

BREXIT AND THE HEALTH & SOCIAL CARE WORKFORCE IN THE UK

EXECUTIVE SUMMARY

Prepared for Cavendish Coalition for the project

“Incentivising the domestic workforce and securing clear, reasonable routes for immigration both during and after the UK’s exit from the EU”

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Executive summary

The UK's H&SC workforce is under considerable strain to provide services for an ageing population with increasingly complex needs. While many of the problems supplying new recruits into the sector pre-date the 2016 Brexit referendum, the vote to leave the European Union (EU) has added another layer of challenge and uncertainty for planning this future workforce.

This report examines recent trends in the UK's H&SC workforce and the critical role of EEA nationals within it. This is a vital issue because the vote to leave the EU and ongoing uncertainty regarding any deal between the UK and EU, will undoubtedly impact on their decision whether or not to stay with significant implications for the sector. It can also impact the decision of EEA nationals to move to the UK in the future.

Below we present a number of key findings and recommendations. These are designed to ensure that Brexit works in the interests of patient care, and to make sure that the H&SC sector is able to secure the skills and people it needs to continue to provide good care going forward.

Our key findings are:

1. In the UK a little over 5% of the regulated nursing profession, around 9% of doctors, 16% of dentists and 5% of allied health professionals were from inside the EEA. Not only are they a sizeable component of the workforce, the patterns of their numbers and their composition by occupation and geography has changed rapidly since the 2016 Brexit referendum.
2. While the contribution of EEA nationals to the NHS is important, it is arguably even more so in social care services across the UK. In 2016, EEA nationals made up 5.4% of the workforce, though in absolute terms their number grew by 68%, or 30,600 individuals, since 2011. Interestingly the strongest growth was in Northern Ireland (206%), followed by Scotland (61%), Wales (56%) and then England (40%).
3. By examining the pattern of leavers and joiners to the NHS over the year prior to June 2016 and the year post June 2016 we were able to estimate what might happen to the overall numbers of doctors and nurses going forward. Our model suggests that in the short run, the UK may have an additional shortage of around 2,700 nurses. Projecting this shortfall over the remaining period of Brexit transition to 2021 we suggest that there may be a shortfall of around 5,000-10,000 nurses (in addition to current vacancies).
4. Our stakeholder engagement strongly suggests that EEA nationals are more likely to work in specialties and locations with weak domestic supply. EEA doctors are well-represented in shortage specialties and there are regional differences in the reliance on EU nationals.
5. We have found that waiting times tend to increase in NHS Trusts which are losing EEA workers (particularly nurses). While inference based on statistical data is subject to caveats,

it is reasonable to suggest that if hospital staff is turning over more quickly, then we would expect that patient outcomes deteriorate.

6. Challenges around developing a sufficient workforce supply pre-date the referendum. However, turnover is reported to have increased since the vote in June 2016. This includes a large fall in job applications in nursing, dentistry and allied health care professions, as well as increased turnover in social care.
7. In addition to this, Government-led reforms to education and training routes have driven down applications to study nursing in the UK by more than 20% since 2016, while applications to read medicine have also fallen by 10% since 2016.

Our recommendations are:

1. **The UK and devolved Governments' must urgently review their workforce planning approaches across the Health and Social Care (H&SC) sector.** Planning needs to recognise that public, private and third sectors form a common system and common labour market. It also needs to recognise that supply has to be sufficient to meet the whole system need and not focus solely on NHS employers. While we acknowledge the devolved responsibility for delivery of services, we would highlight that data, analysis and planning at country level appears to be insufficient and this makes effective planning very challenging.

A number of measures currently in place have the potential to increase future supply to professional occupations. These include investing to expand medical school places and providing additional funds to support clinical placements for nursing, midwifery and physiotherapy. However, other policy decisions, such as replacing the bursary system with student loans and inadequate funding mechanisms for apprenticeships in England for example may need to be reviewed. It appears from our review that there are few significant efforts currently active to increase supply in social care.

Increased efforts could also be made to encourage back individuals who have left H&SC work. This might include formal return to work schemes, encouraging agency workers to move into permanent roles or by providing more opportunities for flexible working. In the social care sector, more access to training could improve the attractiveness of the job offer and small employers may need to find imaginative ways of providing this. These measures could also help bolster any additional recruitment activity targeting specific community groups.

Finally, international recruitment should form part of a costed, holistic workforce strategy. Occupations in health and social care should be acknowledged as being in shortage and therefore any future immigration system needs to cover recruitment from the EEA and outside at all levels of skill. However, the UK Government and employers should not presume that the UK's significant shortfall of H&SC workers can simply be met by hiring them from outside the UK and that more effective ways of sourcing skills through the domestic pipeline need to be developed.

2. **Any future immigration system needs to be uncomplicated to operate.** It should also be transparent and cost effective for applicants, responsive to the changing health needs of the population and agile to meet the needs of employers. At present, many H&SC jobs do not fulfil the requirements for the minimum skills or salary levels of the current non-EEA immigration system. If a future immigration system is to be modelled on the current non-EEA system, it will need to acknowledge the value and contribution of the H&SC workforce and adjust skill and salary levels accordingly to minimise any further detrimental impact to workforce supply.

In addition to reviewing how Tier 2 works for employers in health and social care we suggest that the post-study route also needs to be reviewed. It currently has significant restrictions which limit the ability for skilled individuals to access the UK labour market. International students are a valuable source of talent and their skills could be harnessed by health and social care employers.

3. **The Home Office should guarantee that its settled status programme for EU nationals will be honoured in the event of a no-deal Brexit.** Stemming the outward flow of EU nationals could be achieved by strengthening assurances about their long-term right to settle in the UK. Health and social care employers also need to consider ways in which they could help EEA staff (and other non-UK nationals) to apply for settled status, leave to remain or citizenship.
4. **All levels of Government should work together to review career routes within social care.** In particular, we would advise that they look into the potential for opening up routes from support and social care roles into nursing and allied health professions.
5. **Professional regulators should regularly review their processes for registering international professionals.** This needs to ensure that they are proportionate and do not unnecessarily hinder international recruitment.
6. **The UK and devolved Governments' should introduce measures to monitor and address the decline in the number of applications to medical schools.** This holds for UK and EU applicants, though the decrease is sharpest for prospective EU students. Applications to training places need to be monitored and action taken to mitigate changes which may have a negative impact on future supply of the workforce.