Position Statement

Royal College of Surgeons
ADVANCING SURGICAL CARE

Making the Best of Brexit for the NHS

December 2016

Introduction

Following the EU referendum the Government has been clear that it will proceed with leaving the EU.

Although the Royal College of Surgeons remained neutral during the EU referendum, we have been an active commentator on EU legislation. Surgeons are disproportionately likely, compared with other medical specialties, to have trained in the European Union and our members and patients have been directly affected by Directives on working time and medical devices.

Doctors are trained to show leadership and deal with change**,** challenges, setbacks, and advances - the hallmarks of any modern medical career. It is in this spirit that we set out, on an issue-by-issue basis, how we think the country can make the best of Brexit for our NHS.

The issues outlined in this document deal only with the impact of European legislation. They are not an overview of our wider views on issues such as training, workforce, or research. This document may be amended as Brexit negotiations progress so please refer to the RCS website for the latest version.

Boost funding

The health service is under self-evident financial strain with the NHS suffering from staff shortages, failing to meet waiting times, and restricting access to routine surgery. Against this backdrop, both sides in the EU referendum campaign pledged to strengthen the NHS, thereby demonstrating a political consensus about its financial vulnerability. Those pledges should now be delivered.

Protect our workforce

The health service simply wouldn't be able to function without the enormous contribution that migrants make to our NHS. With 20% having trained in the European Economic Area (EEA) and a further 20% having trained in the rest of the world, surgery is disproportionately dependent on a non-UK workforce.[1] The figures are similarly high in dentistry where 17% of dentists trained in the EEA and a further 11.4% trained in the rest of the world.[2] In recent years this number has been growing. For example, 42% of dentists added to the dental register in 2014 trained outside the UK.

[1] General Medical Council, *The state of medical education and practice in the UK report: 2016* (Data correct as of 31 Dec 2015)
[2] General Dental Council, *Annual Report 2014*

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Maintaining and enticing staff to work here has to be a top priority and there has never been a time in the NHS' history when we have not needed to recruit staff from overseas. However, the figures also demonstrate we are not training sufficient numbers of home-grown staff. A long-term reliance on recruiting from abroad is a risk if, for whatever reason, the UK becomes less attractive as a destination for work. There is also a question about whether it is right to take qualified professionals from countries where the demand for their skills may be even greater. We therefore welcome the Secretary of State's plans to increase the number of UK doctors being trained from September 2018.[3]

Patients are also served by the thousands of technicians, porters, cleaners and other staff who have moved to the UK. Toughened migration rules often particularly affect such groups of workers and the NHS also needs to continue to attract these vital staff.

Our recommendations:

- The UK Government must confirm at the earliest opportunity that it will protect the right of all NHS professionals, already residing in the UK, to continue to work here. The NHS must continue to remain an attractive place for staff to work.
- We welcome the Secretary of State's decision to boost UK training numbers. It can take around 15 years for a surgeon to be trained. In the meantime the UK will still need to attract staff from overseas to address workforce shortages.

More time for training

In 2014 the European Working Time Directive (EWTD) Taskforce[4] – whose members included royal colleges, the BMA, employers, junior doctors, and patients – concluded the EWTD has had an adverse impact in the NHS on training in certain medical specialities, including surgeons and doctors working in acute medicine. This is because it introduced an inflexibility into working patterns on wards which has impacted on the quality of training for some doctors, and continuity of patient care.

A particular problem with EWTD is the subsequent court rulings which established that where rest requirements are breached, compensatory rest must be taken immediately. This has caused inflexibility in rotas. These legal precedents might not apply if the UK is no longer under the jurisdiction of the European Court of Justice although rules around rest periods, as well as the 48 hour week limit, are written separately into the junior doctors' contract and will remain post-Brexit. Any change to EWTD rules would therefore require new legislation for junior doctors. The current consultants' contract does not reflect EWTD rules in

[3] https://www.gov.uk/government/news/up-to-1500-extra-medical-training-places-announced

[4] https://www.rcseng.ac.uk/news/taskforce-report-on-the-impact-of-the-european-working-time-directive-ewtd-on-the-nhs-and-doctors

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the same way and many consultants voluntarily opt out of the EWTD.

Our members have repeatedly called for the need to provide greater flexibility for training time while ensuring we never go back to a culture of excessive working hours that harm patient care. In a survey of 1,200 UK surgical trainees 71% felt EU working time rules had negatively impacted their training.[5] In July 2016 the Association of Surgeons in Training suggested that the EWTD should be slightly relaxed to a maximum of 56 hours a week for surgeons with any extra time spent purely on training.[6]

While Brexit presents an opportunity to potentially change EWTD rules, it is also important to stress that the Directive is not the only problem with training—there are many broader issues that still need to be addressed which we would also be happy to discuss with decision makers.

Our recommendations:

- The recommendations of the EWTD Taskforce should now be fully implemented, including tackling the inflexibility brought about by European court judgements on EWTD. Surgeons should be given this specific flexibility which would require new legislation. The Government should consult widely to assess the need for similar flexibility for other medical specialties.
- These recommendations should be implemented with a commitment to allow more time, within the current arrangements, for training by creating protected education and training time for junior doctors.

Improve language testing

While we continue to need to attract overseas staff, it is also important that they have sufficient English language skills to communicate effectively with patients and colleagues.

As recently set out in a Faculty of Dental Surgery paper *English language testing of healthcare staff and the EU*[7], the RCS and FDS have concerns that different sets of language testing rules apply to NHS staff from the EEA and the rest of the world. The fundamental problem is that under EU law professional regulators can ask candidates to demonstrate their language skills, but they have no powers to systematically require candidates from the EU to sit certain tests. As a result, staff from EU countries tend to demonstrate their language capability through the academic IELTS exam but this does not test someone's language knowledge in a clinical context. On the other hand, staff from the rest of the world are required to sit higher standards of language tests based on clinical contexts. Dentists and doctors from the EEA are disproportionately likely to face complaints, restrictions on their practice,

[5] https://www.asit.org/resources/archived-articles-documents/press-notice-18th-july-2016/res1248
[6] *Ibid*
[7] https://www.rcseng.ac.uk/news/docs/english-language-testing-of-healthcare-staff-and-the-eu

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or be struck off from their register as a result of poor English language skills.

Our recommendations:

- The law should be changed to allow the same language tests to apply to staff from the EU as the rest of the world on the basis of English language capability in a medical setting. This would be consistent with other non-EU English speaking countries such as Canada and Australia who have moved towards using medically specific language tests.
- While we remain a member of the EU or in the event the rules continue to apply, regulators and employers should explore ways to encourage (albeit they are unable to require) applicants from the EEA to demonstrate their language skills in a clinical setting which would be compatible with EU rules. We would also like to see the General Dental Council (GDC) and the Nursing and Midwifery Council (NMC) conform with the IELTS standard required by the GMC. At present the GDC and NMC set lower English language thresholds.

Medical devices and drugs

The current European Medical Devices Directive aims to create EU-wide rules and standards for medical devices. As a result, manufacturers only need to obtain a license in one EU country for their devices to be available in other member state.

With the UK's exit from the EU its regulatory framework for medical devices, as well as drugs, might change. If the UK's regulations were not aligned with the EU, regulatory requirements on manufacturers and the administrative burden ensuing from two separate processes might increase. This could risk delaying access to new and innovative medical devices and drugs.

One of the immediate consequences of the result of the referendum has been a depreciation of the pound. The UK heavily relies on imported medical devices and drugs which may raise costs for the NHS if manufacturers do not lower prices.

Our recommendations:

- The Government should set out how it will continue to attract and facilitate innovative medical devices and drugs to ensure the UK does not experience any delays in the distribution of new medical devices or treatments due to regulatory or financial obstacles.
- The Government should seek to maintain the best possible form of cooperation between the Medicines and Healthcare products Regulatory Agency and the European Medicines Agency.
- Should the UK cease to be aligned with the EU regulatory frameworks on medical devices and drugs, the Government should seize the opportunity to enforce more rigorous standards that could benefit patient safety.

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Recognition of professional qualifications

The UK currently has to abide by the EU's Directive on the Recognition of Professional Qualifications which sets out the framework within which doctors, dentists and other registered professionals can migrate freely between EU member states to practise their profession. The GMC has argued that Brexit presents the opportunity for regulators to test the competence of European health professionals, like they do for international professionals, with rigorous assessments of their knowledge and clinical skills.[8] We would welcome this change as currently the NHS has to rely on the robustness of the medical education and regulation system in the European doctor's or other health professionals' home country for that assurance.

A recent development in healthcare is for staff to develop competencies in areas of specialist practice. These are sometimes referred to as 'credentials'. For example the RCS is developing a certification system for cosmetic surgery. The Department of Health and the professional regulators are currently reviewing how to update the legislation governing professional regulators including whether it is useful for employers and patients to be able to identify practitioners who have acquired such additional experience and skills.

Professional regulators' ability to change the way they regulate professionals, to reflect these changes in clinical practice, is impacted by European legislation. Post-Brexit there may be more freedom for UK regulators to set even higher standards of professional regulation.

Our recommendations:

- We agree with the GMC that, post-Brexit, regulators should have the power to test the competence of European health professionals in the same way as they do for international health professionals.
- As they review how to update professional regulation, the Department of Health and regulators should consider whether there are opportunities to strengthen legislation and rules, especially around the display of doctor and dentists' credentials.
- The Government and GMC should also review whether there are ways to speed up assessments of equivalent qualifications for non-UK doctors given these may now increase in number.
- At a minimum, we would like to see the GMC mandatorily note on its register of doctors instances where a surgeon has acquired a credential in cosmetic surgery.

Foster research and innovation

The EU supports research in the UK by promoting researcher mobility and through different funding programmes. Horizon 2020, a research and innovation funding

[8] http://www.gmc-uk.org/news/27481.asp

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programme aiming to address societal challenges, such as 'health, demographic change and wellbeing', bears the greatest significance for health research, with UK organisations being the largest beneficiary of EU health research funds.

Although the College's research schemes will not be directly impacted in the short-term by the UK's exit from the European Union, surgical research may suffer in the longer-term. One of the College's objectives is to conduct a higher number of international surgical trials. Links with European neighbours are crucial to facilitating this and to exercising influence on the allocation of funds. Furthermore, many surgical researchers may be impacted by the wider effects on their institution's equipment and facilities from a fall in EU funds.

Our recommendations:

- The Government should send an unambiguous message that the UK welcomes international researchers and their contribution, as the country strives to maintain its position at the forefront of research and innovation. Any changes to migration laws should continue to permit international researchers to work alongside colleagues in the UK.
- The Government should continue to seek UK access to Horizon 2020, other key EU funding programmes, and medical research collaborations.

Facilitate organ transplantation

The EU Organ Donation Directives and the Tissue and Cells Directives aim to set minimum quality and safety standards of organ donation and transplantation and harmonised regulation of tissues and cells across all member states.

The Directives aim to help improve patient safety by facilitating the exchange of information, organs, tissues and cells across Europe.

The European Commission has tried to incentivise such exchanges and has committed to support member states in the development of a structured system for exchanges of surplus organs between them. It is possible that Brexit might hinder the country's access to shared information, its participation in future structured systems of organ exchange and, therefore, the chances of patients with low prospects of finding an organ. Furthermore, the European Union funds trials and research to advance organ preservation techniques, where UK medical devices companies and UK researchers take part.

Our recommendations:

- The Government should seek an agreement with the EU to ensure information and best practice on organ donation can still be shared.
- The UK should maintain the highest possible involvement with trials and research to advance organ preservation techniques and with

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possible future projects to exchange organs between EU countries.

Review competition law

Competition law affecting the NHS is primarily derived from the EU and much of this has been controversial along with the greater use of private providers and-not for-profits to provide services. In surgery, independent sector treatment centres have provided much needed extra capacity in the NHS, especially in orthopaedics, although in some cases they have disrupted training opportunities and undermined the sustainability of some hospital services when staff are transferred away. Any unwinding of EU competition rules will therefore need careful consideration.

A particular concern in the sector is how EU legislation has been interpreted to prevent mergers of some hospitals. For example, in 2013 the Competition Commission blocked a merger of Bournemouth and Poole hospitals on the basis it could be seen as anti-competitive under EU law. Some mergers can be beneficial to patients by making some services more sustainable.

Our recommendation:

- Any changes to competition law following Brexit should ensure competition happens on the basis of quality, not price, and where this benefits patients.

Northern Ireland

All of the areas outlined above will also impact on Scotland, Wales, and Northern Ireland. However, Northern Ireland is disproportionately affected by Brexit as it will have the UK's only land border with the European Union and the Northern Ireland HSC has a number of 'All-Island' health services it shares with the Republic of Ireland.

The UK Government has made positive noises about retaining an open border in Ireland to benefit trade, but it will nevertheless be important to monitor the impact of Brexit on cross-border health services and medical training. For example, through INTERREG – an EU programme funding cooperation between national, regional and local actors from different member states - the EU currently funds 12 major cross border health projects in the border region between Ireland and Northern Ireland, including acute hospital services for ear, nose and throat surgery, urology, and vascular surgery. In addition the programme has provided training for over 43,000 health and social care staff. While the funding for 80% of projects, originally provided by the EU, has now been transferred into core HSC and HSE funded activity by both respectively the Northern Irish and Irish Governments, future funding for planned cross border projects is uncertain. Health projects funded by the North South Ministerial Council, some of which are indirectly reliant on EU support also require consideration. The UK and Irish governments need to outline how they will

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deal with any potential funding shortfall for these services.

Our recommendation:

- The UK government should continue to support current and new arrangements which facilitate cross-border healthcare.

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