat rare medical conditions.

ANALYSIS

107 The Government's consistent statements regarding ending the freedom of movement post-Brexit would end the ability of UK citizens access healthcare in another EU country and impact EU citizens qualified for NHS care in the UK, and end the application of the Directive (BMA, 2017). As part of the "exit agreement" in December 2017, the EU-UK negotiations have agreed to continue reciprocal healthcare arrangements for EU and UK citizens residing within the country in question prior to March 2019.

108 This arrangement is considered of particular significance to UK pensioners, of which approximately 190,000 are believed to live within the EEA. In addition, those receiving temporary healthcare will continue to receive emergency treatment under two primary conditions; a) they enter the member state prior to the departure date and b) their visit is classified as temporary (less than 3 months).

109 Phase Two of the EU-UK negotiations will need to ensure that the agreement of phase one is extended during the transition period and after its end. Specifically, continued access to the EHIC is of vital importance for citizens with a pre-existing medical condition which travel insurance may not cover. Furthermore, considerable thought should be given to maintaining S1 arrangements for UK pensioners residing in the EEA post-departure data. According to the last figures released by the Department of Work and Pensions, approximately £500 million was spent in 2014/15 on refunding healthcare costs of EEA member states for UK pensioners.

RECIPROCAL HEALTH CARE CASE STUDIES

Dialysis treatment

110 People suffering from kidney failure need dialysis three times a week in order to stay alive. They cannot take a break from treatment in order to travel: their dialysis sessions must be arranged in advance to ensure vital continuity of care. Currently, if one of the UK's 29,000 dialysis patients needs to travel with the EEA, they can, under the EHIC system, arrange in advance to have dialysis in that country. Private travel insurance is not an alternative for this group of patients – it would be impossible to obtain or cost-prohibitive for many. A continuation of the EHIC system or equivalent is essential to enable dialysis patients across the EEA to travel. (pg.5, Brexit Health Alliance, Maintaining reciprocal healthcare for patients after Brexit, October 2017).

Kent-Calais hospital collaboration

111 In 2015, the South Kent Coast Clinical Commissioning Group (CCG) signed an agreement with the Centre Hospitalier de Calais, a brand-new hospital in the port town of Calais. Under the arrangements, NHS patients requiring routine surgery can be referred to the hospital and receive free healthcare treatment. The patient is responsible only for their own travel arrangements, with subsequent check-ups carried out via Skype or telephone. In the first 18 months of the arrangement, just two UK nationals visited the hospital. However, recent strain on the NHS has seen 140 prospective patients approach the hospital in a two-week period in January 2018. Serge Orlov, who required knee surgery, described the process as 'winning the lottery', adding that 'what would take seven months in England took three months here'.²⁸

²⁸ <http://www.dailymail.co.uk/news/article-5322111/UK-patients-skipping-NHS-queues-free-surgery-France.html>

TRANSPORT AND INFRASTRUCTURE

112 Any and all issues touching on the UK border, as well ports in particular is of key concern to Kent and Medway. Indeed, CEFEUS itself will in Spring 2018 turn from its health and social care focus to exploring the specific issues contingent on safely managing the UK border within the geography of the county.

113 A key issue at this point is the overlap of port and health issues, raised on a number of occasions in our various interviews and deemed as “vital but as key still unrecognised at the highest levels of government decision-making” (CEFEUS interviews, 2018).

114 At the outset is the assumption that the prospective divergence from EU regulatory structure in terms of the UK’s removal from either the Single Market or the Customs Union will inevitably lead to an increase in processing times at the border, and in particular ports. In the short-term, without due preparation, these delays could be chronic, and in some cases, produce acute problems in the health care sector.

115 For example, due to the notoriously short half-life of medical radioisotopes, any delays in the customs process for the import of these products could have a serious impact on patient care. Britain’s expected withdrawal from the Customs Union poses a serious risk of medical isotopes being stuck at ports, which in turn could create a public health concern. Britain has, as of March 2018, indicated that it will withdraw from Euratom. The strict regulations that oversee this crucial area means that the Government will effectively need to create an agency to replicate these same protocols, or risk impeding its ability to import radioisotopes from a third party.

116 In addition, port-based delays could extend to urgent health care needs. For instance, as the Brexit Health Alliance recently pointed out, accident and emergency trauma packs are flown in from the EU to the UK within hours of the order being placed. The quick turnaround is particularly necessary during large-scale emergencies, such as terrorist attacks and environmental disasters. Most hospitals only keep small amount of such packs due to their product shelf life. The BMA anticipates “that post-Brexit customs checks could result, in one of the best-case scenarios, in a delay of five hours. These five hours are critical in life and death situations where critically injured patients need care and treatment as possible” (January 2018).

“Post Brexit, new port health border requirements could be a serious problem for a variety of ports, particularly at Roll-on Roll-off ferry ports. Under present EU rules, plant and animal products could be subject to a hugely disruptive inspection regime at the border. To require lorries to stop and undergo time consuming inspections at ports would lead to significant disruption at the border and create congestion around ports.”

Richard Bellantyne, Chief Executive of the British Ports Association.²⁹

²⁹ British Ports Association, 19th February 2018

<https://www.britishports.org.uk/news/post-brexit-port-health-border-disruption-still-a-major-concern-for-british-ports>

KENT IMPERATIVES: RECOMMENDATIONS FOR 2018-2021

The overarching theme in terms of short-term requirements however, is workforce. As the 2017 House of Commons Health Committee made clear, the first phase must be “addressing the **immediate issues faced by people**, whether they are workers in health and social care or patients who rely on reciprocal healthcare arrangements” (Brexit and health and social care – people and process, p.3).

With 60,000 people from EU member states currently working in the NHS in England, and 90,000 in adult social care, it is clear that “post-Brexit we will continue to need, and benefit from the presence of EU staff in health and social care” (p.3). Failure to address workforce issues impinges on the current overstretch of the NHS, its ability to provide further services for an ageing population (particularly in Kent), as well as exacerbating the overall professional and personal uncertainty of British and EU.

WORKFORCE: HEALTHCARE

The BMA, as part of the Cavendish Coalition, recently identified a number of key principles which they believe should underpin a **future immigration system** (BMA Brexit Brief, 2017). On the basis of these points, CEFEUS’ own one-on-one engagement with key stakeholders and decision-makers suggests that the following comprise reasonable suggestions for national and local government alike:

- Be responsive to individuals and organisations using it, easy to understand and navigate, transparent, predictable and affordable: keep it simple.
- Respond to skill and labour shortages within the health and social care sector, as well as attracting talent to the sector.
- Support the stability of health and social care services in the short to medium term
- Recognise the wider value to society and the economy of certain skills and roles, beyond using salary levels as a determinant of entry to the UK.
- Support the growth of the economy across all parts of the UK.
- Position the UK as a global leader in healthcare industry, science, technology, research and education.
- Support the delivery of high quality public services across all parts of the UK.
- Lead the way on the World Health Organisation Code of Practice on ethical and international recruitment.
- Complement a strategy and plan to develop the UK’s domestic supply of health and social care staff.

WORKFORCE: SOCIAL CARE

Government, both national and local, needs to be far more aware of the **deeply symbiotic overlap** between health and social care; sympathetic to the intense labour pressures upon both which are likely to be exacerbated by Brexit. Short-term recommendations flowing from this area include the following:

- In the many instances across Kent and Medway where European partners are currently part of **valuable collaborative structures**, HMG ought to think rationally about preserving rather than undermining them.
- It is key that post-Brexit shifts impel local actors in health and social care to learn new ways of working. **Home-grown initiatives** that simultaneously maximise the potential of our universities in training the health and social care workforce of the future while attracting other forms of international investment must be put in place now (e.g. via the Kent and Medway Medical School proposal).

More broadly, decision-makers are urged to think strategically about how **innovation and technology** play a solution to post-Brexit coverage of health and social care.

- Domestically, plan more intelligent overlaps between health and social care and the UK's emerging Industrial Strategy. Systems helping to diagnose patients, which in turn promotes greater patient autonomy and self-care (e.g. being able to carry out their own blood tests, self-managing diet and exercise).

MEDICINES AND MEDICAL INDUSTRY

As evidenced above, under no circumstances must there be any negative impacts on patients.

- Avoid profound changes to these areas will in turn reduce the chances of profound impacts to the NHS, the pharmaceutical industry and to the future health and wellbeing of patients.
- Maintaining a close co-operative relationship between the UK and the EU in health research, medicines regulation and safety, and the handling of public health issues, has been, and remains a priority in both the short and long term.
- Future cooperation on medical devices and medicines are to be prioritised in the negotiations, so that patients and the wider public are not negatively impacted from disruptions in the supply of medicines and other health technologies, or from a reduction in standards or safety.
- Ensuring that any replacement structure retains the simplicity of the current one, in which medical and medicines-based information (e.g. patient information leaflet) are consistent across all EU member states, increasing overall public health protection.
- Continued UK participation in the various EU systems such as data sharing networks, pharmacovigilance and the new clinical trials infrastructures post Brexit.

MEDICAL ISOTOPES

With regards to EURATOM, and on the basis of a number of interviews with decision-makers in this area, this report recommends that the UK Government work methodically to address the questions put by Lord Jay of Ewelme Chairman of the EU Home Affairs Sub-Committee to the Secretary of State for Business, Energy and Industrial Strategy, the Rt. Hon Greg Clark MP.

Lord Jay's letter of 8 December, 2017 outlined key concerns "about the health implications of leaving Euratom", specifically regarding the "safe and timely import and export of medical radioisotopes", and identified a number of pertinent questions that should be examined as a matter of urgency, including:

- Identifying precisely "what is being done at Government level to coordinate the work that needs to happen to ensure a smooth transition and facilitate stakeholder engagement";
- Determining the type of post-Euratom system for the uninterrupted and timely import and export of isotopes into/from the UK in both the short and long-term;
- Identifying a reasonable 'Brexatom' replacement that "does not take longer, cost more or carry a higher risk of encountering delays" in terms of current and future providers of medical isotopes;
- Identifying and preparing for potential impacts on the existing workforce and UK health system of failures to transition smoothly to 'Brexatom', including a clear sense of BEIS' role in producing a risk assessment on these issues;
- The impact of the Transition Period upon the UK's changing relations with Euratom;
- Outlining ways in which Britain can remain at the cutting-edge of nuclear medicine and radiology research, including attracting and retaining high quality non-UK researchers, as adequate replacement funding opportunities.

The continued supply of medical radioisotopes must be considered a top priority for the Brexit negotiations, and if necessary, consider continued membership of Euratom to achieve this. Switzerland has associate membership of the organisation which is a path the UK should consider.

PUBLIC HEALTH

Patient safety and public health must be guaranteed post Brexit. At present the consensus from within Kent and Medway is as follows:

- Aligning the UK as much as possible with the EU's current structure and protocols on public health, both via bilateral and multilateral engagements with European countries and key agencies like the European Centre for Disease Prevention and Control.
- Continued membership in the European Centre for Disease Prevention and Control to allow Britain to continue to strengthen its defences against infectious diseases.
- Continued work with the European Centre for Disease Prevention and Control including the pooling and sharing of national surveillance data, reporting on high profile public health issues.
- Continued support for the considerable infrastructure that allows Britain to manage its public health concerns, both domestically and from a continental perspective.

LIFE SCIENCES, RESEARCH AND DEVELOPMENT

The main message here is one of ensuring that UK research continues its world-leading role alongside European partners in working with and delivering research and development in medical science. This in turn visibly improves the health of patients and the public, in the UK and Europe as a whole. Recommendations are as follows:

- The UK Government must ensure that the United Kingdom does not fall behind the EU27 for the trialling of innovative and potentially life-saving medicines; and reflect on the way in which this may necessary involve continued regulatory alignment with the EU within this area.
- Government accepts the critical need for HEIs, institutes, and researchers continue to receive access to EU R&D funding in general (and projects like Horizon 2020 and its successor in particular) or an equivalent funding stream that will allow the UK to remain as one of the leading innovators in the field of medicines.
- Government ensures that British medical specialists and institutions are able to continue to contribute and influence advisory bodies, networks and policies that play a crucial role in the development of research across the EU.
- An assurance that UK labs are able to continue to participate in clinical trials, in particular in the treatment of rare diseases and cancer research.
- Clarity as to how Britain will retain its place as one of the world lead innovators in R&D, which includes the hosting of some of Europe's large scale infrastructures.
- A clear plan as to how a renewed pharmaceutical and biotechnology sector post-Brexit can assist in pushing forward cutting-edge research in medicine, and medical technologies that benefit both EU and UK citizens.
- A short and long term plan, developed with leading stakeholders to continue the UK's role as a global leader in education, including the development of early career researchers.

RECIPROCAL HEALTHCARE

- That the United Kingdom remains a part of the European Health Insurance Card scheme, which does not necessitate EU membership.
- That senior citizens covered under the S1 system continue to receive access to healthcare should they decide to reside in a European Union member state, subject to immigration procedures.
- That the spirit of the S2 system continues to ensure that the UK will maintain its role in the treatment of EU patients who are unable to receive the care they require in their state of residence.
- Retaining some form of access to, membership of, or swift replacing of the European Health Insurance card and its statutory rights guaranteed to those who hold it in terms of the receipt of medical treatment beyond the UK. A clear appreciation of how EHIC works within the wider issue of EU and UK citizens' rights.

REGULATORY REGIMES

In terms of the broader retention of European regulatory systems (whether by alignment, convergence, or some sort of parallel approximation in the short term) it should be noted that at present the UK contributes strongly to, and benefits robustly from its collaboration within an advanced and interdependent structure set up for the advancement of research, development and sophisticated 21st century patient care responses. Recommendations are thus as follows:

- Continued membership of or 'associated membership' of the European Medicines Agency.
- Looking in detail at the administrative streamlining measures such as those used by EFTA states in terms of automatically approving medicines authorised by the EMA.
- Working with the EU during 2018 to ensure that the new Regulation on a new Clinical Trials Regulation to help further simplify current rules, streamlining applications for the conduction of clinical trials and their authorisation, and aiming to increase the transparency of the data produced.

PROFESSIONAL QUALIFICATIONS

Clearly, professional qualifications need to balance patient safety – as served by regulatory rules which may restrict access to the profession – and patient safety as served by having a workforce sufficient to fill the current vacancies within the UK and Kent and Medway.

- In the short-term, retaining the current requirements that all clinicians working in the UK should be asked to demonstrate relevant language, skills and knowledge competence.
- Looking swiftly at how regulations can be vastly streamlined in terms of accepting professional qualifications form within the EU/EEA mainframe, and reducing the current bureaucratic barriers which inhibit the flow of skilled clinicians in to the NHS.
- Considering where in some areas the automatic recognition of some qualifications should not be excluded from possible future regulatory arrangements. Equally, retaining access to alert mechanisms (presently within EU law) which identify potentially dangerous practitioners.
- Examining the opportunity in the long-term to negotiate a more pragmatic approach to the mutual recognition of professional qualifications directive within the British regulatory model.

WORKING TIME DIRECTIVE

While there are a disproportionately greater number of 65+ year olds in the population of Kent and Medway than the rest of the country, the problem cannot be solved by removing the safeguards. Therefore, the Government should increase the workforce through proper resourcing and investment. As argued in the letter to the Prime Minister, 'Brexit must not be used as an excuse to overwork any staff group'.

- That the British Government reassures junior doctors and other health professionals that the core themes of the WTD will remain in place for the foreseeable future.
- That Parliament legislates a new Working Time Directive Bill that ensures that a drop-off in EU staff will not bring an expectation to opt-out of the WTD.

TRANSPORT AND INFRASTRUCTURE

As illustrated above, issues of supply and demand, and the infrastructure needed to guarantee this, whether by air, ship, rail or land is key, and any south-east port-based access is particularly crucial for Kent.

- Ensuring that any Brexit deal does not result in a reduction, or delay, in patient access to safe and effective medicines.
- That considerable thought is given to the impact that leaving the Customs Union may have on products such as medical radioisotopes, which have a notorious short lifespan. This area may be mitigated by either the creation of an 'express' port for products in the national interest, or a priority-based customs process where items of significance are processed at a swifter rate.

CASE STUDY 1: KENT AND MEDWAY MEDICAL SCHOOL

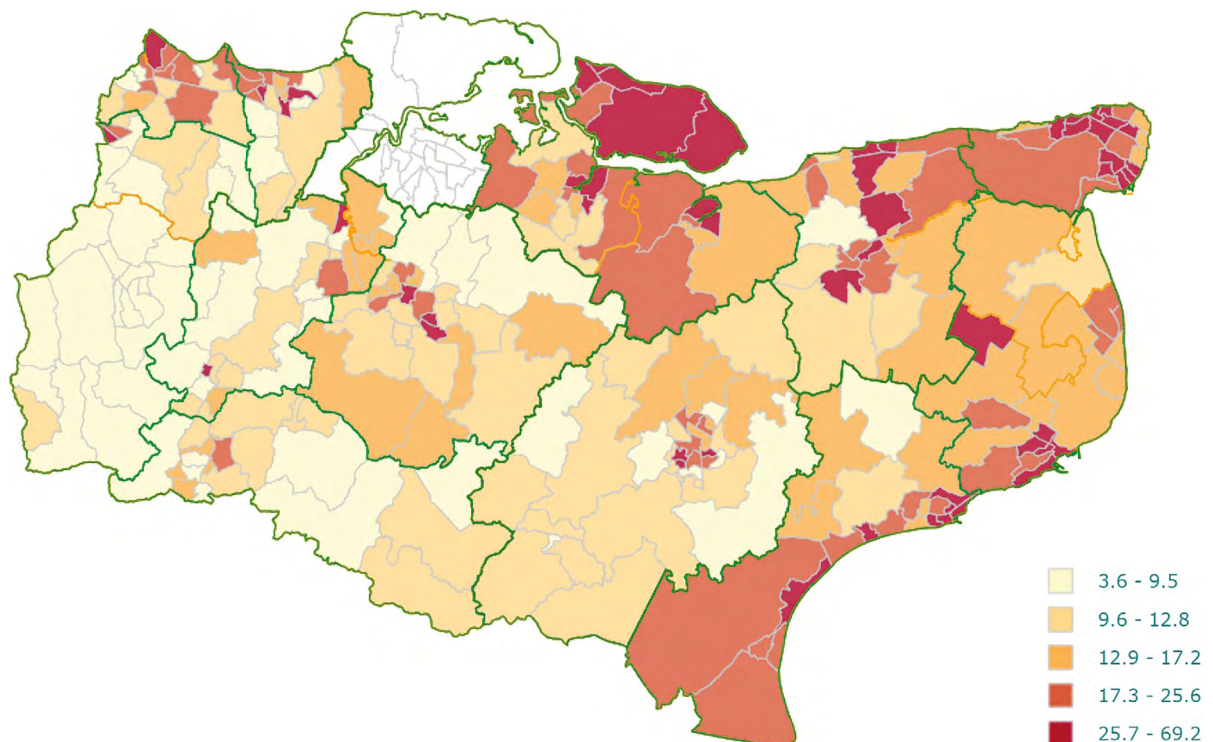
Despite having a population of 1.8 million people and two vibrant universities, the county of Kent does not currently possess a medical school to help train the next generation of health and social care professionals.

Explaining the challenges facing the county, Debra Teasdale, Dean of the Faculty of Health and Wellbeing at Canterbury Christ Church University stated that “Kent and Medway is the largest conurbation without a medical school in the UK. At the same time, it has an increasing and aging population, with some of the worst areas of deprivation in the country, in particular on the north coast and certain areas of the south coast. In addition, it has the highest population of GPs over the age of 55; with 31% of vacancies reported in our mental health services. Together, the joint venture between the two universities allows for the creation of a really positive offer to support medical students going forward.”

Indices of multiple deprivation: Health Deprivation and Disability domain (2015)

Index of multiple deprivation score showing relative deprivation for the health deprivation and disability domain. An area with a higher score is more deprived.

(Source: Department of Communities and Local Government)

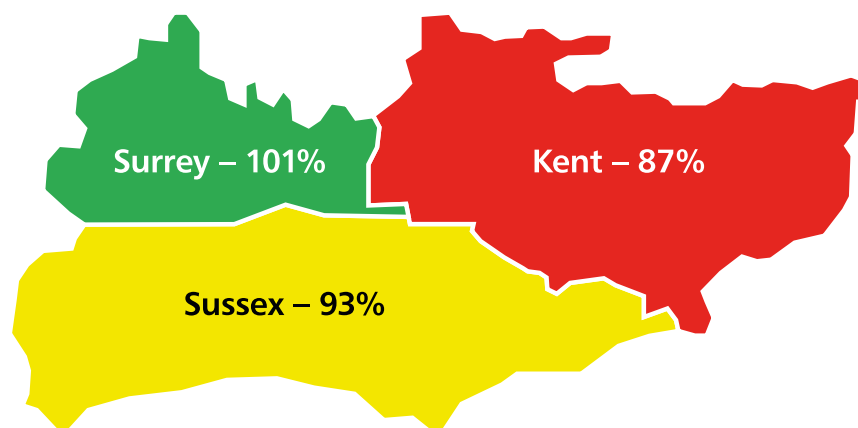


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Share of doctors indexed to share of needs weighted population – Kent, Surrey and Sussex³¹

Key

- < 89%
- 90-94%
- 95-99%
- > 100%



The Kent and Medway Medical School

In November 2017, Canterbury Christ Church University and the University of Kent together announced plans to apply to create the Kent and Medway Medical School.

The venture will see prospective students study at the two institutions' campuses in Canterbury as part of their studies before being awarded a joint degree after successful completion of the five-year programme. Prospective graduates will be jointly-awarded a Bachelor of Medicine and a Bachelor of Surgery. The partnership will also see Brighton and Sussex Medical School serve as a parent partner, with the approved curriculum of the institutional ensuring quality medical education is delivered.

If successfully awarded funding by the Higher Education Funding Council for England (HEFCE) in March 2018, the Kent and Medway Medical School will see prospective students begin their studies in September 2020. As such, the first cohort of graduates will not be ready until 2025, meaning that the venture is very much considered a long-term solution rather than a quick fix. Under the initial funding application, 100 domestic students and 7 international students will be accepted per year for their studies. The outcome of the EU-UK Brexit negotiations will determine under which category EU27 nationalities come under.

³¹ Courtesy of the Faculty of Health and Wellbeing, Canterbury Christ Church University.

“Our hope is that by providing students with an excellent, embedded experience in Kent, a proportion will remain in the county. The population currently serve as a net exporter to the country, and we are confident that we can encourage more prospective medical students to remain via the Kent and Medway Medical School. Finally, we feel that the two universities working together will help challenge some of the current difficulties, with a fresh pair of eyes to come in and help think about healthcare and medicines differently.”

Debra Teasdale, Dean of the Faculty of Health and Wellbeing,
Canterbury Christ Church University

Proposed Kent and Medway Medical School

THE KMMS STUDENT OFFER

KMMS will engage extensively in widening participation by working closely with local schools and colleges, drawing on existing programmes at the University of Kent and Canterbury Christ Church University.

KMMS brings together complementary institutions in the University of Kent and Canterbury Christ Church University.

The school will be based on both campuses with students fully part of both student communities, particularly able to work closely with other students in health and social care programmes.

The medical school is supported by Brighton and Sussex Medical School and will develop a curriculum based upon this, adapted to the circumstances of Kent and Medway.

The distinctive placement model places students within the community setting ‘hubs’ from which they will access ‘spoke’ placements in NHS and private, voluntary and independent settings.

Early clinical placements within Community Education Provider Networks from year 1.

Developing future doctors to support Kent and Medway’s communities into the 2030s and beyond.

CASE STUDY 2: THE HEALTH AND EUROPE CENTRE

The Health and Europe Centre was established in 2001 in Maidstone, Kent and became a Social Enterprise in 2007 (Health and Europe Centre, 2018). As described in its in-house literature, the Centre's aim is to bring European and international learning, practice and policy to the local health community, and its objectives are to:

- Provide training and learning opportunities through collaborations with colleagues from other countries;
- Work with European partners to assess the impact of new legislation on stakeholders' organisations;
- Provide an information service that enables partners and stakeholders to stay up-to-date with developments in health and social care across the world;
- Help people and organisations reach health networks, institutions and other relevant bodies outside the United Kingdom.

The Centre provides four key services, including applying for EU funded programme opportunities with key Kent-based partners, promoting shared learning, boosting networking opportunities, and providing workforce development opportunities in the form of EU-based internships. Since 2005, the Centre has developed and managed more than €31.4 million of European projects from many different funding streams, supporting the priorities of our stakeholders and bringing in €11.65m of new funding into Kent. This equates to £8.91 of EU money being brought into the Kent health sector for every £1 of stakeholder contribution, and does not take into account the unquantifiable benefits such as a more skilled workforce and increased knowledge, or the benefits outside the health sector such as job creation. The Health and Europe Centre has 7 current EU funded project, two of which are described below: CASCADE, and DWELL.

(a) CASCADE – Community Areas of Sustainable Care and Dementia Excellence in Europe

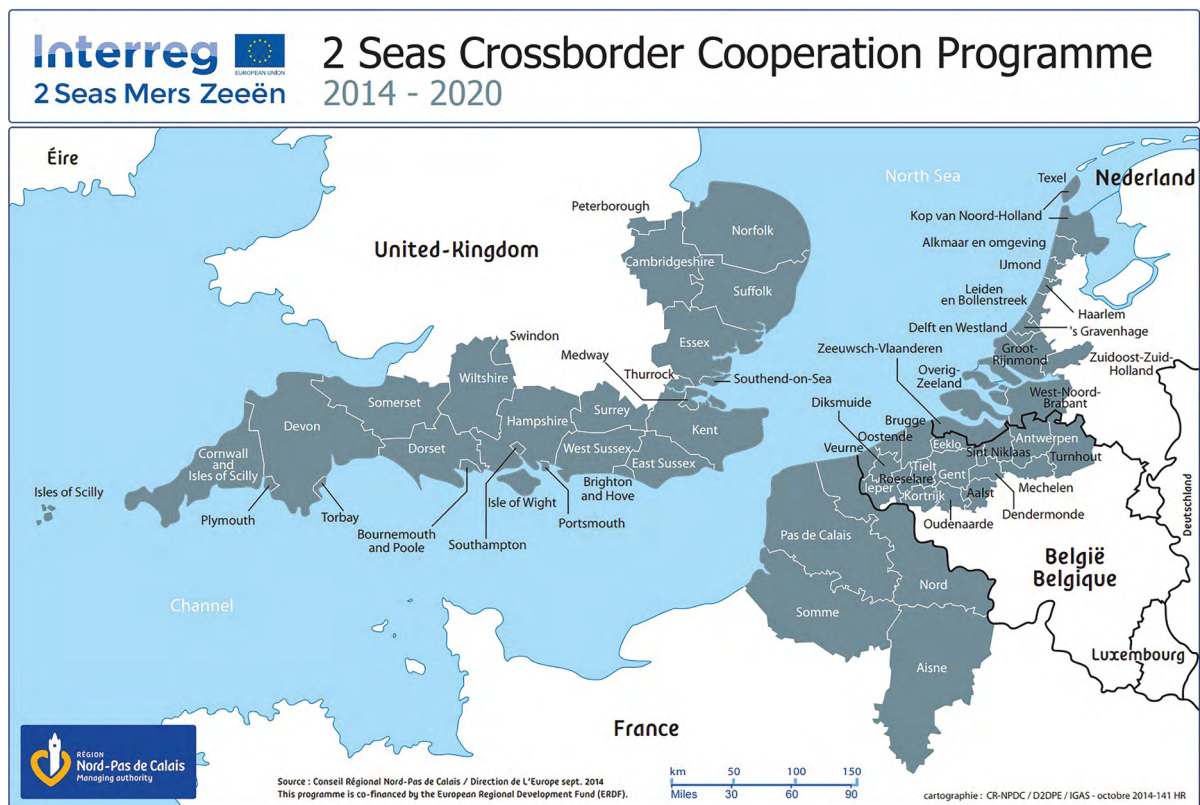
CASCADE is designed to develop a financially sustainable approach to elderly/dementia care (EDC) that can be replicated across the 2Seas area (Coastal France, UK, Belgium and The Netherlands) and potentially further across Europe. Uniquely, this will be tested via existing state-owned buildings.

In 2017, CASCADE got off to a strong start, with all its partners engaging with enthusiasm. The quality of, and commitment to, cross-border collaboration in this project is noteworthy. Four two-day meetings involving all partners took place between May and December 2017, allowing the partners to visit not only the good practice exemplars in the Netherlands, but also some Flemish partners with experience to share. These visits have inspired everyone involved, and are leading to lots of positive thinking about the next steps.

The facilities created will provide short-term respite and longer-term care, and will fully engage with the local community. They will also be the basis for a cascade of shared learning and cross-border excellence in dementia care for the future.

The approach will have wide applicability and plays a significant role in addressing the increasing demand. The outcome will be a step change improvement in EDC in the 2Seas area allowing people living with dementia to stay in their homes for as long as possible. CASCADE will recognise that dementia is long-term syndrome and that a person's needs on day one of diagnosis will be very different to their needs 20 years later and it will create a model that provides appropriate care at every point on the continuum.

Currently, the project is developing the Dementia village at the Buckland site in Dover (alone worth €2.24m) and a further 10-bed facility in Medway.



(b) DWELL – Diabetes and Wellbeing

DWELL is an empowerment programme enabling patients with type 2 diabetes to access tailored support giving them mechanisms to control their condition and improve their wellbeing. Ultimately, they will successfully self-manage their diabetes. This empowerment will increase adherence to treatment, improve health and wellbeing measures, giving economic benefits to health services. The principles of co-creation and co-design are being used leading to patients being healthier for longer, reducing costs to state healthcare.

The project started in August 2016 and involves eight partners from the UK, Belgium, the Netherlands and France. This cross-border partnership is set to last four years and has secured more than €1.9 million (£1.6 million) of European funding under the Interreg 2Seas programme. DWELL's first full year has seen partners focusing on the design and early piloting of a new programme to help type 2 diabetics to manage their condition better, and put them in the driving seat when it comes to their care. They have all worked collaboratively across borders, as well as with their stakeholders and patients to produce the first draft of the programme, and the training to accompany it.

DWELL is a holistic programme, encouraging and motivating patients to make many small changes to their lifestyle – and over the summer, UK partners trialed it with some fantastic results. Patient lives have already been changed, with participants losing weight, and reducing blood pressure and the amount of insulin they need. Seeing patients speak first-hand about the impact the DWELL programme has made on them, and how much better they feel about themselves and managing their diabetes, is truly inspirational, showing the immediate value of the project. Alongside this, partners have collaborated on tools to support patients during and after participation, and versions of the online tool are already being tested in all four languages.

The cross-border value of the project is immense, as combining different areas of expertise has produced the programme, completing individual partners' local expertise. Partners have seen issues in a different way, working with patients from different cultures – and this ensures the robustness of the DWELL programme. Over the next 3 years increasing numbers of patients will benefit from this programme as we roll it out more widely. Patient testimonials can be found online at: <https://youtu.be/sx3TCIWzWT4>

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CONTRIBUTORS

Brexit Health Alliance, British Medical Association, Canterbury Christ Church University, Cavendish Coalition, Centre for Policy Studies, Continuity of Care Services Limited, Dartford and Gravesham NHS Trust, East Kent Hospitals University NHS Foundation Trust, General Medical Council, Health and Europe Centre, House of Commons, House of Lords, Institute for Employment Studies, IoD, Kent County Council, Kent and Medway NHS and Social Care Partnership Trust, Kent Community Health NHS Foundation Trust, Kent Public Health Observatory, Maidstone and Tunbridge Wells NHS Trust, Medway Community Healthcare, Medway NHS Foundation Trust, Mental Health Network, National Audit Office, NHS Digital, Nuffield Trust, Skills for Care, The Health Foundation, The King's Fund, The Royal College of Midwives, The Royal College of Nursing, The Royal College of Radiologists, West Kent Mind, White Gate Design Ltd.

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