

Health Committee

Oral evidence: Brexit and health and social care, HC 640

Tuesday 28 February 2017

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[Watch the meeting](#)

Members present: Dr Sarah Wollaston (Chair); Heidi Alexander; Luciana Berger; Mr Ben Bradshaw; Rosie Cooper; Andrew Selous; Maggie Throup; Dr Philippa Whitford.

Questions 259 - 374

Witnesses

[I](#): Charlie Massey, Chief Executive and Registrar, GMC; and Jackie Smith, Chief Executive and Registrar, NMC.

[II](#): Professor Ian Cumming OBE, Chief Executive, Health Education England; Gavin Lerner, Director of Workforce, Department of Health; and Paul MacNaught, Director of EU, International and Prevention Programmes, Department of Health.

Written evidence from witnesses:

- [GMC](#)
- [NMC](#)
- [Department of Health](#)
- [Department of Health, Director of Workforce](#)

Examination of witnesses

Witnesses: Charlie Massey and Jackie Smith.

Q259 **Chair:** Good afternoon. Thank you very much for coming this afternoon to our second session on Brexit and health. We are hearing this afternoon from professional regulators. I would be grateful if you could introduce yourselves to those following from outside the room, starting with Jackie Smith.

Jackie Smith: Thank you very much and good afternoon. I am Jackie Smith, the chief executive and registrar of the Nursing and Midwifery Council.

Charlie Massey: Hello, everyone. I am Charlie Massey, the chief executive and registrar at the General Medical Council.

Chair: Thank you. Andrew is going to open the questioning today.

Q260 **Andrew Selous:** I would like to ask both of you, perhaps starting with Jackie, how we could improve patient safety if we were not bound by the mutual recognition of the professional qualifications directive.

Jackie Smith: That is an interesting opening question; thank you. One issue that we have as a professional regulator is our ability to be able to test the skills and competence of applicants wherever they come from. With the current directive, we can test English language, which we do for applicants coming from Europe, but we have a system in place whereby we recognise their education and training. I suppose what Europe and Brexit give us is the opportunity to think about having a consistent approach that enables us to put people on a register to deliver care to UK standards. That is not to say that is not what is happening now, but we have a different system in place for nurses and midwives who come from the Philippines, India and the States, as opposed to from within Europe.

Charlie Massey: The first piece of context is that we are incredibly reliant in the NHS on doctors from the EEA. Nearly 10% of our workforce come from the EEA. As the GMC, we have had a long-standing view, predating the referendum, that we think the balance between mobility and patient safety could be improved, and in particular we would like to be able to test the competencies of European doctors coming to practise in the UK in the same way that we would be able to for doctors coming from outside the European Union and, indeed, doctors graduating from UK medical schools. We have recently consulted on an assessment that we would like to introduce for all doctors entering our register. That is the first issue where the directive constrains us.

The second area is in relation to the training of doctors. At the moment, the directive is constructed in such a way that, if a doctor in training chooses to switch specialty from one to the other, they effectively have to start from scratch again. We think that is not great for doctors, for patients and not great for the service.



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Q261 **Andrew Selous:** You do see some advantages or opportunities to do things better if we play our cards right.

Charlie Massey: Yes. From the GMC's perspective, there are some modifications to the way in which the directive applies in the UK that would benefit patient safety.

Q262 **Andrew Selous:** If we were to go down this line that you have outlined, what changes to domestic legislation would we need to bring about these changes? Is that an area you have given any thought to?

Charlie Massey: The way in which the legislation works is that the directive has been imported into the Medical Act 1983, so it is changes to the Medical Act that we would like to see. At the moment, so long as the directive applies, it is difficult to make the changes I have just described because we are bound by the directive. If we were in a different world where we were able to modify the directive or if the directive did not apply at all, which are questions for the Government and not for us, it would then be possible for the Government to change the Medical Act—the domestic legislation—to make the changes I have just described.

Jackie Smith: It is very similar for us. We find ourselves in the same position.

Q263 **Andrew Selous:** This is a straight question: should we seek to opt out of the mutual recognition of the professional qualifications directive as and when we have the opportunity?

Charlie Massey: You can achieve the changes I have described by modifying the way in which the directive applies. These are changes that we called for, particularly the ones as to the common assessment, in a world where a different referendum outcome may have been in place, where the Government may have chosen to negotiate for a modified application of the directive, but, certainly, either in a world where the directive was modified or in the way in which it applied to the UK—

Q264 **Andrew Selous:** Excuse me for interrupting, but you talk about modifying it. Have you taken soundings with the European Commission as to the likelihood of being able to modify it without going through a whole legal process of scrapping it and imposing something else?

Charlie Massey: Our position as to the common assessment is one that we have shared with other European regulators. The question would be less for them but more for the UK Government, in a world where it was not completely opting out of the directive, as to what changes it would seek to achieve in how it would apply to our legislation.

Jackie Smith: We certainly have not had those conversations with the European Commission around modification. We are thinking, if we enter into a situation where we need to assess someone's education and training requirements, what the best way is to do that that enables the UK to have the workforce that it needs and that we have the protection



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around the standards that they need to meet. Charlie is indicating there is a common assessment approach, but we cannot do that unless there is a change to our legislation and we can put to one side the European directive.

Q265 Andrew Selous: Turning now to other elements of European Union employment legislation, are there other areas that we should look to reform given the fact that Brexit is happening?

Charlie Massey: There are not particular other areas that we are at this stage singling out as being ones that we would want to change and that other legislation is beyond our remit, although clearly some of those other aspects of legislation apply to the context in which doctors work in the UK. Certainly, we as a regulator have made it very clear that we have been worried by what trainee doctors have been telling us about the number of hours they have been working and the important responsibility that employers have to ensure that the training of doctors—the time to train and the time for trainers to train—is protected, but that legislation is now more incorporated in the contracts of doctors.

In terms of wider legislation, we see this very much as a watching brief for us, and we would be happy to do some analysis or to reach a view as and when it becomes clear what other changes the Government might seek to achieve.

Jackie Smith: I do not think we would be seeking anything other than what we have articulated.

Q266 Andrew Selous: Charlie, you have mentioned what we heard last week—that the European working time directive is now written into the face of the junior doctors' contract anyway; so this may be, in some sense, a hypothetical question, although I am not sure if there are other groups to whom this could apply. Would there be benefits to medical training of removing the limitations of the working time directive, and how do you suggest that we approach this issue in trying to get the best possible training for clinicians?

Charlie Massey: Those sorts of issues are probably beyond our remit as a professional regulator. We would focus our attention on whether trainee doctors are telling us that they have the time to train and the conditions within which they work. I do not think we have looked to see whether there are particular opportunities from changing the European working time directive that would align with our responsibility, so we have not really formed a view on those other aspects yet.

Q267 Mr Bradshaw: On accreditation, given that there have been plenty of examples of inadequate, negligent care, or even worse, by home-grown nurses and doctors in Britain, what evidence do you have that training and competence in other EU countries is inferior?

Charlie Massey: It is very difficult to give you any evidential base. In so far as the assessment I described applies, the degree to which we



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understand the variation of output from UK medical schools is also something around which we do not have a tremendous amount of evidence. The best proxy we have is the complaints data that we have coming through in relation to different doctors, where doctors from the European Union are marginally less likely to be complained about but marginally more likely to have sanctions or warnings at the end of that process; but we are here talking about very small numbers. We are talking about 1% of EEA doctors in the 2011 to 2015 period who had a sanction or warning applied to them. That is 1% against a stock of over 20,000 licensed doctors within the UK. It is very small numbers.

Jackie Smith: I agree with you. It is an interesting question. I do not think we can point to the data that establishes that fact.

Q268 **Chair:** One point that you have raised in the past, though, Ms Smith, is the fact that, when nursing staff are qualified abroad, they may have been out of clinical practice for some time but you still have to accept them straight on to the register in a way that would not necessarily be the case for UK-qualified nurses. Is that fair to say?

Jackie Smith: Yes, it is absolutely part of the EU directive that we do. If they have been out of practice for 10 or 15 years, there is nothing we can do about that.

Q269 **Chair:** Would you confirm that, if that was the case for a UK-trained nurse, they would not be able to practise?

Jackie Smith: Absolutely. They would have to do a return-to-practice course to get back on our register.

Q270 **Chair:** Is that something you are hoping you would be able to address after this?

Jackie Smith: Yes.

Q271 **Chair:** Likewise, the position with doctors—correct me if I am wrong—has been sometimes that you can go into a specialty here in the UK without having necessarily had the same kind of background training in that specialty in certain other European nations. Is that the case?

Charlie Massey: That is the case. There is quite considerable variability in the way in which doctors are trained in European countries. If you are an oncologist trained in the UK, you will have been trained in radiation therapy and drug treatments. In some European countries, it would be focused just around radiation therapy. If you are going into general practice, it is a core part of our general practice training in the UK to be trained in paediatrics, antenatal and postnatal, but that does not apply in some southern European states because of the way in which their systems are organised. It is that kind of area where we think a common assessment for entering the register would provide much more assurance to patients about the safety and doctors meeting the standards of good medical practice.



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Q272 **Chair:** You referred to variability within the UK as well. How resistant or welcoming are UK medical schools to the idea of having a common assessment?

Charlie Massey: We have only just published our consultation paper on that. The medical schools have generally been pretty welcoming of that approach. There is an increasing recognition that there is variability in the output from UK medical schools and that a common assessment, if integrated well into finals and made operational in a sensible and proportionate way, would bring some benefits. But it is early days. We have only just started that consultation. We are consulting on the principles. We need to work through with medical schools and others how we would apply it in practice.

Q273 **Dr Whitford:** Could I clarify something before going into my questions? The directive was incorporated into domestic law, did you say, in 1983?

Charlie Massey: It is the 1983 Medical Act, which houses all the legislation that applies to the GMC. It is the UK Medical Act 1983 that gets amended to take account—

Q274 **Dr Whitford:** When did the mutual recognition—

Charlie Massey: I am not sure precisely. It could have been in 1983.

Q275 **Dr Whitford:** There are two aspects of it that I do not understand. One is saying that, if someone wanted to change the training path they are on, they had to go right back to the beginning. When did that start, because that certainly was not the case when I was training, and I graduated in 1982, so all my training would have been after that? My perception is that that is a pattern that has come in in the last decade—making people go back. I would have thought that was more around the newer system of training rather than—

Charlie Massey: That may well be correct. I will have to come back to you on the precise dates, but the way in which it operates is that it requires prospects of approval of training for it to be recognised and count towards a CCT. I met a doctor in Northern Ireland last week who switched from paediatrics to general practice. Having worked at a fairly senior level in paediatrics, she had moved to a paediatric rotation for her GP training that was at a much more junior level.

Q276 **Dr Whitford:** Is it the EU making that happen? My perception was that we changed training here.

Charlie Massey: No; it is the directive that requires that prospective approval.

Q277 **Dr Whitford:** Okay. Then that did not come in in 1983, because when I was training you could move from one strand to another, and I have only seen that change happen in about the last decade or so. Mutual recognition has surely been with us longer than that.



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Jackie Smith: There are two bits, and they are different depending on which regulator you are talking to. The directive that drives us is about the number of hours that nurses and midwives do in practice and in theory. The recent change was about our ability to be able to test English language and the European Professional Card. There have been two significant changes to the directive that allow us to do different things. It is different for doctors.

Charlie Massey: The other bit that slightly complicates it for doctors is that it depends which specialties are listed in annex 5 of the directive. Of the 69 specialties in the UK, 44 are listed. The 44 that are listed in the directive are the ones where there are greater volumes of constraints that apply than others, but I can write to confirm precisely how the different elements operate.

Q278 **Dr Whitford:** I am concerned that sometimes, as has been the case for the last four decades, the EU gets the blame for things that are not specifically the EU. There are ways of working around it. I thought the directive only called for people to be treated in the same way as people who graduated here, whereas, Jackie, you are suggesting that, here, we make someone who has been out of practice for 10 years retrain but we are not allowed to do that to an EU national.

Jackie Smith: That is correct,

Q279 **Dr Whitford:** Why is that if it has to be mutual—that it has to be the same? Why are we not allowed to make it the same?

Jackie Smith: Because we are not allowed to test someone's competence.

Q280 **Dr Whitford:** But it is not necessarily a matter of testing if someone is going into a return-to-work scenario; they do not always go through a test.

Jackie Smith: No.

Q281 **Dr Whitford:** They sometimes will work with mentors to bring them back. If someone was out having their family, would they have to go through a new exam system here? Would they have to go through a test?

Jackie Smith: No, not necessarily. It depends on the length of time they have been away from practice.

Q282 **Dr Whitford:** Let us say five or six years.

Jackie Smith: Yes. They may have to do a return-to-practice course before they could get back on to the register.

Q283 **Dr Whitford:** But that is a course, not necessarily a test.

Jackie Smith: Yes. It is not necessarily a test. We are saying that, if European applicants have been out of practice for 10, 12 or 15 years, we



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cannot put them through any sort of process before we allow them on to the register here.

- Q284 **Dr Whitford:** The mutual recognition says that you must treat them the same way as people from here, so, if you are choosing to recruit them anyway, despite them having been out of practice, why are we not able to say we are going to put them on the return-to-work course, the same as someone who is from here? That is not breaking the directive.

Jackie Smith: I do not think we can do that. I am absolutely happy to check that and come back to the Committee on it, but I do not think we can do that.

- Q285 **Dr Whitford:** It is quite important that we are not just, blanket fashion, saying we cannot do that. If we are doing it to people here, it is mutual, and, therefore, anything we are doing to our own people we ought to be able to offer and suggest to them.

Jackie Smith: Can we come back on that?

- Q286 **Dr Whitford:** That would be great. I would like to ask both of you how you see the reforms that you want to bring in affecting the flow of staff, recognising that EU nationals, both within nursing and medicine, constitute a significant part of our workforce that we rely on.

Jackie Smith: At the moment, we have about 38,000 European nurses and midwives on our register. You will have seen some data that we published recently. It is very difficult to make any sort of judgment about what that is showing because I think it is too early. Obviously, we want to be able to work with the system and employers to ensure that they get the staff that they need at the right place and the right time. We have to think about the best way of doing that that allows us to protect the public, which is why we started this discussion by talking along the lines of some type of assessment because that is what we provide for nurses and midwives coming from other parts of the world. Otherwise, we are in the place where we have to enter into discussions with individual countries about the type of educational requirements that they have, and that is for the Government to think about as to the mobility of workers. We want to be able to protect the public and at the same time not create barriers to the workforce and the supply.

- Q287 **Dr Whitford:** That does come back a little bit to Ben's point. Is there clear evidence of inferior standards of competency, or are you in perhaps certain geographical areas having real language issues, even though people have been through the exam that you already set while we are still in the EU?

Jackie Smith: No, I could not honestly say that. This is very early. The language test has not been in place that long. It is a challenge for some, but we could not draw any conclusions from that yet. We need to have a system that is consistent across the world and the UK that allows us to say, as a regulator, we have something in place that protects the public.



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If the legislation goes and there is not anything there, we would find it difficult to say what the mechanism is for doing that. We either enter into individual discussions with countries about their arrangements or we have a test that applies across the UK and the rest of the world.

Q288 **Dr Whitford:** It is very unlikely that we are going to be in individual arrangements with individual countries within the EU. It will be with the EU.

Jackie Smith: Yes.

Q289 **Dr Whitford:** The question then is, if we did not reach an agreement, you would be envisaging or would like to see it being the same as the rest-of-the-world test.

Jackie Smith: Yes. That would be our position in respect of public protection, yes.

Q290 **Dr Whitford:** Obviously, it has to be the same as for people here. All the directive asks for is that we treat people from the EU in the same way as we treat our own citizens. The mechanism is there for how we assess people who have trained here, but you would prefer to have it that it was the equivalent of people coming from elsewhere in the world.

Jackie Smith: Yes.

Q291 **Dr Whitford:** What about you, Mr Massey?

Charlie Massey: There are two different questions around flows, one of which is what we see happening now and then the question about what might happen in the future. In terms of what we are seeing now, it is quite early to say. As to applications from doctors from Europe wanting to join our register, if you compare the July to December 2016 period with the July to December 2015 period—that is, the post-referendum to pre-referendum analogous periods—the latest period is about 10% lower than the previous period, although that is against a backdrop of a slight decline in European doctors joining our register over a period of years. It is not a significant enough number to say that that is attributable to the outcome of the referendum.

The question then is around what we would see happening in flows in the future, particularly if we are applying the common assessment test that Jackie and I both have described. Certainly, we do not want to do that in a way that is unnecessarily bureaucratic or disproportionate. Our best proxy for that is the current professional and linguistic assessment board that we run for graduates coming from outside the European Union to come and practise in the UK. Certainly, we have seen no evidence of a drop-off from international graduates wanting to come and practise. Indeed, in the 2011-15 period there has been a slight increase in joiners from the rest of the world, while there has been a slight decline in joiners from Europe. So, it is quite difficult to say.



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What was quite interesting for us in 2014 was the question of language testing that Jackie described. We saw quite a sharp drop-off of applications from doctors from southern Europe applying to join our register after we introduced the language test. We need to be a little careful with that because there are some slight apples and pears in the data that we shared with the Committee. What happens now is, if a doctor applies to join the register, depending on the evidence they submit, they will either be given a licence to practise straightaway or we might say we want to find some more evidence. The directive requires checking rather than demonstration. We will ask them for more evidence. We need to go through a further hoop with about a third of the doctors that apply before we will grant them that licence.

It is quite difficult to fathom out the drivers behind some of these things. Although I think our language test will have affected the supply of doctors to the UK, first, there could have been other factors in play, such as the prevailing economic climate in southern Europe that improved during that period, and, secondly, we would say that has been quite a good thing for patient safety. There are over 1,000 doctors to whom we have not granted a licence to practise because their English has not been up to the competency they should have been able to demonstrate. We would say that is a good thing to protect and promote patient safety.

Q292 Dr Whitford: Do you think there is a patient safety issue if we end up disrupting the flow of nurses and doctors? We already hear of places where they simply cannot get a GP at all to take on a job. I do not mean that any old person is better than no person, but the vibe we send out may put off people who would be perfectly competent and, indeed, would be a great contributor to our health system. Do you think there is such a danger in the areas where we struggle to recruit?

Charlie Massey: Clearly, one benefit of the directive and mutual recognition has been the ability for the NHS and the UK to attract a very significant volume of doctors in the medical workforce on whom we rely and among whom we do not have avalanches of data suggesting that they are not fit to practise. Undoubtedly, those European doctors provide an incredibly valuable service in the NHS. Our aspiration in introducing common assessment would be to do that in a way that was not unnecessarily burdensome, bureaucratic or disproportionate. For us, it is a question about that balance between mobility and patient safety. At the moment, it does not feel right that a doctor who is coming from an eminent place—say, from Harvard—into the UK has to sit a series of tests to come and practise in the UK, whereas we have no ability to test a doctor from somewhere in Europe in the same way. That for us does not feel quite right.

Q293 Dr Whitford: If we are disentangling from the system altogether, do you not consider that losing the alert system for people who have been in difficulties or have had their registration limited in other EU countries—that we will not be part of that alert—is quite a significant risk?



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Charlie Massey: That is a risk, and the alert system is an incredibly welcome development in the European Union. The legal requirement on regulators to share information on professionals for whom there has been some restriction on practice has to be a sensible thing. One would hope that you would find it difficult for any member state to argue that there should not be some mechanism to continue with that sort of alert system going forward. It is quite early days—it was only introduced last year—but we would welcome its continuation and continuing improvement as it beds down.

Jackie Smith: I agree with that wholeheartedly. We certainly would not want to lose that function.

Q294 **Dr Whitford:** The problem is the quid pro quo.

Jackie Smith: Exactly, yes.

Q295 **Luciana Berger:** Jackie, can I ask some follow-up questions specifically about the number of EU nurses joining the register for the first time? Looking at the data that was sent by the NMC to the Department of Health in January, there is an 85% reduction this year compared with last year—204 in the period September to December 2016 compared with 820 in the same period last year. Could we perhaps explore the reasons for that a little further and how accurate that data may or may not be?

Jackie Smith: The data is pretty accurate. We are monitoring the movement on the register coming in and going off practically on a daily basis. I am speculating now, but certainly for July of last year—the point at which we introduced the language test—from the data, we saw a hike in applicants from Europe beforehand, understandably, and now we have seen a reduction in the number applying to join and a small number seeking to leave. We can speculate as to what that is about; it could be the language test, it could be Brexit or it could be all sorts of things. At the moment we do not know, but it is important that we keep it under close review.

Chair: Are there any other follow-up questions?

Q296 **Dr Whitford:** Can I ask Charlie this? In the BMA's publication of their survey, 40% of EU doctors are considering—that is, obviously, "considering"—leaving. What are your thoughts around that?

Charlie Massey: That is the other dimension to your flow question from earlier: what about stock? The BMA's publication last week was based on about 1,000 doctors replying, and four in 10 of them said they were considering leaving the UK. We have also done our own bit of work, which only closed at the end of last week, which tends to reinforce some of what the BMA survey said. It was a self-selecting piece of work. About 2,000 EEA doctors replied, which is about 10% of the EEA doctor workforce in the UK. Of those, a slightly higher proportion said they were considering leaving the UK—about 60%—and, of those, about 90% said



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that was because of Brexit. Of the 2,000, just over half said they were considering leaving because of Brexit.

That needs to be treated with a degree of caution. This is a self-selecting group of people who have responded to that survey. What people say is not necessarily going to be predictive of future behaviour, but it sends a worrying signal in terms of the stock of doctors currently working in the UK. If you look at what people said in their free text comments in our survey, basically there were two reasons that came out as being the drivers of that: first, a question of whether doctors felt valued and wanted in the NHS; and, secondly, a question of the uncertainty over their continuing and future residence status. Clearly, the question of residence status is a matter for the UK Government. I would say that sends a bit of a warning signal about the stock of EEA doctors. As I say, we need to be a bit careful about it, but what we have seen is very much in line with what the BMA said last week.

Q297 Dr Whitford: Were there any comments in the free texts from people who had had actual difficulties having applied for permanent residency? I have friends who are both German and have been given residency, but, of their three children, their eldest and youngest have been given the right to remain but not their middle one. Bizarre things seem to be happening and then they talk about them, so I wondered whether that came back or if it is just the general understanding.

Charlie Massey: The honest answer is that I do not know. This is a survey we ran that was only completed at the end of last week. This is the first time I am putting that in the public domain in terms of what it said. We will be publishing more detail in due course. More generally, we see the GMC having quite an important role in continuing to hold the mirror up and seeing what the data says and what doctors on our register say, because that will help to inform public debate over the period ahead.

Q298 Chair: Were there any points that either of you wanted to make before the end of the session?

Jackie Smith: I do not think so, no. We have made the points we wanted to.

Chair: Thank you for your detailed written evidence as well. It is much appreciated. Thank you very much.

Examination of witnesses

Witnesses: Ian Cumming OBE, Gavin Larnar and Paul MacNaught.

Q299 Chair: For those following from outside the room, can you introduce yourselves, please, starting with Paul MacNaught?

Paul MacNaught: I am Paul MacNaught, director of international policy at the Department of Health.



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Gavin Larner: I am Gavin Larner, director of workforce at the Department of Health.

Professor Cumming: I am Ian Cumming, chief executive of Health Education England.

Q300 **Chair:** Thank you all very much for coming. Could we start with the issue of reciprocal healthcare? Starting with you, Mr MacNaught, could you set out how you would describe the scale of the administrative challenge ahead that could be involved in redesigning the reciprocal healthcare arrangements that we have with other countries across the European Union?

Paul MacNaught: As Ministers and the White Paper have made clear and as the Secretary of State explained in his remarks to this Committee a few weeks ago, a key objective in the negotiations ahead is to guarantee the rights of existing residents. With a fair wind, we might not need to do a wholesale reorganisation of these arrangements. The way the arrangements are organised at the moment, there is regulation 883, which is quite a complicated set of entitlements, and the administration of that in this country involves a team of about 120 people employed mainly through DWP and the NHS Business Services Authority, which gives you a sense of the scale of the activity.

As to money, on an annual basis, we pay out roughly £650 million a year to cover the costs of UK-insured pensioners in other EEA countries and UK visitors to those countries. That gives you a sense of the scale of the operation.

Q301 **Chair:** Do you feel that those numbers are a reflection of why there is such disparity in the way the UK manages claims from European countries?

Paul MacNaught: You mean why do we pay out £650 million and collect in something more like £55 million—

Q302 **Chair:** Clearly a lot of that is involved with the healthcare costs of those who are retired in other countries, but there has also been a concern that perhaps we are not very efficient at claiming where we could be claiming from EU countries. Would that be a fair assessment?

Paul MacNaught: The Government acknowledge that there is more that can be done to claim more, which is why there is a cost-recovery programme with a target. At the moment, we collect back about £55 million-worth of claims from other countries, and my colleagues in the cost-recovery team estimate there is about £200 million that could, theoretically, be reclaimed. The main reason for the disparity between what we pay out as a country and what we bring in is the volume of UK-insured pensioners living in other EEA countries compared with the volume of EEA-insured pensioners living here. There are about 190,000 UK-insured pensioners currently signed up for the reciprocal healthcare.



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Q303 **Chair:** We are going to come on to that specifically in more detail shortly, but if we look at the EHIC-type arrangements for those who are having temporary insurance, would it be fair to say we are not particularly efficient at identifying and making claims with the system as it is? Would that be a fair judgment?

Paul MacNaught: I think the Government are quite open about that position. That is why there is a cost-recovery programme looking at new ways of making sure that we claim back what we can. One barrier is that, historically, the NHS has not needed to track exactly who is using the service or how much each intervention costs, but one pilot going on at the moment in a number of trusts is looking at whether requiring people to provide ID when they present for planned treatment could be a way of increasing those numbers. We are also updating our IT system that we use to track all these claims, which should make it easier for people working in trusts to capture, record and report the relevant activity so that the Department of Health can in turn be claiming back those costs from other countries.

Q304 **Chair:** Do you feel that, from a purely practical basis, we would be better to try simply to continue the current arrangements if that is acceptable to our EU partners, or do you feel that this is an opportunity to redesign the system?

Paul MacNaught: As I say, we are already looking at what we can do to redesign the administration arrangements to do better there, so it is not about freezing the current system.

Q305 **Chair:** Getting more efficient at administering a system that we already have is one thing, but, after we leave the European Union, is it your plan to try to maintain the existing underlying framework—not our own mechanisms for dealing with it domestically but the underlying framework? Do you think, purely practically, that is your preference, to continue with that system, or to redesign it?

Paul MacNaught: If the objective is to guarantee the existing rights of residents in both countries, then us inventing a totally new system for doing that does not sound very compatible. There are, of course, wider discussions going on for the negotiations about immigration systems and other things that this will play into, but, no, there is not a grand plan to tear up the existing arrangements.

Q306 **Chair:** If we move on from mutual recognition of healthcare costs, do you see that there is a mechanism that would be a preferred alternative?

Paul MacNaught: Do you mean as a contingency option?

Chair: Yes.

Paul MacNaught: We are doing contingency planning, as the Secretary of State mentioned when he was here a few weeks ago. At this point, we do not want to get into speculation about what those contingency options might be for fear of undermining the negotiation objective. You do not go



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into a negotiation and start by saying what you are prepared to do if the negotiation is not successful.

Q307 **Chair:** But you are looking at contingencies, and I understand why you do not want to share them at this point. On the issue of waiving the cost recovery, we have arrangements with several other countries—for example, Malta and Norway—where we do not reclaim those costs. What costs are excluded from those claims? For example, we have heard that sometimes they exclude infrastructure costs. Can you give us a bit more detail about that?

Paul MacNaught: I have not come along prepared to give you that sort of detail, but I would be happy to write to you on that. The reason for these waivers is down to there being parity in the movements of people between the countries; it would be an unnecessary burden on the taxpayer to have an elaborate system of charging each other for very similar levels of expenditure. That is a key principle behind those countries where there are waivers.

Q308 **Chair:** Some of them are small countries and some are much larger countries, but it is not based on the size of the country; it is based purely on if it is more or less an equal claim.

Paul MacNaught: In some cases, it could be down to the very small size of the country and therefore movement of people, but even in larger countries there are very similar movements of people such that it makes no administrative sense to spend money chasing the costs off.

Q309 **Luciana Berger:** Looking at the data that has been made available to this Committee and just trying to understand it a little more, can you help us about whether the Department has an understanding of how the costs incurred through reciprocal arrangements break down, both for different countries and groups of people, and particularly whether you have any handle on the proportion of these claims that come from older people?

Paul MacNaught: Yes. The actual amounts we pay in any given year are greatly affected by the exchange rate, but, if we are talking in general terms, we spend about £650 million a year on the reciprocal healthcare arrangements. Of that, about £500 million is on pensioners, so that is UK-insured pensioners, of which there are about 190,000 in other EEA countries. I think the figures there are 70,000 in Spain, 44,000 in Ireland, 43,000 in France and about 12,000 in Cyprus. Those are the main countries. The other £140 million is spent on the people who hold EHIC cards, of which there are 27 million holders of UK-issued cards. Then there is about £6 million on the dependants living elsewhere in the EEA of workers who are working in this country.

Q310 **Luciana Berger:** As to the costs incurred, are these fixed costs or average costs per person?



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Paul MacNaught: It varies. The regulations require payments to do with use of the EHIC card to be based on actual costs. Countries take different approaches on what they do about pensioner costs. Recently, there has been a trend to move to actual costs for reasons of transparency. Countries such as France and Germany, where they are able through their domestic systems to work out readily what the actual costs are, charge on that sort of basis. Countries such as Spain, Ireland and the UK, charge on the basis of an average cost currently.

Q311 **Luciana Berger:** To what extent have you made an assessment of the claims that have been made—whether they are a fair and accurate representation of the real costs incurred? That applies both to British nationals across the EU and EU nationals that are using the NHS.

Paul MacNaught: The process of deciding how much each country is going to pay takes about three to five years after the healthcare has been received by an individual, which gives you, partly, a sense of the level of rigour and haggling that goes on to work out exactly what kind of payments between countries should be made. Quite a lot of effort goes into making sure that payments are appropriate.

Q312 **Luciana Berger:** At the moment, we are only seeking repayment for healthcare that has been used up until five years ago.

Paul MacNaught: We could be, yes.

Q313 **Luciana Berger:** Is that across all member states, or what is the difference between the three and the five years?

Paul MacNaught: My understanding is that that is a common pattern across member states. At the moment, the administration of this system between member states is largely paper based. You have big cardboard files of papers being posted backward and forward across Europe, which people then have to process. There is an initiative under way by the Commission at the moment to automate quite a lot of that activity, which should have the effect of speeding some of it up.

Q314 **Luciana Berger:** At the moment, we are in the region of over £1.5 billion out on how much we might owe other member states if it is the same amount per year.

Paul MacNaught: Pardon.

Luciana Berger: In terms of how much we might owe to other member states, and on the current amounts we are paying per year, we are at least £1.5 billion out, in what we might owe to other member states and the amounts you said we are spending at the moment per year to other member states.

Paul MacNaught: I am sorry; I do not really understand. What do you mean by “out”?

Q315 **Luciana Berger:** In terms of the money that we might owe—the delay.



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You said there is a three to five-year delay.

Paul MacNaught: I see. I suppose you could look at it like that, but the normal administration of the system involves payments being made in arrears of three to five years, and I am sure that when other countries get those payments they are pleased to receive them.

Q316 **Heidi Alexander:** Anyone listening would be quite surprised to hear of the cardboard boxes of paper claims in effect being sent from one European country to another, and it is welcome to hear that there is an automated system being put in place. With respect to the UK's ongoing involvement in that new system, which would make sense to anyone listening to the evidence that you have just given, are there problems with respect to our involvement in that system now, and, given that we are likely to enter a period of a number of years of negotiations, are we going to be reaping the benefits of this new, automated system, or are you finding that other European countries are now putting our involvement in that on hold?

Paul MacNaught: No, not at all. We are still a member of the EU and all the obligations continue to apply. The cost to the UK of the new systems, in the round, that we are bringing in is, we estimate, about £6 million; we are not talking about a huge, new IT system. In the context of annual payments of about £650 million, if we can make a tiny impact on reclaiming what we ought to be reclaiming, reducing error, speeding up and making the system more efficient, you can see that that cost would quickly repay itself.

Q317 **Heidi Alexander:** Are you confident that in two and a bit years' time, having triggered article 50 and left the European Union, we would still be able to reap the benefits of that new system, having put that money in?

Paul MacNaught: We are bringing this new system in over the next 12 months and we think it will repay itself within a year or so, so there is a good chance that we will have reaped the benefits even before we get to March 2019. If we continue making payments to other EU countries three to five years in arrears, there is going to be an ongoing period of benefit from that system. But, as I say, the objectives that Ministers have laid out for the negotiations are about guaranteeing the ongoing rights of residents. If that sort of arrangement is successful in this space, then there will be benefits for many years to come.

Q318 **Chair:** That would potentially see three years' worth of claims all bunched into one year.

Paul MacNaught: It could, but even in that scenario, in a small way, knowing that we had a better system for tracking what we would be entitled to reclaim in future years would not do us any harm in a negotiation even on that point.

Q319 **Heidi Alexander:** Can I ask one other point that is not related to that immediately preceding discussion? In terms of contact with your



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counterparts in other European countries, how often do you meet them, how much contact have you had since the referendum last year, and how confident are you, in the aspirations of maintaining a similar system to that which we have at present with regard to reciprocal healthcare, that we are going to be able to achieve those aims?

Paul MacNaught: As you know, other EU countries are operating under a strict rule of no negotiation before notification, so any contacts that we have had have been informal, but we are quite confident that there is enthusiasm in a number of other countries for guaranteeing the rights of existing residents in the kind of way that our own Ministers have laid out.

Q320 **Dr Whitford:** I am going to talk more about the British nationals who are in Europe, but thinking of this imbalance in claiming, do you think, going forward, we are going to have, as was shown to us from a member of the panel last week, basically an ID card that shows your eligibility—whether it is your eligibility to work here or to access our NHS in the future?

Paul MacNaught: I am not in a position to comment on plans for ID cards. That is not a matter for the Department of Health.

Q321 **Dr Whitford:** It is not going to get any easier trying to reclaim if we have reciprocity in the future really, is it?

Paul MacNaught: As I mentioned earlier, there are pilots going on in a number of NHS trusts looking at asking people to produce ID when they come to present for planned care. It does not have to be an ID card. There are other forms of ID to show who they are and that they are resident in this country. The kind of IT system that I mentioned would make it easier for managers in trusts to enter in the information that then comes to us. At the moment, it is quite laborious for them to have to do that, which is one disincentive to properly following up these sorts of matters.

Q322 **Dr Whitford:** It strikes me that we have this real obsession with never having an ID card and then we have to knit our own every time someone wants to know we are who we say we are. Not everyone drives and not everyone has a passport; you have a gas bill, and you might get a texted gas bill. We often have to prove our ID, and, obviously, we may have people having to prove it in the future.

Can I ask from the point of view of looking at reciprocity whether the Department accepts that reciprocal healthcare would be a shared competence and, therefore, it will be negotiating with the EU 27, or is there a thought in the Department of trying to focus on countries that have the biggest number of pensioners, such as France and Spain?

Paul MacNaught: The negotiating strategy is still to be finalised, but, looking at what the White Paper says and what Ministers have said otherwise about the objective of guaranteeing the rights of existing residents, it would seem to me to point to negotiating with the EU bloc. As I say, we are looking at a number of other fall-back and contingency



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options, but we do not really want to get drawn into speculating about them now.

Q323 Dr Whitford: Certainly, it came from a representative of UK nationals in Europe last week that, far from no deal being better than a bad deal, they consider no deal to be an unmitigated disaster. Do you think it is recognised by the people who are going to be at the coalface doing this that we could have UK pensioners who are just suddenly dropped from a great height?

Paul MacNaught: Those risks are definitely understood by the DExEU and others. There are other negotiating objectives to do with achieving a smooth and orderly transition, and giving people maximum certainty about how the process is going to unfold. It seems to me that we should look to those kinds of objectives for reassurance in that space during this period where we cannot speculate about contingency options.

Q324 Dr Whitford: Within the other countries of the EU, are there regulations or anything, either EU or national, that would protect some of the UK nationals' rights in those countries? We talk a lot about pensioners because we visualise them and they are the ones who account for the biggest amount of money, but there are people who are working in these countries and paying like any citizen, and, like EU nationals here, they are just as frightened.

Paul MacNaught: I cannot comment in detail on that. It might be that there is information that we could write to you with. The GOV.UK website contains information for people who are thinking of moving to other countries in Europe or travelling there, and the NHS Choices website has a section on each other EEA country, with quite a lot of detailed information to help people access services over there.

Q325 Dr Whitford: Has that been updated since the Brexit vote, or would it still say things as if we were remaining within the EU?

Paul MacNaught: I imagine it would be the latter, because the position is that we are still a member of the EU and all the existing arrangements continue to apply. If people have not yet signed up for them, they should; there are still over two years to go until we get to March 2019. The messages would be of reassurance at this point.

Q326 Dr Whitford: For people who have been in this country a longer time, and particularly people who are higher earning within some of the professions and would reach tier 2 levels, a lot of their concern is not about whether they are allowed to stay or not; it is about keeping things such as right of access to the NHS. It is a big concern that I hear among EU national friends. Has there been discussion within the Department around that?

Paul MacNaught: There has been; that issue is understood and being considered, including as part of contingency thinking.



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Q327 **Heidi Alexander:** When do you think you will know whether you are negotiating with the EU or the 27 member states?

Paul MacNaught: Ultimately, these are matters for the Prime Minister, DExEU and the Cabinet as a whole to decide on, so at this point I cannot say.

Q328 **Heidi Alexander:** You do not know whether it is going to be in three months or six months. Are these negotiations going to extend beyond the article 50 period, or would you intend to have resolved matters regarding reciprocal healthcare within the article 50 period?

Paul MacNaught: We would expect to hear more about the negotiating arrangements pretty quickly, given that article 50 is shortly to be triggered. On the question about negotiating beyond a two-year period, if that is what you mean, I think Ministers have been pretty clear that this question of guaranteeing the ongoing rights of existing residents is something that they want to pursue early on in the negotiations rather than leave until the end.

Q329 **Mr Bradshaw:** You just said that you would expect to hear from Ministers fairly shortly their priorities for negotiation given that article 50 is about to be triggered. Are you saying you have not been given any steer or guidance from Ministers up until now?

Paul MacNaught: No, not at all. The Prime Minister's speech of several weeks ago in the White Paper lays out quite clearly what the overarching priorities are for the negotiation. What I was commenting on, I think, was arrangements for how the negotiations are going to be carried out.

Q330 **Mr Bradshaw:** We are potentially 10 or 14 days away from the triggering of article 50 and you have not been given a detailed dossier, as the Department of Health, of your priorities and negotiation strategy and the details of that, in terms of the practical arrangements.

Paul MacNaught: No, that is correct.

Mr Bradshaw: Good grief.

Q331 **Dr Whitford:** When we were discussing this with the Secretary of State, it was clear he was not in, if you like, the Brexit cabinet. Does it not cause concern in the Department of Health that we are not really seen as being core to this, and—a concern I have raised many times—we talk single market, which makes it sound as if it is about trade, when that is probably the easy bit? Do you not think the Department should be elbowing its way to the table to point out that some of this is much harder to do than trade?

Paul MacNaught: Yes. We elbow our way to the table almost every day in various forums, and, as the Secretary of State said when he was here, when those specific matters are considered by the Brexit Cabinet Committee, he would fully expect to be there.



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Q332 **Dr Whitford:** Who we negotiate with will not be up to us, whether we negotiate with bilateral countries or EU 27. That will be up to them, they will decide, and because it is a joint competency we have to assume they will negotiate as the EU 27.

Paul MacNaught: At this point, yes.

Q333 **Heidi Alexander:** Can you tell me what it is that will determine ultimately whether it is deemed to be a shared competency and negotiated wholesale by the EU? What are the various considerations that you are aware of that will determine whether we end up negotiating with 27 member states or the EU?

Paul MacNaught: If I were to answer that question, I would be straying into hypothetical situations. The Government's objective at the outset is pretty clear about seeking to guarantee the rights of all existing residents. It does not talk about pursuing particular arrangements with particular countries to our advantage or anyone else's.

Q334 **Heidi Alexander:** How many people do you have working specifically on these contingency arrangements at the moment?

Paul MacNaught: In where—in the Department of Health?

Q335 **Heidi Alexander:** Yes. How big is the team?

Paul MacNaught: It will be a bit like the discussion we had the last time, which is that there is a range of policy areas across the Department that are affected; workforce is one of them and—

Q336 **Heidi Alexander:** I am sorry to butt in, but I am asking you a particular question about the number of people who are working on contingency arrangements with regard to reciprocal healthcare.

Paul MacNaught: Apologies. I have a team currently of eight people focused on this sort of issue. There are also the 120 people involved in administering the current scheme. The phase of all this work that the Government have been in since the referendum, up until relatively recently, has been one of scoping out all the possible policy issues. Now, we are moving into a phase of more practical contingency planning and thinking about how we would implement different scenarios. What I have described there is the current set-up, but we keep that under review and we will move others on to the work as necessary.

Q337 **Heidi Alexander:** Can I ask you about bilateral agreements that the UK has with other European countries on healthcare? How many of these bilateral agreements exist and what do they cover?

Paul MacNaught: There are 27 of them, because the way the system works is that regulation 883 is the overarching framework, and then underneath that each member state reaches a bilateral arrangement with every other member state about the basis on which costs are going to be claimed or charged—for example, whether it is going to be average or fixed costs or actual costs. There are some differences with different



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countries. For example, with Gibraltar, there is a particular arrangement because of the historical ties but also the lack of health services they have in Gibraltar, where, if they want to, Gibraltar can send people to the UK for treatment, although, in practice, most choose to go and have their treatment in Spain, for obvious reasons.

Q338 Heidi Alexander: These bilateral arrangements fall under the EU regulations on co-ordinating social security. Is that right?

Paul MacNaught: Yes.

Q339 Heidi Alexander: Are there any bilateral arrangements that predate our membership of the EU? I think Professor Martin McKee alluded to it in the evidence that he gave to the Committee last week. What usefulness, if any, would those earlier arrangements be in any future scenario?

Paul MacNaught: There are some. With Ireland, for example, there has been an arrangement since 1971. Obviously, there is a question about the default legality of those kinds of arrangements, and by their nature they are reciprocal. At this point in the proceedings we are seeking to guarantee the ongoing rights of residents on a reciprocal basis. So turning is a contingency option to some other set of reciprocal arrangements.

Q340 Heidi Alexander: Do they limit the quantum of people that could be treated? Is that the case? You mentioned Ireland, for example. In that early agreement, how does that work?

Paul MacNaught: I do not know.

Q341 Heidi Alexander: In terms of UK citizens living in other European countries, what plans does the Department of Health have to communicate directly with those groups of people, many of whom are probably quite fearful about what the next couple of years may hold for them?

Paul MacNaught: That is where we look to the Foreign Office network of embassies and consulates to do that sort of communicating. They are holding particular events specifically on this sort of thing. For example, there was one recently in Alicante. The messaging that is being offered is, "You are still a member of the EU at the moment. If you are not already signed up to these arrangements, get signed up," and talking about the kind of priority that the Government are giving to seeking to guarantee the ongoing rights of residents. As soon as there is more to say, we would use that network to do the communicating. There are also the GOV.UK and NHS Choices websites that I mentioned, where there is quite a lot of information about what you can do at the moment.

Q342 Heidi Alexander: Finally from me, what assessment have you made about the impact and cost to the NHS if 70,000 pensioners who are currently in Spain return to the UK? There was an argument that we might get quite a good deal at the moment from having a number of UK



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citizens treated in other European countries. What analysis have you done of what the impact might be on the NHS?

Paul MacNaught: That is one of the advantages of the current arrangements. The average cost that Spain charges the UK per pensioner signed up to these arrangements is about €3,500 currently. Ireland charges about €7,500. Our cost in the UK is about £4,500, so let's say €5,000. Overall, the average cost, if you take the £500 million for pensioners and 190,000 pensioners, works out at about £2,300 per pensioner under those arrangements, which is significantly lower than the average cost of treating pensioners in the UK.

Q343 **Heidi Alexander:** It is about half, from what you have said.

Paul MacNaught: That is one advantage of the current arrangements. To put your 70,000 figure in context, there are currently, I think, about 11 million pensioners in this country. Your 70,000 figure would be rather less than 1%.

Heidi Alexander: That is helpful.

Chair: Thank you. We are going to move on to workforce now, and Maggie is going to start.

Q344 **Maggie Throup:** We are all aware that EU nationals play an important role in the delivery of our NHS. Do you regard Brexit as a substantial threat to the future supply of clinical staff in the NHS?

Professor Cumming: About 5% of the entire NHS workforce is EEA nationals, but that varies hugely from one particular group within the workforce to another. For doctors, for example, it is about 9% and nurses about 7%. Interestingly, within our total workforce, about 6% come from the rest of the world—non-UK, non-EEA—so we do have quite a diverse workforce.

We are modelling in HEE at the moment what the impact would be of a reduction in the number of people coming from the EEA to work in this country, although we are not seeing signs of that yet. Obviously, article 50 has not been triggered, but I have just this week seen the figures for applications for doctors for specialist training in this country, and the number is, to all intents and purposes, exactly the same as last year. About 18% of all applications for specialist training in 2015-16 were from EEA nationals and it is 18% again this year, and the overall figure has not gone down. It may be that specialist training in the UK is recognised as being among the best in the world and it may be this particular group of individuals—doctors—are protected from it. Certainly, within the nursing workforce, there is some anecdote that we are seeing people leaving and not entering into this country at the rate at which we have done previously. What we are trying to model is effectively a policy of self-sufficiency, so we make sure that we train enough people in this country to meet the needs of the NHS.



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Q345 **Maggie Throup:** Some of the data we have seen show that the number of nurses from EU countries is slowing down, yet you seem to think it is not.

Professor Cumming: There are peaks and troughs. It has speeded up and it has slowed down. It is dependent on demand and on a number of factors. I think certainly, as you heard from the NMC earlier, the introduction of language testing has definitely had an impact from our perspective on that. I think it is too early to say whether the decision to leave the EU has had an impact, although our anticipation is that it will and we therefore need to put contingencies in place to allow for that.

Q346 **Maggie Throup:** We have perhaps a slowing down from the EU, but at the same time we have a growing demand from patients. Are you going to be able to cope with that?

Professor Cumming: The 7% of the qualified nursing workforce is about 22,000 nurses working in the NHS in England who are EEA nationals. We train about 24,000 nurses a year. On current projections, by 2020 we will produce somewhere between 8,000 and 40,000 nurses, depending on turnover, more than the demand is projected to be at the moment. That is without the impact of Brexit. If we are at the 8,000 end of that and we lose all 22,000 EEA nationals, then we are not producing enough. If we lose all 22,000 EEA nationals and we are at the 40,000 end of that, then we still have a surplus of nurses and the supply and demand will be in balance by 2020.

Q347 **Maggie Throup:** You mentioned that you thought the number of doctors coming in has not decreased because of the quality of training here. What impact do you think Brexit will have on the quality and overall skills base of the nursing workforce?

Professor Cumming: Our policy is to be self-sufficient. That is not to say that we do not want any members of our workforce to go and work overseas, because we do; that is a fundamental part for us of training, allowing people to have experience overseas. But our policy is to see that the UK, or England, in terms of my responsibility, trains the number of doctors, nurses, physios and pharmacists that we need to be self-sufficient, and if we have somebody going overseas for training we have somebody else coming into this country for training to offset that.

Q348 **Maggie Throup:** Are you confident that the Government's recent reforms to nurse training will allow the UK to limit its reliance on foreign-trained nurses?

Professor Cumming: It is too early to say in terms of the impact of the spending review on recruitment this year. We know that applications to nursing training places in this country are down about 23% across the country as a whole. That would still allow every nurse training place to be filled if that 23% was evenly distributed across the whole country and if all the people who apply are of the right academic standards. There are already two big ifs in there. Until we start seeing what happens with



direct applications to universities—those are figures through the UCAS process—and until we see what happens with posts being filled through clearing, it really is too early to say, but, in theory, all the posts that we believe are needed to produce the NHS workforce of the future could be filled by the number of people who have applied this year.

Q349 Maggie Throup: You say “in theory” and you also say it is too early to tell. When do you expect to be able to give a definitive answer?

Professor Cumming: I do not think we will be able to give an absolute definitive answer until all the offers are made post clearing, so you are looking at the end of August, realistically, before a definitive answer. I think we will have a clearer position once offers have been made, and we will then certainly know if there are any areas where there are not enough offers being made to fill all the nurse training places. I would expect that to be May or June.

Q350 Maggie Throup: If you have, potentially, that gap in June, perhaps a continued decrease in nurses coming from EU countries and an increasing demand from patients, we are in a bit of a pickle, are we not?

Professor Cumming: Yes, but we have other mitigation areas as well. Our biggest risk in the short term, as a result of Brexit, may be in the non-professionally qualified workforce across health and social care. We have to consider that workforce as well as the professionally qualified. For example, the nurse associate programme that we have introduced, allowing people to go from healthcare support worker to a new role of nurse associate in two years and then on to a degree-level registered nurse, is part of a strategy that we are calling careers, not jobs, to encourage people to come into careers in the NHS where, even if you are starting with limited academic qualifications, we can offer you this opportunity to progress. This is because we are going to be competing for the non-professionally qualified workforce with hotels, agriculture and tourism, and we need to make sure that we are an attractive employer. But the nurse associate role is also another route into nursing. So, 2,000 people have started now on nurse associate training programmes. In two years, they will become nurse associates. Two years beyond that, if they wish, they could become degree-level registered nurses. We are building other supply pipelines as well.

Q351 Maggie Throup: Finally, having talked about doctors and nurses, has any assessment been made of the impact of Brexit on non-clinical staff within the NHS?

Professor Cumming: Yes, although they are a much smaller percentage than you will find within the clinical workforce and, generally speaking, those jobs are easier to fill than the clinical workforce.

Q352 Maggie Throup: Can you give an example?

Professor Cumming: On the non-professionally qualified staff, as an example, within catering in the NHS, within our hospital kitchens, you will



find quite a lot of people who are EEA nationals, or indeed non-UK, non-EEA nationals. Those again come in through a programme called Talent for Care. We bring people in and give them qualifications; we train them up to become a chef, or whatever it may be. You do not just come in and do a job; you come in with a pathway. Our strategy is to offer that alongside apprentice routes into training to make the jobs more attractive for our own nationals—so, again, the self-sufficiency route.

Q353 Mr Bradshaw: When do you expect the UK to be self-sufficient in home-grown doctors?

Professor Cumming: If you consider completely self-sufficient, we are dependent on the 1,500 medical students that the Secretary of State announced last year. They will not be starting at medical school until 2018-19, so they will be coming out of medical school in 2024 and entering postgraduate training then. It then depends on whether they go down a consultant route or a GP route as to when they come out at the other end, but that 1,500 is made up of 500 to fill current vacancies in postgraduate training and 1,000 to fill people whom we recruit into postgraduate training from non-UK backgrounds, so not just EEA but international backgrounds.

The technical answer to that question is that, for us to become completely self-sufficient and have no reliance whatsoever internationally, you are looking at somewhere in the region of 10 or 12 years from now. However, unless something very significant changes, we are still seeing the international applications coming through for postgraduate training and we are not anticipating a huge drop-off in that, subject to legislative changes, mutual recognition and so on.

Q354 Mr Bradshaw: Does that prediction of self-sufficiency in 10 to 12 years' time take into account the number of doctors we subsequently lose post training to places like Australia and New Zealand?

Professor Cumming: Yes. We lose, but we gain. There is an inflow and an outflow on an annual basis. The consultant workforce in the NHS has grown over the last 10 years by an average of 5% a year and is continuing to grow by 5% a year. We lose some, but we are still producing more than we lose.

Q355 Mr Bradshaw: Nevertheless, we are talking about a big gap, are we not, for about a decade? What changes do you think we would need to see in the immigration rules from non-EU countries to fill that gap, assuming everything we have heard about EU nationals based here either not going back or others not coming because of the uncertainty?

Professor Cumming: Subject to retention, we know exactly how many GPs and consultants we are going to produce in each of the next three to five years because they are already in training. That will allow for a growth in the workforce of about 5% in each of those years. The question then is whether that is adequate to meet demand, and with GPs in particular we are gearing up to produce 5,000 extra GPs by 2020. From



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our perspective, the area we want to explore is opportunities around people to be able to come and train in this country and then return home at the end of their period of training because we believe that is valuable for the NHS, for the individuals and for the countries that they return to. From our perspective, we would want to see the ability to do that through the various initiatives that allow that to continue.

Q356 Mr Bradshaw: Where are the particular regional and specialty concerns that you have about workforce capacity going to be?

Professor Cumming: Mental health—psychiatry—and general practice are the two areas: general practice because we are trying to grow the numbers significantly, and psychiatry because for a number of years it has not been a popular specialty, although we are starting to see something of a shift there with more people applying to train in psychiatry. If you had asked me that question three years ago, I would have said emergency medicine. However, in the last three years we have had 100% fill rates of training posts in emergency medicine, so that is now starting to correct.

Q357 Mr Bradshaw: There are some specialties, are there not, that seem to be particularly dependent on EU people to fill—specialists and skills?

Professor Cumming: There are; that is partly because of quality of training and partly where there have been more opportunities because we have not filled them with our own people who have been trained in this country.

Q358 Rosie Cooper: When the Secretary of State was here he talked about—almost a phrase we used to use in business—“growing our own,” developing nurses from staff in care roles now. If that was a career path that leads to nursing, would it exacerbate the problem we have with getting those social care jobs filled lower down? How does the system plan to cope with that?

Professor Cumming: Yes, absolutely, there is a risk of that. However, as to the first 1,000 people that we have recruited on to nurse associate training posts, a number of the hospitals in particular that employed those individuals have said that they have found it easier to recruit healthcare support workers into the jobs in that hospital because people see that as being an opportunity that they may pursue.

There is an area on which we are keen to make sure we do not have an adverse impact, which is that, because health is pursuing the policy of nursing associates, we do not then take all the care staff out of the social care environment and make things much worse in that environment. One thing we have done for many of the nurse associate training posts is to have rotations through nursing homes or social care placements, and we are encouraging nursing homes and social care providers to put people on to nurse associate programmes as well, because we think these nursing associates will be just as valuable working in social care and in the community as they are going to be in hospitals and in general



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practice. But it is absolutely a risk, and for that workforce we have to consider health and care to be a single workforce because people move freely between them.

Q359 Rosie Cooper: In the modelling you are doing, how are you planning that in? You have talked about 8,000 to 40,000 training places, and we could be at one end or the other. How are you going to model in the number of nurse associates—the normal route?

Professor Cumming: Our original plan was to train 1,000 nurse associates this year, and, partly because of the popularity and partly because we want to mitigate against uncertainty, we doubled that number to 2,000; so we have put 2,000 in already. The indications that we are getting back from employers are that they want to go further faster—I apologise for the jargon—to seek to potentially significantly increase that number in the financial year 2017-18. These are in addition to the number of nurses that we are training through, I suppose, the traditional degree route coming through university. These are on top of our workforce planning assumptions as part of the mitigation before any impact of Brexit.

Q360 Rosie Cooper: What assessment have you made of the extent of the reliance in certain parts of the country on social care where there is almost low unemployment, rural areas, and in fact in parts of the country where EU staff form a large proportion? Where are you going to get those people from?

Professor Cumming: My organisation does not take specific responsibility for social care, so perhaps we can bring Gavin in on that, but you are absolutely right. In healthcare, I have talked about the percentage of EEA staff overall being 5%. In London, it is 10% to 11%. In the north and the south-west it is between 2% and 5%, so there is very significant geographical variation. We need to make sure we build in to the additional training posts that we are putting in place that geographical variation because people do not tend to be mobile in these sorts of jobs. If we want people in a particular geographical area, we need to train in that area.

Gavin Larner: There are 90,000 EU nationals working in the social care sector, which is about 7% of staff there. If you look at the direct care piece, which is the lower paid workforce, then there is a total of about 969,000. Of those, 83% are UK nationals; 115,000 are overseas non-EU EEA nationals, so that is about 11%; and about 67,000 are EU nationals, so about 7% of the lower paid direct-care workforce providing direct care in the social care sector. There is considerable regional variation in that, as you say there was. In London and the south-east, it rises to about 11% of direct care, but if you go to Yorkshire and Humberside it goes down to about 3%. Effectively, the further away you get from London, the less European the workforce is. That is a substantial labour market filled by overseas nationals.



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Unlike the healthcare story, where there is a higher skilled workforce where we have much more direct training routes, there is likely to be a continued need for employers to look beyond domestic supply to overseas labour for some time. We are doing a number of things to fill that gap. The key component of that working for Skills for Care is apprenticeships, and Skills for Care have been very active in this area since 2010. We brought in over 400,000 new starts into apprenticeships in the social care sector. But, even with that, it will be some time before we can say we are close to self-sufficiency. There is clearly an ongoing migration need in that sector.

We have been working closely, both bilaterally and in working groups, with the Department for Exiting the European Union, the Home Office and Cabinet Office to make sure that the sort of numbers I am telling you here and the geographical breakdowns we have are fed into their thinking about what the future migration regime needs to be. The Home Office's intention is, over the summer, to consult further with business generally and with the social care sector to get a better picture of what sort of migration regime they might need to accommodate that sector.

Q361 Mr Bradshaw: Mr MacNaught, just going back to your answer to some earlier questions on our preparedness for this very important negotiation on Brexit, in so far as the NHS and our healthcare system is concerned, have you at least had a preliminary meeting with the Secretary of State about our priorities?

Paul MacNaught: Yes—with the Secretary of State for Health, yes. We meet him almost weekly on this stuff.

Q362 Mr Bradshaw: You meet him regularly but still do not have any idea as to what our priorities or strategy should be over the next weeks and months.

Paul MacNaught: Perhaps I misunderstood your earlier question. As he explained when he was here a few weeks ago, the big-ticket issues affecting health, which are our priorities, are workforce, medicines and devices regulation and the implications for the life sciences sector generally, reciprocal healthcare and health-protection systems, because, as a country, we are part of cross-European arrangements. Those are his priorities.

Q363 Mr Bradshaw: Do you meet regularly with your colleagues from No. 10 and the Brexit Department as well to make sure that those issues are on their agenda?

Paul MacNaught: Absolutely—almost daily.

Q364 Heidi Alexander: Can I ask you a quick question about the overseas pilot that you have been running in Lincolnshire to get GPs into that part of the country? In the note that was prepared for us—it might be more accurately directed towards Professor Cumming—you said that you were planning a more extensive round of overseas recruitment. Could you give



us more detail on how you are going to scale that up over the next couple of years?

Professor Cumming: One phenomenon that we have seen developing over the last five years or so is an increasing number of medical schools in the EEA teaching medicine in English and a number of UK citizens who perhaps have not got into medical schools in this country going to those medical schools and, therefore, graduating with a degree from that university but having learned or studied medicine in English. One thing we were keen to do was to explore with those individuals the opportunities for postgraduate training back in their own home country.

I went to Bucharest myself about nine months ago and met with a number of people who are studying medicine there, who were interested in coming back to train to be GPs in this country. We are trying to pursue that. To be honest, although we do not have any figures—this is only anecdote—we are aware of some non-UK nationals who may have been interested in coming to this country to train as general practitioners, who perhaps are less interested now until they are clear about the impact of Brexit on their primary medical qualification, their training and their ability to live and work here. But, generally speaking, as part of our approach to generate 5,000 extra GPs—a net increase of GPs—in this country, we are looking at a range of initiatives, of which this is one.

Q365 **Heidi Alexander:** Will you be looking to run a similar scheme in parts of the country other than Lincolnshire, and, if so, where?

Professor Cumming: We have a variety of schemes. This is not really linked to the EU issue, but we are offering an extra year of training post qualification for GPs to attract them into parts of the country where it is hard to recruit. We have been running an incentivisation scheme where, if people take a GP training post that has not been filled in any of the last three years, we make available a one-off salary payment to them, and that has been very successful. That has filled 105 jobs this year that have not had any GP training in them for at least the last three years and in some cases ever. I can write to you separately, but there are about 15 or 20 of these initiatives to help boost recruitment into general practice.

Q366 **Heidi Alexander:** You were talking about people who might not get into medical school here but then choose to do their studies in another European institution and then may come back to practise as doctors. We heard last week from one of the witnesses about the financial benefit that can accrue to educational institutions of taking overseas students on to their medicine degrees. It seems quite strange that you have this sort of flow of people who do not get into courses here going out to Europe and yet we are bringing in people from Europe to do medicine degrees here. What work are you doing with the higher education institutions around this and is there any way, and would it be desirable, to bring down the number of overseas students who are accessing medical degrees here?



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Professor Cumming: Medicine is still one of the most oversubscribed degrees when it comes to number of applications from young people. It is still one of the most sought-after jobs. There are many young people who get the tariff—the A-level entry requirements—to get into medical school but then do not get in because of the level of competition. A number of those people have been looking at other options, and we know that the University of Pavia in Italy, the University of Bucharest and Charles University in Prague—there are about five or six examples—have therefore opened an international medical degree taught in English to anybody from around the world who is proficient in English, who is willing to pay to study medicine in their universities. Obviously, the student loan facility is not available to students in those countries, so they are either dependent on parental contributions or some form of loan system.

To the best of my knowledge—but it is not really my area—the international medical students who are coming to study in the UK are by and large not from Europe; they tend to be more from the middle east and other countries outside the EEA. I am sure there are some EEA nationals in there, but, to the best of my knowledge, they tend to be from other countries. There is a cap set at 7.5%; medical schools cannot take more than 7.5% of their intake from outside the UK.

Q367 **Heidi Alexander:** Do you think that cap should come down?

Professor Cumming: Come down—

Heidi Alexander: Yes.

Professor Cumming: Or go up. It depends on whether you share the view that education should be open to the market. Certainly, our medical education at both undergraduate and postgraduate level is widely considered to be among the very best in the world. Therefore, an awful lot of people want to come to this country to study medicine. My personal view would be that if that does not have a financial impact on the NHS, and if it has a beneficial impact on the NHS, then why should we not allow it?

Q368 **Heidi Alexander:** To play devil's advocate, it may enable more home-grown students to study here who may have a greater likelihood of remaining and working in the NHS.

Professor Cumming: That is true, so my answer or the caveat to that would be that it needs to be on top of the 1,500 additional medical places that we need to make sure we are self-sufficient. So, no, I would not support it being part of that. We need the 1,500 to be self-sufficient, but if there is then a market to go beyond that, my personal belief is that we should offer that opportunity to our universities.

Q369 **Chair:** We heard from witnesses last week how extraordinarily difficult it can be to bring scientists and doctors into the country from outside the European Union. Are you contributing any evidence to the DExEU Committee directly to try to influence how we can make that process



easier?

Professor Cumming: No. We would link through the Department of Health in terms of issues on specific shortages, although, historically, we have contributed to discussions about professions that should be on shortage occupation lists and those areas.

Q370 **Chair:** What about mechanisms such as exchange schemes? Is that something you are looking at?

Professor Cumming: We are, and it is something that is really important to an individual's training. As part of our organisation, we run something called Global Health Exchange, which gives predominantly postgraduate trainees, but in some cases undergraduate trainees, the opportunity to work overseas as part of their training but also brings people from overseas into this country as part of their training. That is absolutely invaluable for some of our young doctors in particular, but not exclusively. It is something that we very much want to continue. We run, for example, the Uganda UK Health Alliance that operates an exchange between those two countries for doctors in training.

Q371 **Chair:** Certainly, there is a huge amount of evidence of benefit from these kinds of schemes. That is something you are going to continue to take an interest in.

Professor Cumming: Yes.

Chair: Do we have any further questions?

Q372 **Dr Whitford:** I am not sure, Professor Cumming, whether you have any involvement at all in the medical academic side, because within the universities in general—and that includes medical academia and research—there is real concern around Brexit. I do not know whether you have any involvement or responsibility in that.

Professor Cumming: We do not have a direct involvement in the university side of it, although we do fund medical academic training posts at specialty training level; but we do not have a direct involvement with the universities, no.

Q373 **Dr Whitford:** Coming back to you, Mr MacNaught, and the discussions with the Home Office, and so on, around immigration, how much is that relating to the dependants and families of EU nationals who either are already here or whom we might want to attract? All of us as MPs deal with cases where British citizens struggle to come back to this country if they have married an overseas spouse. Is that on the table as well, because that is as big an issue as their own personal right?

Paul MacNaught: I am not sure I am in a position to comment on that particular topic. Maybe Gavin can do so.

Q374 **Dr Whitford:** Is it being raised—not just looking at the doctor or nurse who is on the occupation list?



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Gavin Larnar: It has not come through specifically in talking about the health workforce in relation to migration, but I will certainly take that back and add it to the list.

Dr Whitford: As I mentioned in the earlier panel, I have friends here who have had a middle child turned down for permanent residency in a totally Kafkaesque fashion. If that applies when people are trying to come here, people are not going to come here without their kids. Thank you.

Chair: Are there any further points that any of you would like to make? Thank you very much for coming this afternoon.