# Response to the Migration Advisory Committee's (MAC's) Call for Evidence on European Economic Area (EEA) and non-EEA migration

## Introduction

1.1 The Royal College of Nursing (RCN) welcomes the opportunity to respond to this Call for Evidence from the Migration Advisory Committee (MAC) looking at the economic and social impacts of recent immigration from the European Union (EU), and how immigration policy going forward can align and support a modern industrial strategy as the UK prepares to leave the EU.

## Structure of our response

2.1 For purposes of ease, and in line with the MAC's request, we have only answered those questions where we have a position and evidence to underpin this.

2.2 Some of our responses overlap in terms of their focus, so we have grouped questions with a common theme together with a comprehensive answer and supporting evidence. These are:

- **The numbers and skills of European Economic Area (EEA) nationals currently coming into the UK;**
- **The impact of changing immigration trends; and**
- **Future reform of the UK's immigration system for non-EEA workers.**

2.3 We welcome queries or calls for further clarification from the MAC regarding any of the data and/or analysis contained in this response.

## Summary of our key points

3.1 In the context of nursing, we challenge the position presented in the accompanying note to this Call for Evidence that the EEA workforce is low-skilled, or has become increasingly low-skilled over time. Nursing and midwifery professionals are highly skilled and the number of EEA nationals entering these roles has grown over recent years.

3.2 Despite this contribution, the nursing workforce across the UK is facing a protracted workforce crisis – both in terms of supply and retention. This is because increasing numbers of UK, EEA and non-EEA nationals are leaving the nursing profession before reaching retirement age, with fewer new joiners coming in to replace them.[i] Between

July 2016 and July 2017 there has been a 180% fall in the number of new EEA nurses coming to the UK.[ii]

3.3 This decline is putting the UK's existing nursing workforce under even more pressure than it was previously, as evidenced by over 40,000 nursing vacancies in England (more than double what it was three years ago)[iii] and a rising vacancy rate in Scotland.[iv] Insufficient staffing levels for safe and effective care are compounded by the absence of credible workforce strategy in every country of the UK and piecemeal efforts by policymakers to improve retention of current staff through obvious levers such as pay.

3.4 To help the UK move towards a stronger focus on developing its domestic nursing workforce, we believe that a transition period immediately after Brexit of up to four years is needed. During this time the UK health and care sectors should be able to continue to recruit internationally educated nurses as they currently are, to maintain service levels while simultaneously shifting its focus and investment to this area.

3.5 Achieving this transition will require the Government, employers and all parts of the sector to act on the observed offered by the MAC in 2016 which added nursing to the Shortage Occupations List (SOL).[v] The MAC was clear that the present nursing shortage is mostly down to factors that could, and should, have been anticipated by policymakers.

3.6 Reporting in 2016 the MAC said that: *"The restraint on nurses' pay instituted by the government was presented to us, and in the evidence to the pay review bodies, as an immutable fact. It is not. It is a choice."*

3.7 We agree that addressing pay has, to date, been ignored by the Government as a viable lever to improve recruitment and retention. The Government therefore needs to make a conscious political decision to change its position, lift the public sector pay cap and give the nursing community an-above inflation pay rise to begin to close the gap. This should be funded further to the existing financial envelope.

3.8 On the use of overseas nurses, the MAC said: *"There seems to be an automatic presumption that non-EEA skilled migration provides the sector with a 'Get Out Of Jail, Free' card and that there is a historic pattern of peaks and troughs to the supply of migrant nurses. This pattern offers, at least highly suggestive indications that migrant nurses have been used to save costs."*

3.9 The UK currently trains 42 nursing graduates for every 100,000 people in the UK which is substantially lower than the average of 47 across the Organisation for Economic Co-operation & Development (OECD).[vi] We agree that while the UK has benefitted enormously from the contribution and commitment of overseas nurses, international recruitment has often been used as a substitute for Government investing adequately

in growing the domestic workforce. This is essential for enabling employers to recruit from within the UK.

3.10 The ability of employers to incentivise more UK-trained nationals into the health and care sector is dependent on the funding envelope given by Government. To that end, Government holds primary responsibility for giving employers the resources they need to help change this situation. This is particularly crucial in light of the accountability Government should hold for ensuring that there is sufficient workforce to ensure safe and effective care for both patient safety and public protection.

3.11 The present state of the nursing workforce highlights a clear lack of oversight, strategic planning and accountability for workforce supply, especially in response to demand. We believe that this can be remedied, in part, through legislation for the provision of safe and effective staffing where it does not currently exist.[1] Such legislation needs to clarify accountability and responsibility politically, nationally and locally for:

- A credible and robust workforce strategy across health and care;
- Adequate funding for provision of this workforce (above and beyond existing service envelope);
- Total transparency in data definition, collection, monitoring and reporting, irrespective of provider and setting; and
- Mandatory centrally collected data for service activity and workforce in all publicly funded health and care settings, irrespective of provider or sector.

3.12 In terms of future immigration reform, we have previously expressed concern about some aspects of the Tier 2 visa system, particularly the overemphasis on salary levels for prioritising visas, rather than wider benefits to the economy, society and health of some highly skilled professionals, such as nurses. We do not recommend any radical changes to the non-EEA immigration system until the UK's settlement and future cooperation agreement with the EU is clear - particularly in relation to free movement of labour.

3.13 We also believe that a transition period following Brexit is necessary in order to preserve the benefits of common EU standards for training and recognition of qualifications through the Professional Qualifications Directive 2013/55/EU.

[1] We believe that having a law related to nurse staffing is the only way to put a legal duty on governments, agencies and providers to ensure local and national accountability for safe and effective staffing. Wales introduced the Nurse Staffing Levels (Wales) Act in 2016. Following a period of consultation, implementation guidance is due later this year. The Welsh Government has committed to extending the legislation to further settings. Following its consultation on a proposed Safe and Effective Staffing Bill, the Scottish Government has confirmed it is intending to bring forward legislation on staffing. However at the time of writing, the scope of the Bill is unclear. Northern Ireland and England have no legislation relating to nurse staffing levels.

3.14 This Directive has enabled mobility, helped raise educational standards and put safeguards in place across Europe. It also includes language checks on EU nurses and a duty to inform other health regulators about suspended or banned professionals, both of which are important and positive developments for the UK. We are concerned that a potential disassociation from these jointly developed standards could lead to a loss of safeguards, loss of access to alert mechanisms, and other exchange between regulators and potentially much slower recognition mechanisms for both inward and outward mobility.

3.15 We recognise that impending change also presents an opportunity to align regulatory requirements and recruitments routes between EU/EEA and the wider international workforce, in particular within the context of the necessary development of a coherent UK workforce strategy for health and social care. The Directive also currently sets the minimum training standards, including the split between theory and practical hours to qualify registered nurses. In the context of a continued need to help meet the demand for registered nurses in the UK from external sources, any changes to existing arrangements must be considered carefully and any future proposals be evidence-based, evaluated for potential positive and negative impact, and risk appropriately mitigated.

## Detailed submission

**4. Numbers and skills of EEA nationals coming into the UK. This covers the following questions asked by the MAC:**

- *Please provide evidence on the characteristics (e.g. types of jobs migrants perform, skill levels etc.) of EEA migrants in your sector. How do these differ from UK workers?*

- *What information do you have on their skills levels? To what extent do these differ from UK and non-EEA workers?*

**Our answer and evidence**

4.1 In the context of the health workforce, the EEA workforce has become more highly-skilled, not less. This is underscored by the growth of EEA nationals in the registered nursing workforce roles and by the rise of UK nationals deciding to leave these roles before reaching retirement age.

4.2 In the health sector a very significant portion of the EEA workforce falls under the EU's Professional Qualifications Directive (PQD) which stipulates common training and education standards across the EU for a number of regulated, highly-skilled professions including Registered Nurses and doctors. The UK Government also recognises Registered Nurses as highly skilled, degree-trained professionals.[vii] More

robust and comprehensive data is available on this part of the workforce and so we have focused on this.

4.3 The number of EEA migrants entering the regulated nursing profession has grown significantly over recent years. We also know that the same is true of other highly skilled professions such as doctors, who also fall under the EU mutual recognition of qualifications regime.

4.4 Data collected shows that in the NHS in England, EEA nationals are overwhelmingly concentrated in highly-skilled roles. Unfortunately comparable data from Scotland, Wales and Northern Ireland is not available. As of December 2016 nearly 10% of all doctors in the UK had EEA citizenship. The equivalent figure for nurses and health visitors was 7.4%. By contrast, only 3.6% of support staff were from the EEA and only 3.9% of infrastructure support staff were from the EEA.[viii]

4.5 Measured since 2009, the trend of EEA migration into the highly skilled sections of the health sector has been one of growth while non-EEA migration has been in decline. Today there are substantially fewer nurses from many non-EEA nationalities than in 2009. To take a few examples, over 36% of all Zimbabwean nurses in the UK left the Nursing and Midwifery Council (NMC) register between 2009 and 2017. The number of South African nurses declined by 51% over the same period, while Malaysian nurses fell by 46% and Australian nurses by 37%.[ix] There have also been large reductions of nurses of Philippine, Indian and Nigerian nationality.

4.6 This has occurred in parallel to a surge in EEA nationals over the same period. The number of registered nurses/midwives of Portuguese origin, for example, has risen from 210 to 3,621 (an increase of 1,724%), the number of Italian nurses has risen from 192 to 2,780 (an increase of 1,447%), and the number of Spanish nurses has risen from 406 to 4,657 (an increase of 1,147%).[x]

4.7 In terms of skills, EEA nationals who work in the UK as registered nurses and/or midwives have to evidence that they have comparable qualifications and advanced competency in English in order to register with the NMC.[xi] In addition to this, once they join the register they have to revalidate every three years in order to maintain their registration. A mandatory part of this process is the acquisition of at least 35 hours of continuing professional development (CPD) to ensure that their skills-sets are continuously improving.[xii] This is a legal requirement in order to legally practice, and mirrors the regulatory approach for doctors and other highly-skilled professional groups.

4.8 NMC data shows that since 2012/13 the number of UK-trained registrants leaving the nursing and midwifery profession has increased from 19,819 to 29,434 (a rise of 48%).[xiii] In tandem, data from NHS Digital indicates that the number of senior nursing roles in acute, elderly and general care settings in England has grown slightly over the

same period, with Nurse Manager positions for example increasing from 3,200 to 4,162 and Nurse Consultants from 501 to 513.[xiv] This is a speculative point because drill-down data on where EEA nurses are within the system and their seniority is non-existent. However, it is possible that as more UK nationals leave the nursing profession more EEA nationals will have to step in to fill these senior positions. These roles will require even more advanced skills around leadership, communication, management of staff and budgets.

4.9 To address this lack of more detailed data, we repeat our call in our submission to the MAC's 2016 Review of the Shortage Occupations List (SOL) that improved collection of comparable workforce data across and within the health and social care sector in each country of the UK be mandated in order to provide a more accurate picture of what the workforce looks like, irrespective of type of health and care provider (public and independent) and across settings.[xv] Without this, meaningful and credible workforce strategy and planning for the health and care is not really possible, nationally or locally.

**5. Impact of changing immigration trends. This covers the following questions asked by the MAC:**

- *Have the patterns of EEA migration changed over time? Are these trends different for UK workers and non-EEA workers?*

- *Have you conducted any analysis on the future trends of EEA migration, in particular in the absence of immigration controls?*

- *Are there any relevant sources of evidence, beyond the usual range of official statistics that would allow the MAC to get a more detailed view of the current patterns of EEA migration, especially over the last year?*

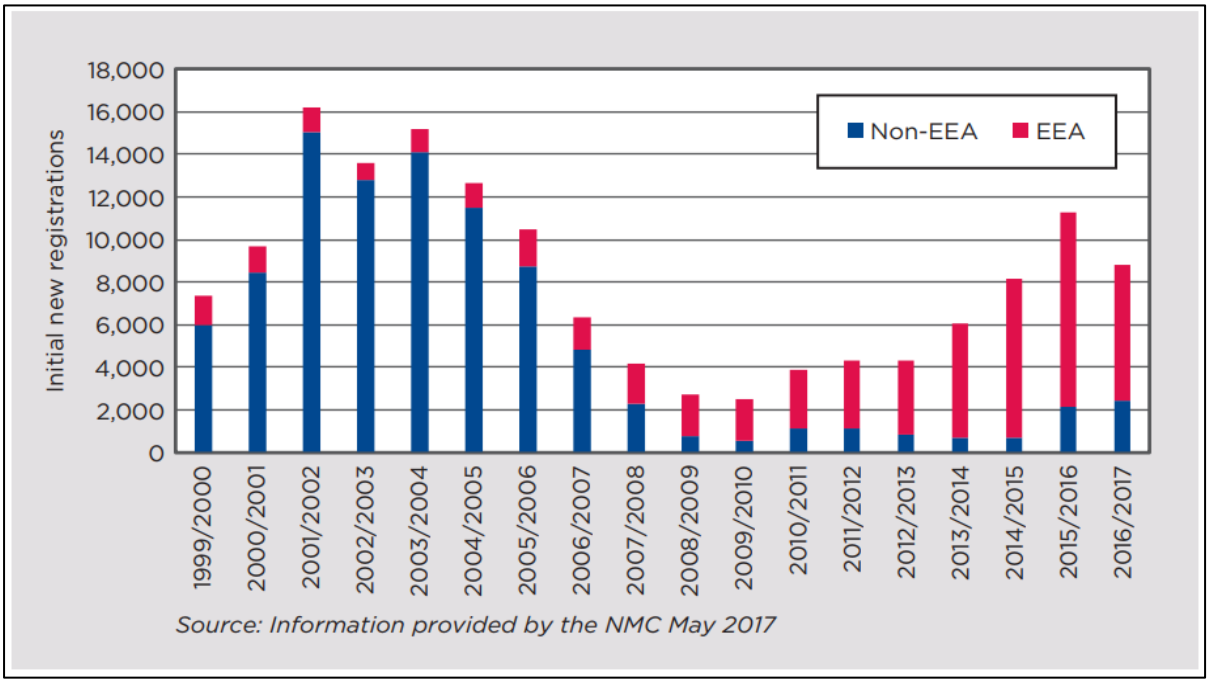
- *Have you made any assessment of the impact of a possible reduction in the availability of EEA migrants (whether occurring naturally or through policy) as part of your workforce? What impact would a reduction in EEA migration have on your sector/local area/region? How will your business/sector/area/region cope? Would the impacts be different if reductions in migration took place amongst non-EEA migrants? Have you made any contingency plans?*

**Our answer and evidence**

5.1 Historical NMC data shows that over the last decade the number of nurses educated/trained in the EEA coming to work in the UK has grown significantly - both in terms of absolute numbers and as an overall percentage of the registered nursing population.

5.2 In 2013, EEA nationals comprised 2.4% of the NMC register (16,798 individuals). By 2015 this had risen to 3.9% (27,012 individuals) and the latest data for 2017 now shows this to be 5.5% of the register (38,024 individuals).[xvi] The below graph shows how this change has developed since 1999/2000.

**NMC register broken down by EEA (excluding UK) and non-EEA new joiners 1999-2017**




5.3 NMC data also shows that for the first time in many years there are now more nurses and midwives leaving the register than joining. Between 2016 and 2017, 20% more registrants left the register than joined it. This compares to previous years when there were more joiners than leavers. The primary driver for this shrinking of the registered workforce has been UK nationals exiting before reaching retirement age. The data also shows that the average age of those leaving the register has reduced significantly from 55 years of age in 2013 to 51 years of age in 2017. In addition, EEA nationals and non-EEA nationals are also leaving the register in greater numbers[xvii]:

- The numbers of UK nationals leaving the register increased from 19,819 in 2012/2013 to 29,434 in 2016/2017 (a rise of 48%);
- The numbers of EEA nationals leaving the register increased from 1,173 in 2012/2013 to 3,081 in 2016/2017 (a rise of 162%); and
- The numbers of non-EEA overseas nationals leaving the register has increased from 2,095 in 2012/2013 to 2,426 in 2016/17 (a rise of 15%).

5.4 Importantly this data also identified some of the key reasons why EEA nationals were leaving the register. Of those asked, 58% said that they were already planning to leave the UK anyway regardless of Brexit, 32% said that Brexit had encouraged them to leave and 32% said that poor working conditions, i.e. staffing levels and workload had persuaded them to leave.[xviii] This represents a significant material loss to the nursing profession and shows that not enough is being done to retain both UK and EEA nationals already in the sector.

5.5 This trend is also evidenced from other data sources. Since May 2015 the number of new EEA nationals entering the nursing workforce has been falling, while the numbers leaving has increased.[xix]

5.6 This represents a potentially significant trend. Between 2013 and 2016 the registered nurse population in the UK grew from 645,362 to 659,310 (an increase of 2.1%). To date in 2017, this has fallen to 656,219.[xx] It is possible that this is a temporary dip and that numbers may recover as new nursing graduates enter the workforce in the autumn of 2017. However we believe that this is unlikely (see section 5.7 onwards) and that the risk of a long term decline in nursing numbers is significant because international recruitment from both the EEA and non-EEA shows signs of plateauing at the same time as challenges around recruiting and retaining UK-trained nationals remain fundamentally unresolved.

5.7 To increase the supply of nurses, in England the UK Government has prioritised expanding the range of routes into nursing, such as the new nursing degree apprenticeship scheme, as well as the nursing associate role. This has also taken place alongside the decision to remove publically-funded nursing degree courses. In totality, these decisions have been developed with no coherent strategic approach and minimal investment to the level and quality required for patient safety and public protection. A direct consequence of this is that while, on paper, the number of opportunities to become a registered nurse have increased, there is currently insufficient capacity in the system to provide adequate clinical-training time and mentorship provision for this intended growth of the workforce – and critically, insufficient capacity for Governments across the UK to be assured of the health and care systems ability to deliver both patient safety and public protection.

5.8 To explain this in more detail for England, where reform has been significant, before 2017 both tuition and clinical placements for nursing training were centrally commissioned by the Department for Health (DH) through Health Education England (HEE). Since August 2017 bursaries for degree training were replaced with standard loan-based tuition fees. This has effectively decentralised the commissioning of higher education places to grow the registered nursing workforce.

5.9 In the previous system, Government set a financial limit for funding of tuition and clinical placements (a core requirement to meet standards). NHS organisations annually told HEE how many new nurses they were likely to need. This was primarily calculated on the basis of how many nursing staff each local organisation could afford to employ, rather than identifying the genuine level of required registered nurses in response to measurement of population need and patient safety (as described by the National Audit Office[xxi]).

5.10 Since reform, the central commissioning of clinical placements remains with HEE, and continues to be capped based on the amount of funding UK Government chooses to provide. Higher education institutions (HEI's) are currently dependent on this placement funding in order to ensure courses fulfil the standards and education requirements for registered nursing. This means that despite the Government expectation that this reform of student funding will grow the workforce, there remains a limit to the number of HEI places for university nursing degrees that the Government can reasonably "generate", based on political decisions about levels of placement funding, the requirements of which are not appropriately or meaningfully identified or modelled.[xxii] The self-defeating approach described in 5.9 remains in place for both HEE and employers.

5.11 We also do not believe that the new Nursing Associate role and nursing degree-apprenticeships are likely to make a significant impact on increasing the domestic supply in the short to medium term. With nursing degree apprenticeships, as of autumn 2017 there are only an estimated 30 starting and it will take at least four years to train through this route.[xxiii] In terms of Nursing Associates (which are not degree-educated positions) only 2,000 of these positions are currently being trialled with training taking up to two years.[xxiv] It is expected to take at least two further years for a Nursing Associate to reach degree-level registered nursing.

5.12 As a result of this we believe the new routes into nursing in England are unlikely to deliver an increase in numbers of newly qualified registered nurses in the short to medium term.

5.13 These insufficient efforts to develop a degree-level registered nursing workforce for patient safety and public protection also do nothing to address systemic workforce retention challenges such as restricted pay and a lack of flexible working options. Without coherent workforce strategy and considerable commitment of funding to grow and retain the workforce, including fair pay, it is unlikely that the UK health and social care sector will be able to move away from current dependence on international recruitment, despite clear evidence that this supply is less available. Data shows that in the twelve months since July 2016 there has been a 180% fall in the numbers of new EEA nurses coming to the UK.[xxv]

5.14 All of this is happening at a time when the UK's existing nursing workforce is already under severe pressure. Analysis has shown that in the last three years vacancy rates have increased across the UK, and doubled in England to over 40,000.[xxvi] Data from other UK countries is not as consistently collected but for the NHS in Scotland the evidence also shows an increasing vacancy rate for nursing and midwifery, rising from 4.2% in June 2016 to 5.2% in June 2017.[xxvii]

5.15 In addition, 76% of senior nurse leaders say that they are concerned about ensuring safe staffing levels. 90% said they are concerned about recruiting new staff, whilst 84% were concerned about retaining current staff. Four in five (82%) said that their organisations run on the goodwill of their staff to keep services running.[xxviii] Taking this into account, a continued significant reduction in EEA migration would have severe implications for the sustainability of service provision and for safe patient care.

5.16 It has been reported that the Government in England is looking into the possible impacts of falling numbers of EEA nurses. A leaked Department of Health workforce model concluded that in the worst-case scenario, the UK's nursing supply could fall by 42,000 individuals by 2020 in light of Brexit[xxix] – adding yet more pressure to the already existing 40,000 vacancy gap in England alone. It is not clear what approaches each country of the UK is taking to assess and respond to potential scenarios following departure from the EU.

5.17 To help the Government and health and social care sector put in place the systems and investment needed to grow the UK's domestic workforce supply we believe that a transition period immediately after Brexit of up to four years should be agreed. During this time the UK should be able to continue to recruit international nurses as they do now in order to maintain service levels while moving towards a stronger domestic focus.[xxx]

5.18 This is particularly vital because the UK's reliance on international staff is highly stratified on a regional basis. The most expensive areas to live and work (especially in the south-east of England) have developed the strongest dependence on overseas recruitment.[xxxi] There is no viable way for employers to grow the domestic workforce in these areas if investment in pay, staffing levels, flexible working and other incentives is not increased. This is likely to take commitment, effort and time and so an interim transition period is necessary.

5.19 Summarising our position on this, we agree with the findings and views of the MAC's 2016 Partial Review of the Shortage Occupation List. MAC said that the present nursing shortage was mostly down to factors that could, and should, have been anticipated by statutory agencies such as the DH and related bodies, and that the restraint on incentives designed to attract and retain UK nationals into nursing careers – such as the pay – was a choice made by Government and not an immutable fact.[xxxii]

5.20 In terms of focusing migration reduction policies to non-EEA immigrants, the RCN has not yet undertaken any new research. However, as part of the Cavendish Coalition we have commissioned independent economic analysis which will set out a range of scenarios for policymakers on what the likely impacts of restricting immigration too early will be, as well as the correlating requirements to adequately grow the domestic workforce. A set of initial interim findings will be included in the Coalition's collective response to this Call for Evidence.

**6. Views on future reform of the UK's immigration system for non-EEA workers. This covers the following questions asked by the MAC**

- *How well aware are you of current UK migration policies for non-EEA migrants? If new immigration policies restrict the numbers of low-skilled migrants who can come to work in the UK, which forms of migration into low-skilled work should be prioritised? For example, the current shortage occupation list applies to high skilled occupations; do you think this should be expanded to cover lower skill levels?*

**Our answer and evidence:**

6.1 We are aware of current migration policies. The RCN has a dedicated immigration advisory service for nursing staff [xxxiii] and the College's policy function has made previous evidence submissions to the MAC regarding reform of the Tier 2 visa salary thresholds[xxxiv] and the Partial Review of the Shortage Occupations List (nursing), [xxxv] both of which occurred in 2015/16.

6.2 In terms of future immigration reform, we have previously expressed concern about aspects of the Tier 2 visa system, particularly the overemphasis on salary levels for prioritising visas, rather than wider benefits of some highly skilled professionals such as nurses, in terms of the economy, society and health of the whole population[xxxvi].

6.3 We would not recommend any radical changes to the non-EEA immigration system until the UK's settlement and future cooperation agreement with the European Union is clear particularly in relation to free movement of workers.

6.4 In relation to the Shortage Occupation List we argued strongly for the inclusion of adult nursing in 2015. We hope that in the long term nursing will be able to come off the list, on the proviso that that the Government invests more in developing our domestic supply. We agree with the MAC's view that international recruitment has often been used as a "get out of jail free" card to avoid long-term planning and investment in developing the UK nursing workforce. In order to encourage a sustainable transition away from this situation it is necessary to keep existing immigration routes open for

the medium term, as opposed to making it even easier to recruit internationally, perpetuating over-dependency. [xxxvii]

6.5 In relation to long term immigration changes we have identified a set of principles as part of the Cavendish Coalition, which should guide any reform to ensure an immigration system which is fair to individuals, and supports the need to develop our domestic supply of health and care staff. On that basis, we believe our future immigration system should:

- Support growth of the economy across all parts of the UK;
- Support delivery of high quality public services, across all parts of the UK;
- Position the UK as a global leader in healthcare, industry, science, technology, research and education;
- Facilitate reciprocal opportunities for UK nationals;
- Respond to skill and labour shortages and attracts talent to the sector;
- Recognise the wider value to society and the economy of certain skills and roles, beyond measuring salary levels; and
- Not destabilise social care and health services in the short-to-medium-term.

6.6 We continue to believe that the existing salary thresholds for Tier 2 visas are appropriate and should remain within the Tier 2 visa framework to ensure all nursing staff are paid equitably irrespective of country of origin. The minimum salary threshold should be linked to Band 5 within Agenda for Change[xxxviii] to ensure that employers are able to recruit nurses to address short term shortages without undercutting the resident labour force.

**The Royal College of Nursing**

With a membership of around 435,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the RCN is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector.

The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

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