Royal College of Anaesthetists

26 October 2017

Royal College of Anaesthetists' submission to the Migration Advisory Committee call for evidence on the EEA-workforce in the UK labour market

We are pleased to have the opportunity to provide evidence to the Migration Advisory Committee (MAC). This submission outlines the vital contribution that a truly international anaesthetic workforce plays in supporting the delivery of a sustainable health and social care system in the UK.

As the single largest hospital specialty, anaesthesia plays a prominent role in secondary care, facilitating service delivery throughout the NHS, both inside and out of the operating theatre. That role will only be maintained with a system which enables the continued contribution of clinicians from around the world in the areas of anaesthesia, intensive care and pain medicine. As evidenced by our perioperative medicine programme, the contribution from other healthcare professionals and non-clinical staff – working within a multidisciplinary team – is equally important to the successful delivery of secondary care services.

If you have any questions regarding our submission please contact Elena Fabbrani, Policy and Patient Information Coordinator, at efabbrani@rcoa.ac.uk or on 020 7092 1694.

About the Royal College of Anaesthetists

- 16% of all hospital consultants are anaesthetists making anaesthesia the single largest hospital specialty in the UK[1,2,3]
- Anaesthetists play a critical role in the care of two-thirds of all hospital patients[4] and 99% of patients would recommend their hospital's anaesthesia service to family and friends[5]
- With a combined membership of 22,000 fellows and members, representing the three specialties of anaesthesia, intensive care and pain medicine, we are the third largest Medical Royal College by UK membership.

Summary of key points

- Projections indicate that a shortage of anaesthetists working in NHS hospitals is likely to continue over the coming years, regardless of the Brexit deal
- Arrangements to ensure that EEA citizens can continue to work in the UK's health and social care sector is needed to mitigate the potential severity of staff shortages
- A flexible migration model should be considered so that UK healthcare providers can continue to attract talent from outside the UK to enable a planned response to skills shortages and enable continued collaboration between the UK and EU member states
- Changes to the legislative framework post-Brexit should incorporate an assessment for eligibility for all doctors to work in the UK. The General Medical Council's (GMC) proposal for a Medical Licensing Assessment (MLA) would be an appropriate mechanism to achieve this aim
- A new tier in the migration system, with a lower salary threshold than is currently stipulated at the existing Tier 2, should be agreed to ensure that non-clinical staff will not be discouraged from migrating to the UK to contribute to the health and social care workforce.

Implications for the specialty of anaesthesia

The NHS relies heavily on doctors trained outside of the UK and, as the largest single hospital specialty, anaesthesia is a service delivered by a diverse and international workforce.

Around 12% of all NHS staff working England are citizens of a country other than the UK and almost 10% of doctors working in the NHS in England have an EU nationality. In addition, 6.8% of NHS staff working in England are citizens of a non-EU country[6].

Notwithstanding the limitations of the data acknowledged in the working paper[a], the GMC review, 'Our data about doctors with a European primary medical qualification' (February 2017)[7], shows that across the UK 8.8% of doctors in Northern Ireland graduated in the EEA, in Scotland 5.7% and in Wales 6.4%. The same paper shows that 13% (1323) of graduate doctors in the practice area of anaesthetics and intensive care are EEA medical graduates.

Our own data shows that 7% of our members received their Primary Medical Qualification (PMQ) from a country in the European Economic Area (EEA) and a further 23% received their PMQ from a country outside of the EEA[8].

There is also variation in the proportion of anaesthetists who received their PMQ outside of the UK across different medical grades. Our latest workforce census showed that Specialty and Associate Specialist (SAS) anaesthetists make up 22% of the UK anaesthetic workforce[9] and our data suggests that 14% of SAS anaesthetists obtained their PMQ in an EU country (which was not the UK).[10]

The location of graduation of registered doctors provided in the GMC data and our data on the where our members received their PMQ is not directly comparable. However, all the respective figures demonstrate that a significant proportion of care delivered by anaesthetists working in the UK is being delivered by doctors who are either not citizens of the UK, or have been able to take advantage of an opportunity to train outside of the UK.

Impact of regulatory frameworks on the movement, training and recruitment of anaesthetists

Following the introduction of English language requirements in June 2014, the number of new doctors who graduated in the EEA joining the profession in the UK nearly halved (48% decrease) from 2014 to 2015 (3,387 to 1,777).

A previous tightening of immigration rules for non-EU citizens brought in by the government between 2008 and 2010 has been shown to be the most significant factor in the reduction of healthcare workers from non-EU countries[11]. However, during that period, workforce shortages in the NHS were mitigated by an influx of EEA staff that had the right of free movement throughout the EU[12].

While we acknowledge the restrictions on the availability of evidence at this stage, it is our view that limitations to the freedom of movement between the UK and the EU will limit the the ability of the NHS to solve workforce shortages in the future.

[a]There are limitations to the General Medical Council (GMC) data in terms of how doctors are allocated to each UK country. In addition, it should be noted that 73% of EEA graduates in Northern Ireland are from the Republic of Ireland.

The failure to provide certainty as to the status and rights of EEA citizens living and working in the UK is already impacting on the morale of doctors currently working in the NHS. Separate surveys run by the GMC and the British Medical Association (BMA) in early 2017, and more recently last September, have found that over 40% of EEA doctors are considering leaving the UK in the near future.[13] [14] [15]

A report from the London School of Economics notes similar concerns about the implications and uncertainty that Brexit is having on EU academics currently working in the UK and reports that many in the sector are now looking to academic institutions outside of the UK for long term employment[16].

This is particularly worrying for the medical field, as EU academics play a vital role in the training of healthcare professionals in the UK and make up one in five of all academic staff in clinical medicine posts at Russell Group universities. Russell Group institutions train more than 80% of the UK's doctors and dentists. [17]

Furthermore, the importance of collaboration and knowledge-sharing to the advancement of medical innovation and research cannot be underestimated. Both EU and UK academics should be able to travel and take advantage of placements across European academic institutions without fear of not being able to re-enter their countries of residence.

For the specialties of anaesthesia and ICM a 2015 report by the Centre for Workforce Intelligence (CfWI), found that the number of anaesthetists and intensivists holding a certificate of completion of training (CCT) needed to meet demand by 2033 would be 11,800 full-time-equivalents: nearly double the current level of around 6,100 and a 33% shortfall of the 8,000 projected to be trained by this date.[18]

While we have welcomed the plans to increase medical school places[19], this new cohort of medical students will not graduate until 2023 and are anticipated to complete specialist training in anaesthesia in 2032 and cannot, therefore, be considered a short-term 'auxiliary' in the immediate post-Brexit period after 2019.

In response to the Prime Minister's speech in Florence on 22 September, the Cavendish Coalition (of which the RCoA is a member) welcomed the offer on the status of EU citizens in the UK, but also reiterated the need for the health and social care sector to continue to recruit from the EU/EEA after Brexit to fill vacancies in the short to medium term[20].

Opportunities to change the assessment for fitness to practise of EEA doctors coming to work in the UK

Under the existing EU legislative framework, doctors from the EEA are entitled to automatic entry to the GMC's Specialist Register without the need for any formal assessment of fitness to practise.

In April 2017 we provided a response to the GMC's consultation, 'Securing the licence to practise: introducing a Medical Licensing Assessment (MLA)'. Whilst we are concerned by the potential decreases in the number of EEA doctors working in the NHS, as indicated by

recent surveys[21] [22], we support the GMC's proposals for the introduction of an MLA to demonstrate that doctors entering UK practice meet a common threshold, no matter where they obtained their medical degree.[23]

As the UK leaves the EU and the current legislative framework is reviewed, we believe there is an opportunity to introduce an MLA which would provide for a common threshold for all doctors to practise in the UK.

The contribution of the non-clinical workforce in health and social care

NHS hospitals rely heavily on free movement within the EEA to facilitate the recruitment, not only of clinicians, but also of non-clinical staff, such as nurses, porters, cleaners and technicians. Without this range of support staff, a hospital simply cannot operate.

Around 130,000 people from the EU are employed in the NHS or in the social care sector, including 1 in 20 of all staff employed in social care.[24] [25] In England 7% of all nurses and almost 5% of scientific, therapeutic and technical staff are EU nationals.[26] Data from the Health Foundation reveals a 96% fall in the number of EU nurses registering to work in the UK since last July.[27]

The briefing note which accompanies the MAC call for evidence outlines several immigration models. It would be beyond the remit or expertise of the College to advise the Home Office on the operability of national immigration policy, with consideration of the full range of issues (such as welfare, security, provision of infrastructure etc.).

However, we would make the assessment that simply transposing the current work-related migration system (aimed currently at higher-skilled workers) as a 'catch-all system' for EEA citizens working in the UK could disadvantage non-clinical health and social care staff. The current system operates on the basis of a required £30,000 salary threshold at Tier 2, but the average salary for someone employed as a care assistant in the UK is £14,313[28] and around £23,000 for a nurse[29].

We therefore take the view that a future, comprehensive immigration policy will need to accommodate a lower salary threshold to ensure that (a) individuals are not discriminated against simply by being lower-paid and (b) individuals are not discouraged from taking lower paid jobs in the UK's health and social care sector.

Non-clinical healthcare workers from Europe make a vital contribution to the NHS – as evidenced by our perioperative medicine programme[30] - and we strongly advise against any immigration model which equates 'pay' with 'contribution' and which implies that only highly paid clinical specialists need to be attracted to roles in the UK healthcare sector.

We echo the view of the Cavendish Coalition that it will not be 'feasible to meet current health and social care sector staffing needs through either additional domestic recruitment or training activity alone'[31] and anaesthetists – as the largest single specialty of hospital doctors – must be considered a crucial component of future workforce planning.

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[2] Stats Wales. *Medical and dental staff by specialty and year.* March 2017.
[3] Information Services Division Scotland. *HSHS Medical and Dental Staff by Specialty*. December 2016.
[4] Audit Commission. *Anaesthesia under examination: The efficiency and effectiveness of anaesthesia and pain relief services in England and Wales*, National report, 1998.
[5] EMK Walker, M Bell, TM Cook, MPW Grocott, and SR Moonesinghe for the SNAP-1 investigators. Patient reported outcome of adult perioperative anaesthesia in the United Kingdom: a cross-sectional observational study. British Journal of Anaesthesia 2016
[6] House of Commons Library. *NHS staff from overseas – statistics*. April 2017
[7] General Medical Council. *Our data about doctors with a European primary medical qualification*. February 2017
[8] *RCoA Survey 2016, Q9. Please indicate where you received your Primary Medical Qualification. Base: (5,196). Data collected from 1-22 April 2016.*
[9] Royal College of Anaesthetists. *Medical Workforce Census Report 2015.*
[10] Royal College of Anaesthetists. *SAS Anaesthetists – Securing our Workforce.* June 2017
[11] European Observatory on Health Systems and Policies. *Health professional mobility in a changing Europe - New dynamics, mobile individuals and diverse responses.* 2014
[12] NHS Improvement. *Evidence from NHS Improvement on clinical staff shortages – a workforce analysis.* February 2016
[13] General Medical Council. *GMC survey of EEA doctors*. February 2017
[14] British Medical Association. *An exit from Brexit*. February 2017
[15] British Medical Association. *BMA survey of EU doctors working in the UK.* September 2017
[16] London School of Economics. *No longer welcome: the EU academics in Britain told to 'make arrangements to leave'*. January 2017
[17] Russell Group analysis of HESA staff (excluding atypical) Full Person Equivalent, 2015-16.
[18] Centre for Workforce Intelligence. *In-depth review of the anaesthetics and intensive care medicine workforce*. February 2015
[19] BBC Health. *Medical places to increase next year.* August 2017
[20] *Cavendish Coalition welcomes positive comments from Prime Minister on status of EU citizens*. September 2017
[21] General Medical Council. *GMC survey of EEA doctors*. February 2017
[22] British Medical Association. *An exit from Brexit*. February 2017
[23] The Royal College of Anaesthetists. *Response to the GMC consultation on Securing the licence to practise: introducing a Medical Licensing Assessment (MLA)*. April 2017
[24] NHS Confederation European Office. *The UK voted to leave the EU: what now for the NHS?* June 2016
[25] Care Home Professional. *Brexit uncertainty hits social care staff.* April 2017
[26] House of Commons Library. *NHS staff from overseas – statistics*. April 2017
[27] Health Foundation. *New data shows 96% drop in nurses from EU since July last year.* June 2017
[28] *Adult Social Care salaries in the United Kingdom.* Indeed
[29] Pay Scale Survey. *Staff Nurse Salary (United Kingdom)*
[30] Royal College of Anaesthetists. Perioperative Medicine: The Pathway to Better Surgical Care.
[31] *Cavendish Coalition welcomes positive comments from Prime Minister on status of EU citizens*. September 2017