Submission to the Health Select Committee inquiry on the priorities for health and social care in the negotiations on the United Kingdom's withdrawal from the European Union

Key summary

- Ensuring that the UK Government is appropriately addressing the needs of our population through health and social care is essential to making the UK's exit from the European Union (EU) a success. The relationship with the EU has had, and continues to have, a substantial direct and indirect impact on delivery of health and social care within the UK. Among other things, it is critical that patient safety standards, quality of care, and the workforce supply chain are not adversely affected by the forthcoming process of change or resulting outcomes. Nursing staff, and the wider health and care community, are central to the successful delivery of UK health and social care. Their needs (as well as those of the workforce we need to recruit) should be considered carefully. The UK's exit will have a profound impact on the existing and future nursing community in a wide range of areas, ranging from workforce strategy and planning, regulation, standards, public health, research, employment and social law and cross-border exchange.

- To ensure the UK's settlement for Brexit is a success in health and social care, and to ensure sustained improvement in population health outcomes, the Government must, among other things:

    1. Develop a coherent workforce strategy and planning for implementation that maintains and grows the domestic health and social care workforce, as well as preserving the rights of European Economic Area (EEA) nationals currently working in the sector, to resolve existing challenges and set appropriate strategy for the future;

    2. Ensure appropriate education and professional regulatory frameworks, including for nurses trained outside the UK, to maintain an agile and responsive workforce and patient safety, and to enable improvement and innovation;

    3. Address public health issues collaboratively where appropriate, including communicable diseases crossing borders;

    4. Safeguard decent working conditions, health and safety at work and employment rights for those working in the sector; and

    5. Maintain opportunities for collaboration and shared learning across borders.

1. Develop a coherent workforce strategy

1.1 Sustainability of the nursing workforce in health and social care is a major problem: not enough nurses are being trained, recruited and retained. This puts an unacceptable pressure on nursing and healthcare staff and threatens the quality and safety for delivery of services, as well as health outcomes. EEA nationals make an invaluable contribution to our health and social care sector, but also help fill the persistent shortages in the UK workforce. Nursing is a global profession, and the UK has benefited from freedom of movement across the EU. The number of EU/EEA nurses has been rising over the last ten years[1] and 5% of nurses currently on the Nursing and Midwifery Council (NMC) register trained within the EU and 10% trained outside the EU. This equates to more than 33,000 EU trained nurses, which is more than the total number of nurses currently working in Wales.[2] In spite of their vital contribution and the UK's aggressive recruitment agenda, EEA/international nurses are not a substitute for a sustainable domestic supply - as evidenced by the continued existence of over 24,000 nursing vacancies.[3]

1.2 There is an enduring shortage of nurses in the UK, and nursing continues to be included on the Home Office national shortage occupation list because of this. One in three nurses is due to retire in the next 10 years. It is therefore crucial that the Government begins to develop a workforce strategy that maintains the rights of current EEA nurses to remain in the UK and ensures domestic growth, to both address existing strains within the health and social care system as well as to build a workforce that is fit for our future health and social care system.[4]

1.3 As this is a pressing and cross-sector issue, we are a leading partner in the Cavendish Coalition, along with other health and social care organisations, who are working together to secure a sustainable UK health and social care workforce through growth of domestic supply and effective migration policy.[5] We have committed to do this, and also to deliver continuing quality in health and social care through:

1. Supporting the economic, as well as social health, of the communities we work within through the creation of opportunities for training and employment;

2. Promoting employment policy and practice which ensures that the UK continues to be able to attract vital skills from Europe and around the world to work in health and social care; and

[1] UK nursing labour market review 2016, RCN, p.10, https://www.rcn.org.uk/professional-development/publications/005779
[2] NMC freedom of information request, June 2016. See Annex A for further details on EU country of training of nurses and midwives who joined the register in 2015/16
[3] Royal College of Nursing Evidence to the NHS Pay Review Body 2017-18, https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2016/september/005803.pdf
[4] See also https://www.rcn.org.uk/news-and-events/news/nursing-workforce-heading-for-perfect-storm
[5] http://www.nhsemployers.org/your-workforce/need-to-know/brexit-and-the-nhs-eu-workforce/the-cavendish-coalition

3. Seeking certainty for those already working in the UK by advocating for the right of the current health and social care workforce originating from EEA members to remain here.

The Coalition is submitting a separate response to this inquiry.

Key outcome

1.4 Leaving the EU is an opportunity for the UK to develop a properly planned domestic health and social care workforce, through a strategic and balanced approach that recognises the value and importance of our internationally recruited nurses, while growing our domestic supply through stronger investment within the context of a proper workforce strategy to equip us for the future. It is crucial that the UK harnesses this opportunity to finally deliver this vital change needed for sustainable health and social care.[6] We have significant expertise on health and social care workforce issues and look forward to working with Government and system partners on this, as working together to design a workforce vision, strategy and plan for the workforce requires collaboration and constructive partnership working to design and deliver meaningful change with professionals.[7]

2. Ensure appropriate regulation

2.1 The sector has done considerable work shaping common EU standards for training and recognition of qualifications, in particular through the Professional Qualifications Directive 2013/55/EU. This has enabled mobility and also helped raise educational standards and put safeguards in place across Europe, which facilitated the UK to recruit from Europe to make up for its own shortfalls. The Directive now includes language checks on EU nurses and a duty to inform other health regulators about suspended or banned professionals, both of which are important and positive developments for the UK.[8] We are concerned that a potential disassociation from these jointly developed standards could lead to a loss of safeguards, loss of access to alert mechanisms, and other exchange between regulators and potentially much slower recognition mechanisms for both inward and outward mobility.

2.2 At the same time, impending change also presents an opportunity to align regulatory requirements and create a level playing field between EU/EEA and the wider international sphere, in particular within the context of the necessary development of a coherent UK workforce strategy for health and social care.

2.3 The Directive also currently sets the minimum training standards, including the split between theory and practical hours. This impacts on the number of clinical placements available to nursing students.

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[6] See also RCN Briefing on International recruitment 2015 https://www2.rcn.org.uk/__data/assets/pdf_file/0007/629530/International-Recruitment-2015.pdf

[7] See, for example, the RCN Annual labour Market Reviews: https://www.rcn.org.uk/professional-development/publications/005779

[8] See http://www.nhsemployers.org/your-workforce/recruit/employer-led-recruitment/international-recruitment/mobility-of-health-professionals-across-europe

Key outcome

2.4 In the context of a continued need to meet the UK nursing demand from external sources, any changes to existing arrangements must be considered carefully and evidence-based. We propose a thorough review to be undertaken to find an approach that places a greater emphasis on increasing domestic supply whilst recognising the need for continued recruitment from Europe and beyond at least in the short term. This will need to form an existential part of developing the workforce strategy, which we expect to substantially contribute to.

2.5 It would be beneficial for such a review to look at evidence available regarding the theory/practice split. Any potential changes must be based on sound evidence and maintain the commitment to outcome-based degree-level nursing education, whilst recognising the importance of practice placements and greater flexibility.

2.6 There is a wider regulatory dimension in which alignment with the EU and its single market will be crucial for patient safety, and access to cutting-edge treatments, which includes the regulation of pharmaceuticals, medical devices, research data and clinical trials.[9]

3. Address the importance of a continued public health community

3.1 Whilst the EU's remit to protect and improve public health is small with no full harmonisation and competence, it is nevertheless significant and includes areas particularly relevant to nursing such as tobacco and alcohol abuse and most importantly cross-border health threats, such as infectious diseases and the threat of antimicrobial resistance. This must not be overlooked in the upcoming negotiations.

3.2 Regardless of the future settlement, there will continue to be cross-border societal health challenges, relevant to the UK population and its nurses. Regarding infectious diseases, the European Centre for Disease Control (ECDC), in collaboration with the World Health Organisation (WHO), manages disease surveillance and response for detecting emerging health threats, such as pandemic influenza and Middle East Respiratory Syndrome Coronavirus.

3.3 In terms of wider health objectives, it is important to maintain our influence and support to the public health community within EU, in particular in the context of the potential exclusion from the EU's Health programme.[10] Given the UK's important contribution and the cross-border nature of public health challenges, this would disadvantage both the remaining EU member States and the UK.

3.4 There may be an opportunity, in a new pursuit of public health objectives, outside the potential constraints of single market regulation and European Court of Justice (ECJ) jurisdiction. Unit pricing of alcohol is an example: "Minimum alcohol price measures have been condemned by the ECJ in the past. So, too,

[9] HM Government. *Review of the Balance of Competences between the United Kingdom and the European Union: Health.* July 2013. https://www.gov.uk/government/consultations/review-of-the-balance-of-competences-health

[10] See http://ec.europa.eu/health/programme/policy/index_en.htm

has minimum tobacco pricing" on the basis that "alternative measure, less restrictive of trade, could attain the health objective just as well" and "the market interference resulting from minimum pricing would be disproportionate to the benefit sought."[11] The ECJ has referred the Scotland case to the Scottish Courts which have backed the Scottish Parliament but this may yet be challenged in the UK Supreme Court.[12]

Key outcome

3.5 It is essential that the UK seeks a close working relationship with the ECDC following exit from the EU, to mitigate the risk stemming from being outside these European coordination measures on disease threats. As there are a number of associative models available, this should be a relatively easy process.[13] The UK must retain the ability to contribute to, and compare, surveillance data to ensure UK health systems are prepared as the epidemiology of resistant organisms develops. It is paramount that Brexit will not negatively affect this. We have considerable expertise in this remit and would be happy to advise Government on this.

3.6 The wider public health remit must also be considered in the negotiations process, this includes maintaining association to the EU's Health programme and other best practice sharing mechanisms and the governance of public health objectives under the final trade/single market settlement.

3.7 Any new trade deals the UK may negotiate outside the EU must exclude health services to avoid detrimental impact on patient care and health workers' employment conditions. We have been very clear about this during the negotiation of the Transatlantic Trade and Investment Partnership (TTIP)[14] and would be very concerned, were any new UK trade deals considering this.

4. Safeguard employment and social law provision

4.1 A substantial proportion of UK employment law originates from the EU and provides important protections for nurses and healthcare assistants (see Annex A for a non-exhaustive list), in particular, rules on health and safety at work, working time and information and consultation on collective redundancies and safeguarding employment rights in the event of transfers of undertakings (TUPE).

4.2 The EU's key health and safety related directives provide a legal framework for employers to reduce the risks of musculoskeletal disorders (MSDs), biological hazards, stress and violence to health care staff. MSDs and stress are particularly prevalent in the nursing workforce and the main cause of sickness absence in the sector and, arguably, without the directives the situation would be

[11] Srinivasa V. Katikireddi, James A. McLean. "Introducing a minimum unit price for alcohol in Scotland: considerations under European Law and the implications for European public health", The European Journal of Public Health. Oxford Journals, Oxford. July 2012. http://eurpub.oxfordjournals.org/content/22/4/457

[12] http://www.bbc.co.uk/news/uk-scotland-37725251

[13] See http://ecdc.europa.eu/en/aboutus/Partnerships/Pages/Partnerships.aspx for more information.

[14] See RCN Position on Transatlantic Trade and Investment Partnership, October 2014, https://www.rcn.org.uk/about-us/policy-briefings/pol-2114

worse. The implementation of hoists and other lifting equipment, as required by the Manual Handling Directive, has been proven to significantly reduce the risks for nurses and patients.[15] [16]

4.3 The Working Time Directive provides a framework to reduce fatigue within the nursing workforce and put safeguards in place such as compensatory rest and controls on working time to address the health and safety effects of shift work and long working hours. We strongly supported its adoption in the 1990s and the need subsequently for updating the directive.[17] Fatigue, long working hours, lack of rest breaks and poorly managed shift rotas are not only a risk factor that can impact on the health of nursing staff, but can also impact on patient safety.[18]

4.4 The NHS, public health and social care have seen significant changes in recent years, which has led to growth in independent provision of publicly funded health and social care services, as well as the transfer of staff working in public health in England from the NHS to local government. It is important that nurses and other staff, who continue to ensure continuity of care and service provision during these reforms, are not disadvantaged in terms of working conditions and employment benefits if their employer changes. The EU's TUPE legislation has been a cornerstone in providing legal protection to staff when such reconfigurations take place. Through cross industry "social dialogue" negotiations agreements have also been reached, and adopted as EU directives, to ensure part-time workers, of which there are many in the health service, and those on fixed term contracts, are treated no less favourably than full time permanent employees, in terms of leave, and access to training, for example.

Key outcome

4.5 We are encouraged by the commitment for full transposition of all of the above legislation into UK law through the proposed Great Repeal Bill and would be very concerned were any changes undermining the standards of existing legislation – as already predicted by legal experts[19] - sought by this or by an succeeding Governments. Our employment relations experts have significant experience of negotiating within both the domestic and European legislation and can help in ensuring a smooth and stable transition.

5. Maintain cross-border exchange

5.1 The health and social care challenges that society is facing, such as antimicrobial resistance, infectious diseases and ageing populations and workforces, are global – they are not unique to the UK and know no borders. International collaboration and exchange increases the speed and likelihood of

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[15] Health and Safety Executive (2002) *Second Evaluation of the Manual Handling Regulations (1992) and Guidance*. HSE Books: Sudbury

[16] Health and Safety Executive (2003) *Evaluation of the implementation of the use of work equipment directive and the amending directive to the use of work equipment in the UK*. HSE Books: Sudbury

[17] http://www.rcn.org.uk/__data/assets/pdf_file/0010/318493/Working_Time_Directive.pdf

[18] Patient Safety Network, *Nursing and Patient Safety*, July 2016, https://psnet.ahrq.gov/primers/primer/22/nursing-and-patient-safety

[19] Birrell et al., (2016) *The Impact of Brexit on UK Employment Law Rights and health and Safety Legislation*. Thompsons Solicitors: London.

finding the solutions to these challenges, as well as adopting insight and innovation at faster rates. For example, through collaborative research and academic exchange, it is well evidenced that international research collaboration increases research excellence and mobility increases researcher productivity.[20] Whilst many of these activities take place internationally beyond Europe, the EU has developed frameworks to ease collaboration and make it more effective, it also funds collaborative activities through its various programmes.[21] We are very active, both bilaterally and through umbrella bodies, in influencing, developing and implementing changes in policy and practice, as well as working in partnership with nursing organisations for mutual benefit, for example on care in community settings, addressing staffing levels and an ageing workforce.

5.2 There is a risk of loss of access to the research funding and student exchange programmes (Horizon 2020 and Erasmus+) for nursing faculties in higher education,[22] and to the wider policy exchange mechanisms that European Commission initiates and funds, in particular the Health Programme. The UK is a global player in the fields of research, education and health – collaborating both within Europe and beyond - and there is now an opportunity to re-focus on this strength.

Key outcome

5.3 The cross-border nature of health and social care challenges must be considered in the forthcoming negotiations and access to funding and networks must be preserved wherever possible. In this context, domestic and international funding arrangements also need to be reviewed to ensure sustainability. We will continue to work with our European partners and help Government achieve its aims in this area wherever possible.

Royal College of Nursing, October 2016
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About the Royal College of Nursing: with a membership of more than 430,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

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[20] Department for Business, Innovation & Skills, *International Comparative Performance of the UK Research Base – 2013.*
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/263729/bis-13-1297-international-comparative-performance-of-the-UK-research-base-2013.pdf

[21] For research, see for example, The Royal Society, *UK research and the European Union. The role of the EU in international research collaboration and researcher mobility.*
https://royalsociety.org/topics-policy/projects/uk-research-and-european-union/

[22] For wider higher education priorities, see http://www.universitiesuk.ac.uk/policy-and-analysis/brexit/Pages/short-term-priorities.aspx and the separate Council of Deans of Health submission to this inquiry.

Annex A: Country of training - EEA nurses in UK 2015/16

Country	Number of nurses and midwives who joined the register from April 2015 to march 2016 by country of training
Austria	8
Belgium	17
Bulgaria	87
China	1
Colombia	1
Croatia	29
Cyprus	65
Czech Republic	30
Denmark	15
Eire	235
Estonia	9
Finland	55
France	70
France, Metropolitan	1
Germany	58
Greece	255
Hungary	50
Iceland	5
India	10
Italy	2132
Latvia	10
Lebanon	1
Lithuania	29
Malta	5
Netherlands	46
Nigeria	5
Norway	5
Philippines	4
Poland	337
Portugal	1038
Romania	2534
Slovakia	17
Slovenia	2
Spain	2197
Sweden	14
Switzerland	11
Total	9388

Source: Freedom of Information Request to the Nursing and Midwifery Council in June 2016

Annex B: List of EU employment and health and safety law

- Directive 2003/88/EC of the European Parliament and of the Council of 4 November 2003 concerning certain aspects of the organisation of working time
- Directive 2000/34/EC of the European Parliament and of the Council of 22 June 2000 amending Council Directive 93/104/EC concerning certain aspects of the organisation of working time to cover sectors and activities excluded from that Directive
- Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems
- Regulation (EC) No 987/2009 of the European Parliament and of the Council of 16 September 2009 laying down the procedure for implementing Regulation (EC) No 883/2004 on the coordination of social security systems
- Council Directive 79/7/EEC of 19 December 1978 on the progressive implementation of the principle of equal treatment for men and women in matters of social security
- Council Directive 91/533/EEC of 14 October 1991 on an employer's obligation to inform employees of the conditions applicable to the contract or employment relationship
- Council Directive 1999/70/EC of 28 June 1999 concerning the framework agreement on fixed-term work concluded by ETUC, UNICE and CEEP
- Council Directive 97/81/EC of 15 December 1997 concerning the Framework Agreement on part-time work concluded by UNICE, CEEP and the ETUC
- Council Directive 2010/18/EU of 8 March 2010 implementing the revised Framework Agreement on parental leave concluded by BUSINESSEUROPE, UEAPME, CEEP and ETUC and repealing Directive 96/34/EC
- Directive 2008/94/EC of the European Parliament and of the Council of 22 October 2008 on the protection of employees in the event of the insolvency of their employer
- Council Directive 2001/23/EC of 12 March 2001 on the approximation of the laws of the Member States relating to the safeguarding of employees' rights in the event of transfers of undertakings, businesses or parts of undertakings or businesses
- Council Directive 98/59/EC of 20 July 1998 on the approximation of the laws of the Member States relating to collective redundancies
- Directive 2008/104/EC of the European Parliament and of the Council of 19 November 2008 on temporary agency work
- Council Directive 2000/78/EC of 27 November 2000 establishing a general framework for equal treatment in employment and occupation
- Council Directive 89/391/EEC of 12 June 1989 on the introduction of measures to encourage improvements in the safety and health of workers at work
- Regulation (EU) 2016/425 of the European Parliament and of the Council of 9 March 2016 on personal protective equipment and repealing Council Directive 89/686/EEC
- Directive 2009/104/EC of the European Parliament and of the Council of 16 September 2009 concerning the minimum safety and health requirements for the use of work equipment by workers at work
- Directive 1999/92/EC of the European Parliament and of the Council of 16 December 1999 on minimum requirements for improving the safety and health protection of workers potentially at risk from explosive atmospheres

- Council Directive 92/58/EEC of 24 June 1992 on the minimum requirements for the provision of safety and/or health signs at work
- Council Directive 98/24/EC of 7 April 1998 on the protection of the health and safety of workers from the risks related to chemical agents at work
- Commission Directive 2000/39/EC of 8 June 2000 establishing a first list of indicative
- occupational exposure limit values in implementation of Council Directive 98/24/EC on the protection of the health and safety of workers from the risks related to chemical agents at work
- Commission Directive 2006/15/EC of 7 February 2006 establishing a second list of indicative occupational exposure limit values in implementation of Council Directive 98/24/EC and amending Directives
- Commission Directive 2009/161/EU of 17 December 2009 establishing a third list of indicative occupational exposure limit values in implementation of Council Directive 98/24/EC and amending Commission Directive 2000/39/EC
- Directive 2009/148/EC of the European Parliament and of the Council of 30 November 2009 on the protection of workers from the risks related to exposure to asbestos at work
- Directive 2004/37/EC of the European Parliament and of the Council of 29 April 2004 on the protection of workers from the risks related to exposure to carcinogens or mutagens at work
- Council Directive 2013/59/Euratom of 5 December 2013 laying down basic safety standards for protection against the dangers arising from exposure to ionising radiation, and repealing Directives 89/618/Euratom, 90/641/Euratom, 96/29/Euratom, 97/43/Euratom and 2003/122/Euratom
- Directive 2013/35/EU of the European Parliament and of the Council of 26 June 2013 on the minimum health and safety requirements regarding the exposure of workers to the risks arising from physical agents (electromagnetic fields)
- Directive 2006/25/EC of the European Parliament and of the Council of 5 April 2006 on the minimum health and safety requirements regarding the exposure of workers to risks arising from physical agents (artificial optical radiation)
- Directive 2003/10/EC of the European Parliament and of the Council of 6 February 2003 on the minimum health and safety requirements regarding the exposure of workers to the risks arising from physical agents (noise)
- Directive 2002/44/EC of the European Parliament and of the Council of 25 June 2002 on the minimum health and safety requirements regarding the exposure of workers to the risks arising from physical agents (vibration)
- Directive 2000/54/EC of the European Parliament and of the Council of 18 September 2000 on the protection of workers from risks related to exposure to biological agents at work
- Council Directive 94/33/EC of 22 June 1994 on the protection of young people at work
- Council Directive 92/85/EEC of 19 October 1992 on the introduction of measures to encourage improvements in the safety and health at work of pregnant workers and workers who have recently given birth or are breastfeeding
- Council Directive of 25 June 1991 supplementing the measures to encourage improvements in the safety and health at work of workers with a fixed-duration employment relationship or a temporary employment relationship