Brexit Advisory Commission
For Public Services

Observation: April 2018

Securing an EU Workforce Deal that Works for Public Services

Executive Summary

- EU workers make a substantial contribution to public services. Vital staff range from care workers to lecturers, nurses, technicians, doctors and academics.
- The need to continue recruiting staff from the EU has to be seen in the context of significant constraints on public spending and chronic staff shortages, notably in social care and the NHS.
- The shape of the Brexit deal in relation to the public sector workforce will have major implications for other policy areas such as public sector spending and immigration from the rest of the world.
- Recruitment from the EU is desirable as well as necessary, notably at the top levels of academia and medicine. If we keep out top EU talent there is a serious risk that more of our own leading professionals will go abroad to work with the best.
- The ideal solution would be a bespoke agreement which allows reciprocal free movement for staff defined as skilled public sector workers, such as doctors, nurses, university technicians and academics, alongside sector-specific quotas for lower skilled posts which cannot be filled domestically.
- As well as its specific workforce needs, the public sector is critically dependent on other sectors of the economy for which Brexit has major workforce implications, such as construction, IT, engineering and transport. Again, these need both highly skilled and lower skilled EU workers.

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Introduction

EU workers make a critical contribution to the success of the UK public sector. Their involvement ranges from large numbers of lower-skilled workers providing social care to world-class university academics and doctors.

A Brexit deal which works for public services and those who depend on them needs to fulfil two needs – meeting our domestic requirements for large numbers of staff such as care workers, and enabling us to compete globally for the best talent in areas such as higher education and medicine to develop world-leading practice, research and knowledge.

There are important differences in the impact of being unable to recruit the right talent for each group. Shortages in the first group will be apparent immediately because they will exacerbate existing staff shortages in services such as nursing and social care, threatening the scale and quality of provision.

If Brexit undermines our ability to attract world-class talent the consequences will be longer term and more difficult to calibrate, but the impact will be far-reaching and hard to reverse. For example, a failure to attract the best doctors would not only affect the quality of NHS services but would harm our health industries. It would inhibit our ability to attract a growing share of the global medical tourism market[1], which currently exceeds £43bn and is growing at around 15% a year, as well as the expansion of renowned NHS institutions overseas, built on their international reputation for excellence.

The current shape of the EU workforce in the public sector

Health

Approximately 62,000 of the 1.2 million NHS workforce in England are from other EU countries, including 11,000 doctors, 21,000 nurses and health visitors, 1,400 midwives and 7,700 scientific and technical staff and therapists, according to NHS data analysed by the House of Commons Library.[2]

This represents around 5.6% of the workforce. British staff make up 87.5%, with 6.9% coming from the rest of the world. (No equivalent data on staff nationality are published for Scotland, Wales or Northern Ireland.)

Doctors have the highest proportion of EU staff among the professions, at 9.6%. Around 9% of NHS doctors in England qualified in EU countries.

Services in cities and major towns are particularly dependent on EU staff. The numbers are greatest in London and the South East. Analysis of 2015 figures highlights the dependence of some NHS trusts on European Economic Area (EEA EU plus Norway, Iceland and Lichtenstein) nurses. For example, 20% of nurses at the Royal Brompton and Harefield NHS Foundation Trust came from the EEA, along with 15% at Papworth Hospital NHS Foundation Trust and around 10% at West Suffolk NHS Foundation Trust, Mid Essex Hospital Services NHS Trust and Frimley Health NHS Foundation Trust.

Recruiting and retaining sufficient staff is now widely seen in the NHS as a challenge equal to the current funding difficulties, and more difficult to solve.

In November 2017, Nursing and Midwifery Council (NMC), data showed more nurses and midwives were leaving its register than joining, the first year this had happened. This included a 67% year-on-year increase in EU staff leaving the register.[3]

Number of nurses and midwives leaving the register by country of initial registration

Country	October 2015 to September 2016	October 2016 to September 2017
UK	26,653	29,019
Europe	2,435	4,067
Rest of the world	2,090	2,277
Total	**31,178**	**35,363**

This jump in the number leaving came on top of a collapse in new registrations from the EU, which fell year-on-year by 89% from 10,178 to 1,107. A serious aggravating factor behind this collapse was the government's insistence in 2016 that public bodies introduce a stricter language test for public sector employees as part of measures to control immigration; even native English speakers struggled. The NMC, along with the General Medical Council, has since introduced a less stringent test.

NHS Employers said trusts putting less effort to recruiting from the EU until the current uncertainty is resolved could have contributed to the fall. The UK has also become a less attractive place to work because of the fall in the value of the pound since the Brexit vote.[4]

While the number of EEA doctors has been holding up better, there is still a net loss. In 2012, more than 3,000 EEA doctors joined the GMC register while just under 2,000 left; in 2016, around 2,000 joined and 3,500 left.[5]

Global competition for healthcare staff is intense and growing. The World Health Organisation estimates that demand for healthcare staff will reach around 80 million by 2030, compared with a likely supply of 65 million. There are around 40,000 nursing vacancies in the UK. According to Health Service Journal, 96% of hospitals in England are missing their nurse staffing plans.

Of the 150,000 doctors in the NHS about 25% are from other countries, and that still leaves 10% of posts vacant.

Health Education England is developing a new NHS workforce strategy, and Health and Social Care Secretary Jeremy Hunt has pledged to make England "self-sufficient" in training doctors by 2025. Medical training places are being expanded from 6,000 to 7,500 a year from 2018.

Despite this welcome expansion of training there are serious doubts about the likelihood of home-grown talent being able to meet future demand for doctors, and if so, when. In addition, overseas recruitment is always likely to be needed to fill shortages in particular disciplines. At present these are in psychiatry (19%) and general practice (17%).

It is important to recognise that the medical workforce is not simply a numbers game. Medicine is a global community with ground-breaking innovations in science, technical skills, technology and systems management happening across the world. The international movement of doctors is essential to that progress. Losing foreign doctors would hold the NHS back. Onerous immigration rules and any perception of hostility to foreign doctors would deprive us of global talent. Perversely, that could encourage our most promising doctors to move overseas if the leaders in their field were no longer coming to the UK.

Continuing to recruit and retain EU staff requires continued mutual recognition of qualifications. Theresa May referred to mutual recognition (albeit in the context of business) in her March 2018 speech on our future economic partnership with the EU, while the European Council's draft guidelines for the negotiations published that month highlight the importance of a framework for recognising professional qualifications.

The NHS also needs continuing access to alert mechanisms identifying potentially dangerous clinical staff. Cooperation of this sort is referred to in Article 27 of the draft withdrawal agreement published by the EU in February 2018.

Social care

There are around 95,000 EU workers in the adult social care workforce in England – around 7% of the total across local government and the private sector of 1.4 million.[6] This compares with around 9% who come from outside the EU. European staff include 4% of occupational therapists, 8% of care workers, 3% of social workers and 16% of care sector nurses.

Like the NHS, the highest proportions are in London and the South East. Only 61% of the social care workforce in London and 77% in the South East are British, compared with more than 90% across the North. But there are nuances within this regional picture, with some rural areas highly dependent on EU workers because it is difficult to attract British citizens into local care jobs.

The high proportion of EU nationals working in social care is driven by low wages and demanding working conditions. This in turn is driven by the squeeze on local authority budgets. Brexit secretary David Davis has said that it will take "years and years" for British employees to take on low-paid jobs such as care work and hospitality.

So far Brexit has not obviously affected the social care workforce; the number of EU nationals has continued to increase.

Staff turnover in adult social care is high, at around 28%. Many leave soon after joining. The vacancy rate is 6%.

It is worth noting that the common designation of care workers as "low skilled" is both inaccurate and unhelpful in understanding the contribution they make. It has been suggested that referring to the work they and other key groups of workers do as "valued skills" would be more appropriate.

Central government

There are around 40,000 EU nationals in public administration and defence, 2.1% of the workforce.

In a survey by Leave Watch, most Whitehall departments could not say how many EU staff they had. Of the four that did, by far the largest was the Department of Health and Social Care, with 816.[8]

In 2017, a survey by the Institute for Government and others of more than 400 public bodies identified significant concerns about shortages of expertise in key specialist areas currently managed by EU institutions.[9] This is a particular issue for regulators. European bodies have extensive regulatory roles in areas such as agriculture and fisheries, human and veterinary medicines, aviation, environmental standards and chemicals. This is likely to create demand for a small number of key specialists. Some will be employed by the UK government while others will need to be taken on by the devolved administrations.

Education

There are around 149,000 EU nationals working in education, 4.5% of the total. Around 80,000 are described as high skilled, according to the government's independent adviser the Migration Advisory Committee.[10]

Around 25,000 university staff come from the EU, 15% of the workforce. Among academic staff, 22% come from the rest of the EU, with 12% from the rest of the world. Almost a quarter of academic staff in humanities – which includes languages – are from other EU countries, but EU staff are also prominent in mathematics and biological and physical

sciences. Around 27% of staff on research-only contracts are EU nationals.

Among the Russell Group of 24 leading UK universities, EU nationals make up 38% of academic staff at the London School of Economics, 32% at Imperial College London and 29% at King's College London. Cambridge has 27% and Oxford 26%.[11]

One of the greatest concerns among universities is that they will find it difficult to recruit world-class research talent from Europe, particularly given the uncertainty over the UK's continued involvement in EU research programmes.

But the Russell Group stresses that its Brexit worries go beyond top level appointments. These universities employ 9,000 technicians, of which around 750 come from the EU.[12] Technicians are important in STEM disciplines and are prevalent in clinical medicine, biosciences and engineering. UK universities already struggle to recruit skilled technicians, while potential staff from outside the EU are ineligible under the criteria for a Tier 2 visa – the most common visa for working in the UK – because the skill level is deemed too low and most of the salaries do not make the minimum threshold.

Issues specific to Scotland, Wales and Northern Ireland

In Scotland, 39,000 EU nationals work in public administration, education and health – accounting for 18% of the 219,000 EU nationals living there. They make up 3.3% of the public sector workforce, compared with 2.4% by non-EU nationals.

According to the Scottish government, migration will account for all of Scotland's population growth over the period 2016-2041.[13] If EU migration is constrained, the overall population is projected to peak in the 2030s and then decline, in contrast to the picture for UK as a whole. Therefore there is a compound risk to the public sector that tax revenues and the working age population will fall as the ageing population pushes up demand for health and social care.

EU citizens already make an important contribution to the full range of public services, notably NHS Scotland and social care. The government stresses the particular importance of EU migrants to maintaining services in rural areas, notably schools.

The Scottish government wants the different parts of the UK to be empowered to develop their own solutions to migration.

The Welsh government is also arguing for a role in shaping migration policy so that public services can continue to recruit from the EU. It estimates that 9,100 EU nationals work in health and social care, education and public administration. Drawing the link with other parts of the economy, it notes that another 1,900 work in construction including on social housing.

The largest proportion of EU workers is in higher education, where one in 10 staff is an EU national. In healthcare EU staff account for one in 20 health professionals and 2% of staff overall, while they make up 3% of the social care workforce.

The Royal College of Physicians has reported that there are trainee vacancies in every acute hospital in Wales. Data from 2015/16 indicates that around four in 10 consultant physician posts were unfilled.

The Bevan Foundation highlights possible indirect risks in Wales from Brexit, with doctors and others in high demand occupations being attracted to leave Wales to fill vacancies generated by the departure of EU nationals elsewhere in the UK.[14]

To develop policy responses to Brexit, Welsh public sector organisations need more detailed workforce data. The establishment this year of Health Education and Improvement Wales to coordinate workforce planning and training in the NHS should improve analysis and planning in the health service. The BMA in Wales has stressed that the pattern of workforce shortages in specific medical disciplines may differ from other parts of the UK.

In Northern Ireland around one in seven employees work in health and social care. There are around 2,000 nursing vacancies. Clearly, difficulties concerning the border could pose problems for the public sector workforce. Up to 30,000 people are 'cross-border', in that they live and work on different sides of the border, so anything which inhibits easy movement across it will undermine the ability of public services to recruit staff.

In 2015, around 8.8% of doctors in Northern Ireland had qualified in the EU, which is high by UK standards. This rises to 11% for GPs, of which there is a serious shortage.[15]

Public sector checklist for a Brexit workforce settlement

Similar to other parts of the economy, the public sector needs a settlement with the EU which allows it to recruit enough people with the right skills to provide the services on which the public depends. This ranges from world-class talent in academia and medicine to large numbers of skilled and lower-skilled workers who keep the public sector running.

If the settlement fails to meet these needs there will have to be balancing changes in other policies, notably the funding of public services to make lower skilled jobs attractive to UK workers, and immigration from other parts of the globe.

A deal with the EU which supports public services would have the following characteristics, which are in line with the needs of other parts of the economy:

- **A.** Recruiting talent: Be flexible enough to ensure public sector organisations can recruit the talent they need.
- **B.** International skills: Ensure public services are still able to recruit the best international talent to the most skilled posts, such as medicine and academia.
- **C.** Essential staff: Enable the public sector and private providers such as care homes to recruit essential, lower-skilled staff, notably care workers.
- **D.** Regional workers: Be flexible enough to meet the varying workforce needs of different regions.
- **E.** Funding levels: Be consistent with the likely funding level of public services.
- **F.** Future demand: Support public services in meeting future demand, particularly in health and social care.
- **G.** Bureaucracy: Avoid unnecessary bureaucratic barriers which would inhibit recruitment.

Possible outcomes from the Brexit negotiations

Drawing on the work of the IPPR, the Brexit negotiations could adopt one of the following models for a deal on workforce, assuming freedom of movement will end:[16]

1. Temporary controls on free movement: the government would temporarily introduce limits on free movement for particular sectors or regions during periods of high EU inflows.
2. Free movement for people with a job offer: free movement would continue as before for workers, students, family members and the self-sufficient, but jobseekers would no longer have the right to reside in the UK unless they already had a job offer.
3. Free movement for particular groups of workers: free movement between the UK and the EU would continue for certain professions and workers in particular sectors.
4. Points-based system: EU nationals seeking the right to work in the UK would need to meet the requirements of a points-based system. Points could be allocated on the basis of criteria such as qualifications, age and language ability.
5. 'Preferential' system for EU nationals: EU nationals coming to the UK to work would face a more relaxed version of the rules for non-EU nationals.
6. Work permit system: EEA and non-EU workers are treated equally and the government sets quotas for different categories. This would include opening up lower skilled jobs currently excluded from non-EU migration.
7. A bespoke deal – this could include, for example, reciprocal free movement for skilled workers and sector-based quotas to fill lower-skilled jobs which are unlikely to be taken by UK workers. Switzerland has a bespoke deal which broadly allows free movement but gives Swiss-based jobseekers priority for jobs and requires EU migrants to register for residence permits.

How do the options match up against the public sector workforce checklist?

1. **Temporary controls on free movement**

   Allowing free movement to continue largely unhindered except when inflows from the EU were regarded as excessive would be a good outcome for the public sector, but it is unlikely to be politically tenable.

2. **Free movement for people with a job offer**

   Free movement for people with a job offer would be viable for high skilled positions such as those in universities or the senior ranks of medicine, but would be a significant barrier to the employment of large numbers of skilled workers such as lecturers, teachers, doctors and nurses, and lower-skilled staff such as care workers. This option would impose costs and delays on the employer.

   The immigration debate is often seen in the UK in terms of who we are prepared to let in, but the UK also needs to be an attractive proposition for the staff we are seeking to recruit. Bureaucratic systems will drive people away.

3. **Free movement for particular groups of workers**

   Free movement for particular groups could be seen as an extension of the Shortage Occupation List which is used for attracting specified groups of workers from the rest of the world. These occupations are exempted from the Resident Labour Market Test and do not have to meet a minimum income requirement to secure eventual settlement. It includes specific medical disciplines such as emergency medicine and radiology, paramedics, maths and physics teachers and social workers in children's and family services.

   It would be difficult to set up and run an administration system and, judging by the restrictive and specific nature of the current shortage list, it is questionable whether there would be a willingness to allow free movement for broad categories such as doctors, nurses and academics. Businesses trying to bring people in under the Shortage Occupation List often encounter long delays. This approach would not work for lower-skilled workers.

4. **Points-based system**

   Points-based systems are used by many OECD countries to manage high-skilled migration. It favours desired characteristics such as education, occupation and age. A job offer may also be required.

   The Migration Advisory Committee says a points system would be complex for migrants, verification of skills would be cumbersome and it is unclear how it would be applied to lower-skilled workers. Staff such as university technicians may well fall foul of this approach.

5. **'Preferential' system for EU nationals**

   A preferential system might allow job offers to be made for levels below those likely to be accepted for non-EU nationals, and have a lower salary threshold for permanent residency. But it is highly likely this would fail the test of enabling public service employers to recruit large numbers of lower-skilled staff.

6. **A work permit system where EEA and non-EEA workers are treated equally**

   Assuming it was based on the current non-EEA system, this would exclude a wide range of essential talent, from lower-skilled staff to doctors. The Cavendish Coalition, which represents the views of health and social care organisations on Brexit, has warned against extending the non-EEA system to cover European countries.[17]

   The current system of Tier 2 visas already inhibits public sector recruitment. The Home Office grants 20,700 visas a year with a monthly limit of around 1,700. A recent spike in applications resulted in the minimum salary needed to qualify to be increased from £30,000 to £55,000 in December and £50,000 in January. This blocked recruitment of urgently needed doctors.

   Similarly, schools have struggled to recruit teachers through the Tier 2 visa route, forcing some to resort to plugging gaps using short term Tier 5 visas.

   The arbitrary impact of the salary cap is detrimental to the public sector.

7. **A bespoke deal**

   A bespoke deal offers the possibility of being able to recruit top-end talent as well as sufficient numbers of skilled workers such as lecturers, technicians, social workers and nurses and lower-skilled staff such as care workers.

   With the Brexit secretary stating that it will be many years before UK nationals will be taking jobs such as care worker in large numbers, public services need a deal which at least takes a realistic view about how long it will be before British workers take up the lowest paid public sector jobs in large numbers.

   For those at the top of the skills market, a deal allowing UK nationals to work in the EU would be mutually beneficial – supporting the cross-fertilisation of ideas, knowledge and skills that is essential in higher education and medicine.

   One option would be reciprocal free movement for those defined as skilled workers coupled with sector-based quotas for lower-skilled jobs which employers are struggling to fill.

Wider policy issues

Risk assessment and planning

Over the coming months central government and the public sector need to develop far closer collaboration in terms of data sharing, forecasting, risk analysis and planning. This is essential if and emerging difficulties are to be identified and address quickly.

How do the options match up to the public sector workforce checklist?

Public sector checklist

Possible outcomes	A. Recruiting talent	B. International skills	C. Essential staff	D. Regional workers	E. Funding levels	F. Future demand	G. Bureaucracy
Temporary controls on free movement	✓	✓	✓	✓	✓	✓	✓
Free movement for people with a job offer	x	✓	x	x	x	x	x
Free movement for particular groups of workers	x	✓	✓	x	x	x	x
Points-based system	?	?	x	?	?	?	x
'Preferential' system for EU nationals	x	✓	✓	?	?	?	?
Work permit system where EEA and non-EEA workers are treated equally	x	x	✓	x	✓	x	x
A bespoke deal	✓	✓	✓	✓	✓	✓	✓

✓ = meets the requirement   x = Does not meet the requirement   ? = Not enough information available to determine

For example, any exacerbation of nursing shortages would have immediate consequences for waiting lists, treatment times and patient safety. Bodies such as Health Education England and NHS Employers need to be planning now with the Department of Health and Social Care (DHSC) to identify trigger points for action, and what that action should be. These might include pay increases, greater migration from other parts of the world, return to work and retention strategies and increasing the number of nursing students and their financial support.

The plans for an increase in medical student numbers and eventual "self-sufficiency" in doctors coincide with Brexit but are not obviously coordinated with it. The DHSC needs to ensure the volume and timing of the increases in student places match the expectations of the impact of Brexit, and can be adjusted to meet changing circumstances.

Short lead times in decision-making could be vital. Delaying a decision on student nurses by a few weeks could put back its implementation by an academic year.

Similarly, the Department for Education needs to be working with the Russell Group, Universities UK and others to determine how to monitor the impact of Brexit and potential responses.

Potential for regional variations in migration

It would be possible to introduce regional variations in immigration policy, to allow for parts of the country which are dependent on particular types of worker to recruit from the EU.

For example, in the public sector this might see London and the South East being given greater flexibility to recruit care workers, because of the high dependence on EU staff.

Among voters in England, London and the South East were relatively sympathetic to remaining in the EU (although there were still areas firmly in favour of leaving). This might make the idea of regional variations more politically viable.

While potential difficulties with policing a regional element to the visa system are an obvious concern, the Migration Observatory argues that it would be little different to managing the current system for Tier 2 visas.[18]

Regional variations could be delivered in tandem with greater local control over skills. For example, areas such as the West Midlands and Greater Manchester with directly-elected mayors would be in a good position to balance the needs of local public sector organisations with other considerations such as pressure on housing.

Clearly the government is unlikely to let a combined authority have direct control over any aspect of immigration policy, but involving them in assessing local needs and allowing for an approach to immigration which can be fine-tuned locally and for which mayors would be politically accountable could be a way forward.

Successive governments have struggled to deliver a regional economic strategy which exploits the strengths and overcomes the difficulties of different parts of the country. The commission believes that coordinating immigration policy at a regional level with the government's successor to the current EU support for regions of greatest economic need is exactly the sort of Brexit opportunity that ministers should seize. The CIPFA Brexit Commission's report on EU funding in UK public services describes how we believe the successor to EU regional funding should be managed.[19]

The long-term approach to the treatment of EU students in UK higher education offers another opportunity to develop immigration policies which are sensitive to the needs of particular regions and economic sectors. The coming year is currently scheduled to be the last one in which EU students joining our universities have the same access to student loans and grants as UK students. National and local government, including the mayors of combined authorities, could identify which parts of the country could particularly benefit from being an attractive proposition for EU students. Key to this would be post-graduation work permits – an ideal opportunity to retain the best and most energetic European talent.

Funding

There is a risk that staff shortages will put pressure on pay levels to make jobs more attractive to UK workers at a time of tight public sector budgets. The impact of this would be significant. For example, around 40% of the £126bn NHS budget in England is spent on staff.

Low wages in the care sector are a direct response to the impact of austerity on local government funding.

The alternative would be to increase immigration from other parts of the world.

Medical education and training

NHS Employers points out that students from other EU countries come to the UK to pursue medical training on the same basis as British students, and growing numbers of British students are studying medicine at European universities, where the medical degrees are often taught in English. European rules support mutual recognition of qualifications.[20]

The successor arrangements need to take these issues into account, as well as looking at other options such as encouraging greater mobility between the UK and English-speaking non-EEA countries.

Reassessing the working time directive

The Working Time Directive limits working hours to an average of 48 per week and guarantees rest breaks and leave. Parts of the medical profession – from the Royal College of Surgeons to some junior doctors – have complained that the directive undermines the quality of medical training and patient care by restricting time with patients. The counter view is that better control of doctors' hours has improved patient safety and made working conditions more tolerable. Both are true.

While the directive allows doctors to opt out of the 48-hour limit, Brexit offers the opportunity to set a framework for managing doctors' time to meet both needs. However, there are sensitivities around doctors' contracts. The directive is now part of the junior doctors' agreement. Any changes would need to encompass pay and training reform, and could only be pursued with doctors' support.

Recommendations

1. The government needs to balance its desire to control immigration with pragmatic steps to ensure public services can recruit the talent they need. A failure to do so would have a substantial impact on many aspects of British life, from education to healthcare and social care.
2. The deal on workforce needs to reflect the fact that public services do not have time for a long adjustment – key areas of the public sector which depend on EU workers are already experiencing chronic staff shortages.
3. Any shortfalls in recruitment as a consequence of Brexit will need to be balanced by other actions such as increasing funding for public sector pay or increasing immigration from other parts of the world. Simply hoping the slack will be taken up by British workers in the absence of other policy initiatives is not a credible option.
4. To minimise disruption to public services and seize opportunities presented by Brexit, government and the public sector need to look beyond the formal transition deal with the EU in planning the content and timing of policy responses. This should include a joined-up, imaginative and ambitious approach to regional policy, encompassing service provision and economic and skills development.
5. The government needs to explain to the public that in many cases recruitment from the EU is not just necessary but desirable, enhancing the quality of our public services.

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