
CAVENDISH COALITION

SUBMISSION TO HEALTH SELECT COMMITTEE INQUIRY ON THE PRIORITIES FOR HEALTH AND SOCIAL CARE IN THE NEGOTIATIONS ON THE UK'S WITHDRAWAL FROM THE EUROPEAN UNION

Key points summary

- Many aspects of the UK's health and social care services have been influenced by European Union policies and legislation over the 45 years of the UK's membership of the EU. Depending on the settlement, the UK's exit from the EU could have a profound impact on the economy, our workforce and the delivery of services.
- This submission focuses particularly on the workforce challenges and opportunities, in line with the coalition's agreed focus:
 1. Supporting the economic as well as social health of the communities we work within, through the creation of opportunities for training and employment.
 2. Promoting employment policy and practice which ensures that the UK continues to be able to attract people with vital skills from Europe and around the world to work in social care and health.
 3. Seeking certainty for those already working in the UK by advocating for the right of the current health and social care workforce originating from European Economic Area (EEA) members to remain in the UK.
- It identifies two negotiating priorities:
 1. *To ensure that the UK can continue to recruit and retain much needed health and social care staff from the EU and beyond, whilst increasing the domestic supply.*
 2. *Offer certainty to existing EEA nationals working in the health and social care sector by agreeing 'right to remain' in the UK.*
- We also highlight the importance of the relationship between the EU and UK employment legislation and employment practice within the sector. The link between this and workforce supply across the sector, makes it a priority area for discussion alongside planning the external negotiating activity.

1. Training and employment

Negotiating priority: ensure that the UK can continue to recruit and retain much needed health and social care staff from the EU and beyond, whilst increasing the domestic supply.

- 1.1. At present, the sustainability of some health and social care services is a major problem: insufficient staff, including nurses, doctors and physiotherapists are being trained and retained. This puts an unacceptable pressure on all health and social care staff and threatens the delivery of essential services.
- 1.2. EU nationals are providing a vital contribution in our sector and helping to fill the persistent shortages in the UK workforce. There are currently approximately 167,500 EU nationals known to be working in social care and public and independent health organisations across England alone, with EU staff also working in services in Northern Ireland, Wales and Scotland.
 - 90,000 in adult social care in England
 - 58,000 in the NHS in England
 - 13,500 in independent health organisations.

Specific sector and occupational detail is described in paragraphs 1.11 to 1.22.

- 1.3. Expansion of training places and exploring other development opportunities need to be central to a domestic strategy. Additional domestic efforts need to include engaging fully across local communities to encourage and attract individuals into health and social care employment, improving retention of current staff and ensuring employment practice supports efforts to be an employer of choice.
- 1.4. We recognise that the health and social care sector cannot plan for the future on the basis of an ever-increasing workforce who will simply not be available in sufficient numbers.
- 1.5. Employers are already looking at ways in which to make best use of all available staff and reconsidering the way in which services are provided. The sustainability and transformation plans in England currently being drawn up will look at the health and social care needs of local populations and at how integrated care can best be designed to meet future needs in a realistic and sustainable manner.
- 1.6. However there is a gap in workforce supply in many parts of the sector which requires the ability to attract and retain staff from the EU and beyond.
- 1.7. Ensuring the ability to attract and retain staff from outside of the UK is not just simply about ensuring that the UK's migration system enables continuing inward recruitment from the EU and overseas. Staff from outside the UK will also have concerns about, for example, social protection rights and portability of benefits such as pensions if EU-wide rules no longer apply.
- 1.8. Those professions with mutual recognition of qualifications across Europe could also be impacted by any changes to recognition arrangements which allow them to practise in the UK.
- 1.9. Economic factors such as the exchange rate will also influence people's decisions about whether to migrate and if so to which other countries. Negotiations will need to take these factors into account.

1.10. The following section provides specific occupation detail.

Nursing

1.11. The number of EU/EEA nurses has been rising over the last ten years,¹ 5 per cent of nurses currently on the Nursing and Midwifery Council (NMC) register trained within the EU and 10 per cent trained outside the EU - this equals more than 33,000 EU trained nurses.² In spite of their vital contribution and the UK's proactive recruitment, EU/international nurses are not a substitute for a sustainable domestic supply - as evidenced by the continued existence of over 23,000 nursing vacancies in England, Wales and Northern Ireland and a 3.6 per cent vacancy rate in Scotland.³

1.12. Nursing remains on the Home Office shortage occupation list for the short-term given the immediate shortages - thereby facilitating recruitment from outside the EU. The Migration Advisory Committee report provides substantial detail and recommendations following their review of the issues around shortage of nurses.⁴

Midwives

1.13. In maternity services, EU nationals made up 6 per cent of NHS midwives in England in July 2016, expressed as a full-time equivalent figure.⁵ This rose as high as 19 per cent in the area covered by Health Education North Central and East London and 17 per cent in the Health Education North West London area.

Doctors

1.14. Doctors from the EU and across the globe play a crucial role in the delivery of care. Without them the current significant rota gaps would be further exaggerated leaving service sustainability increasingly vulnerable. Around 10% of doctors working in the NHS and 6.6 per cent of the UK medical workforce received their medical qualification in other EU countries.⁶

1.15. Research between 2014-2015 shows that 40 per cent of advertised consultant vacancies remained unfilled; the most common reason was due to a lack of suitable candidates.⁷ This is significantly impacting on the ability of doctors to deliver high quality care for patients. 28 per cent of consultants have reported 'significant gaps in the trainees' rotas such that patient care is compromised'. Together with a shortage of nurses, this has left our healthcare providers at risk of being understaffed.⁸ This increases pressure on staff, impedes morale and puts patient care at risk.

¹ UK nursing labour market review 2015, RCN, p.10, https://www2.rcn.org.uk/data/assets/pdf_file/0005/649922/RCN_Labour_Market_2015.pdf

² NMC freedom of information request, June 2016.

³ Royal College of Nursing Evidence to the NHS Pay Review Body 2017-18, <https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2016/september/005803.pdf>

⁴ Migration Advisory committee News Release, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/510626/MAC_press_release_on_nurses_report.pdf

⁵ Information in this paragraph based on numbers released to the RCM after a request to NHS Digital; email from NHS Digital dated 25th October 2016.

⁶ http://www.gmc-uk.org/doctors/register/search_stats.asp

⁷ Federation of the Royal College of Physicians of the UK. *Census of consultant physicians and higher specialty trainees in the UK 2014-15*. London: Royal College of Physicians, 2016

⁸ Institute for Employment Studies. *One in three nurses to reach retirement age within ten years*. Brighton: IES, 2016. www.employment-studies.co.uk/news/one-three-nurses-reach-retirement-

1.16. The government has announced it is to raise numbers of medical training places by 1,500 in order to increase the supply of UK trained doctors and reduce reliance on doctors from overseas, including EEA countries, with an end of goal of the UK being 'self-sufficient' in doctors⁹. Recognition of workforce shortages is to be welcomed, however, the value of an international workforce, bringing together skills and experiences from across the world enhances the medical workforce and should continue to be encouraged as well.

Dentists

1.17. EU nationals play a significant role in UK dentistry, both NHS and private. Within the overall sector 17 per cent of dentists come from other EU member states. However, they are of particular importance in delivering NHS dentistry, not least because there are increasing problems over the supply of NHS dentists and other trained staff in a number of regions of the country. Further data collection on the number of dentists and other dental staff in active practice is required but the most recent independent estimates show that 6816 dentists from other EU countries were on the General Dental Council (GDC) register at the end of 2015. Around 670 other skilled dentistry workers are also on the GDC register.

Pharmacy

1.18. Pharmacy was recognised as a shortage occupation by the Migration Advisory Committee (MAC) in 2009 but removed from the Shortage Occupation List in 2011 following significant efforts to address the national shortage. However, it is regularly reported that local recruitment and retention issues continue to exist which place pressure on the appropriate delivery of services in certain parts of the country (for example the South West of England).

Physiotherapy

1.19. The gap between the demand for trained physiotherapists and the numbers trained and available, particularly in England, has led to a growing reliance on physiotherapists from overseas, including from the EEA¹⁰. Figures from the Health Care Professions Council (the regulator) shows that as of October 2016 there are 7088 (13.7 per cent) physiotherapists registered to work in the UK who were trained outside of the UK, of which 3652 (7 per cent of all HCPC registered physios) qualified in the EEA .

1.20. There is a current shortfall in physiotherapists, creating capacity issues now and storing up problems for the future as demand grows. Annual surveys of physiotherapy managers in 2015 and 2016 have revealed widespread difficulties in recruitment. The Chartered Society of Physiotherapy workforce modelling¹¹ shows that at least an additional 500 physiotherapy student places a year are needed every year for the next three years to keep pace with changing population needs.

⁹ Secretary of State for Health, Rt Hon Jeremy Hunt speech to Conservative Conference, 4 Oct 2016

¹⁰ The Health and Care Professions Council. FOI Disclosure Log; London, The Health and Care Professions Council; 2016. <http://www.hcpc-uk.co.uk/aboutus/foi/disclosurelog/>

¹¹ The Chartered Society of Physiotherapy. The Workforce Data Model; London, The Chartered Society of Physiotherapy; 2016. <http://www.csp.org.uk/professional-union/practice/evidence-base/workforce-data-model>

Social Care

1.21. Skills for Care and Independent Age have both published data on the proportion of the adult social care workforce that is from outside the UK, including both EU/EEA nationals and non-EU/EEA nationals. Skills for Care estimates that in 2015/16, those with non-British EU nationality made up 7 per cent of the adult social care workforce, equating to around 90,000 jobs.

1.22. EU workers were more highly represented for regulated professional roles, accounting for 11 per cent (7,500 jobs) of these jobs, whereas managerial roles had the lowest percentage of EU workers (4 per cent; 5,000 jobs). Between 2014/15 and 2015/16 the number of adult social care jobs filled by EU (non-British) workers increased by an estimated 10,000 (the proportion of all adult social care jobs filled by EU workers increased from 6 to 7 per cent). This points to nursing in social care being particularly affected by the loss of EEA staff and highlights a major risk to care provision in future.

It is estimated that 5 per cent of social workers have an EU (non-British) nationality. That equates to around 900 social workers in total.

1.23. **For the long term, the UK needs:**

- ***a robust domestic health and care workforce strategy to help reduce dependence on both EU and international recruitment***
- ***to ensure that we are training sufficient staff with the right skills and supporting them to reach their full potential and retain them in health and social care***
- ***to recognise the contribution that overseas staff make to our services now and will continue to do in the future.***

2. **Preserving the rights of EEA nationals working in the sector**

Negotiating priority: Offer certainty to existing EEA nationals working in the health and social care sector by agreeing 'right to remain' in the UK.

2.1 The immigration system that is in place after the UK leaves the EU will need to ensure that, alongside our domestic workforce strategy, it supports the ability of our sector to provide the best care to our communities and people who use our services. Our workforce provides care and support to increase people's independence, to prevent ill health and unnecessary hospital admission and to care for people when they are most vulnerable.

2.2 To achieve this is to give the right to remain in the UK to EU nationals currently working in the health and social care sector. The current rules for obtaining a permanent residence card require the individual to have been living in the UK for five years. To ensure stability in the social care and health sector, this would need to be changed to ensure it was applicable to all staff, regardless of how long they have been in the UK. Generally, any approach to changing the system needs to be evidence-based and take into account the scale of the impact of different options on different sectors.

- 2.3 Whatever immigration model is adopted and agreed as part of the negotiation and extrication process, it must be flexible enough to allow the health and social care systems and employers to recruit appropriately from outside of the UK to fill workforce shortages and maintain services.
- 2.4 A key element to retaining staff from other EU countries is also ensuring that those EU nationals working in our health and social care sector are made to feel valued and welcomed.
- 2.5 As a coalition we have been deeply concerned by the reports of increased levels of racial hatred and xenophobic remarks that some in our employment and local communities have experienced. Many of our organisations have taken steps to address this.
- 2.6 ***Quickly confirming the right to remain for EU nationals currently working in health and social care across the UK removes the uncertainty and anxiety for individuals and their families and mitigates the risk of staff leaving. Agreement on these rights, including any 'cut off' period post Brexit, need to be communicated in a way that actively supports community cohesion.***

3. Legislation, employment policy and practice – impact on current and future workforce

Priority area: Understanding the relationship between the EU and UK employment legislation and employment practice, and its impact on the workforce is critical. Unlike the two priorities described above, we recognise UK employment law and policy is not an issue for external negotiation.

It is however a priority issue for the UK Government to discuss and agree a way forward with partners that has a positive impact on individuals, employers and promotes good employment practice.

- 3.1 A substantial proportion of UK employment law originates from the EU and provides important protections for health and social care staff, in particular, rules on health and safety at work, information and consultation on collective redundancies and safeguarding employment rights in the event of transfers of undertakings (TUPE).
- 3.2 The EU's key health and safety related directives provide a legal framework for employers to reduce the risks of musculoskeletal disorders (MSDs), biological hazards, stress and violence to health and social care staff. MSDs and stress are particularly prevalent in the nursing workforce and the main cause of sickness absence in the sector and, arguably, without the directives the situation would be worse. The implementation of hoists and other lifting equipment, as required by the Manual Handling Directive, has been proven to significantly reduce the risks for health and social care staff and the people they care for.^{12 13}

¹² Health and Safety Executive (2002) *Second Evaluation of the Manual Handling Regulations (1992) and Guidance*. HSE Books: Sudbury

¹³ Health and Safety Executive (2003) *Evaluation of the implementation of the use of work equipment directive and the amending directive to the use of work equipment in the UK*. HSE Books: Sudbury

- 3.3 The NHS and care sector has seen significant changes in recent years, which has led to a growth in independent providers of publicly funded health and care services as well as the transfer of staff working in public health in England from the NHS to local government. Health and social care staff who ensure continuity of care and service provision during these reforms are currently not disadvantaged in terms of working conditions and employment benefits if their employer changes.
- 3.4 The EU's TUPE legislation provides legal protection to staff when such reconfigurations take place. Through cross industry 'social dialogue' negotiations agreements have also been reached, and adopted as EU directives, to ensure part-time workers, of which there are many in the social care and health sector, and those on fixed term contracts are treated no less favourably than full time permanent employees, in terms of leave, and access to training, for example.

Cavendish Coalition
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About the Cavendish Coalition

The Cavendish Coalition is a group of social care and health organisations united in their commitment to provide the best care to their communities, patients and residents.

The coalition recognise that the talented and diverse group of people we all employ and represent are central to the success of that commitment, and that these individuals from the UK, Europe and across the world make a vital contribution to delivering care to the UK's population.

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

The Cavendish Coalition is made up of 31 health and social care organisations all committed to the purpose of the group, these are:

- Association of Dental Groups, David Worskett, Chair
- Association of Directors of Adult Social Services, Margaret Willcox, Vice President
- Academy of Medical Royal Colleges, Professor Dame Sue Bailey DBE FRCPsych, Chair
- Association for Real Change, Lisa Lenton, England Director
- Association of UK University Hospitals, Peter Homa CBE, Chair
- British Medical Association, Dr Mark Porter, Council Chair
- Care England, Professor Martin Green OBE, Chief Executive
- Care and Support Alliance, Vicky McDermott, Chair
- Chartered Society of Physiotherapy, Karen Middleton CBE, Chief Executive
- Mental Health Network, Rebecca Cotton, Director of Mental Health Policy
- National Association of Primary Care, Dr Nav Chana, Chairman

- National Care Association, Nadra Ahmed OBE, Chairman
- New NHS Alliance, Merron Simpson, Chief Executive
- NHS Clinical Commissioners, Julie Wood, Chief Executive
- NHS Confederation, Stephen Dalton, Chief Executive
- NHS Employers, Daniel Mortimer, Chief Executive
- NHS European Office, Elisabetta Zanon, Director
- NHS Partners Network, David Hare, Chief Executive
- NHS Providers, Chris Hopson, Chief Executive
- Northern Ireland Confederation for Health and Social Care, Heather Moorhead, Director
- Pharmacy Voice, Elizabeth Wade, Director of Policy
- Registered Nursing Home Association, Frank Ursell, Chief Executive
- Royal College of Nursing, Janet Davies, Chief Executive & General Secretary
- Shelford Group, Sir Michael Deegan, Chair
- Skills for Care, Sharon Allen, Chief Executive
- The National Care Forum, Vic Rayner, Executive Director,
- The Royal College of Midwives, Professor Cathy Warwick CBE, Chief Executive
- The Welsh NHS Confederation, Vanessa Young, Director
- UNISON, Christina McAnea, Head of health
- United Kingdom Homecare Association, Bridget Warr CBE, Chief Executive
- Voluntary Organisations Disability Group, Professor Rhidian Hughes, Chief Executive