Evidence on EEA nationals working within the health and care system, focusing on England

The Department of Health’s written response to the call for evidence issued by the Migration Advisory Committee (MAC) on 4 August 2017
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Executive Summary

European Economic Area (EEA) staff make a vital contribution to the UK’s health and care system and services. They work in every role across the NHS and social care sectors delivering high quality care to patients and utilising their skills for the benefit of the UK population.

As early as 1949, the health and labour ministries launched recruitment campaigns in the Caribbean that resulted in thousands of nurses arriving in the UK and being dispersed to hospitals all over the UK.

The health and adult care sectors employ some 3 million people in England, representing around 11% of the total workforce (all industries). Within the health and care workforce, over 150,000 are EU and EEA nationals (excluding the UK and Ireland).

In the NHS, over 5% of staff are EEA nationals but this hides variations across roles. EEA staff are particularly important in key frontline clinical roles where they make up around 15% of dentists, over 9% of doctors, and nearly 6% of nurses and midwives. However, this masks substantial regional differences. In London around 14% of doctors are EU27 nationals, and nearly 15% of nurses and health visitors.

In social care the situation is more pronounced. EEA staff make up around 7% (90,000) of the adult social care workforce. In absolute terms, most are employed in relatively low-paid direct care roles, numbering approximately 69,000. However, it is in the regulated professions that there is the greatest proportional reliance on EEA staff. Here EEA staff make up 11% of the workforce, driven predominantly by the 16% of registered nurses in social care who are EEA nationals. The reliance on EEA staff is made more acute by the high level of vacancies (around 90,000) that social care already faces.

The Department of Health recognises that domestic supply needs to continue to increase. In October 2017 the Secretary of State announced a 25% increase in training posts for nurses. In addition a further 5,000 nursing associates will be trained through the apprentice route in 2018, with an additional 7,500 trained in 2019. We have also expanded the number of medical training places by 1,500 to provide a continued boost to medical numbers. However, there is a lag in the time it takes to train a new member of staff, especially for medics and therefore continued migration across the NHS is vital to maintain service levels.

If the NHS were no longer able to recruit EEA doctors, nurses and other health professionals it is estimated that after five years there would be around 6,000 fewer EEA doctors and 12,000 fewer EEA nurses. Extra training places and reduced attrition rates could help reduce this shortfall, but such interventions are likely to be less effective given the action that is already underway and would be insufficient to fully bridge the gap. If social care employers were no longer able to recruit EEA direct care staff, after five years there could be some 28,000 fewer workers in the sector.

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1 The EEA nationals’ figures in the executive summary include the EU27 countries whilst the main body of this submission is based on figures for EU26 countries (excluding the UK and Ireland).
The risks to EEA workforce supply need to be considered in the context of continued rising demand across the health and care system. Considering rising life expectancy, population structural changes (significant increases in those aged 85 and over) as well as increases in the number of people living with one or more long term conditions, there are significant demand implications for the health and social care workforce.

Unless we ensure such demand is met, there is a wider risk to labour market participation more generally especially when considering increasing social care needs. If we fail to meet social care needs adequately we are likely to see a decrease in labour market participation levels, especially among women, as greater numbers undertake informal care.

However, even if it were possible to boost domestic supply sufficiently to meet projected future demand (something that can only be considered in the medium to long-term) these demand projections are inherently uncertain. For example, the role of technology may ameliorate some of the projected increased demand, but can also create its own demand through creating treatments, expressed demand from patients and services that are currently in their infancy.

Migration will need to continue to play a vital role in meeting future demand and providing a means of ensuring flexible supply in response to changes in demand for health and care. It is vitally important that any approach to migration prioritises the health and care sector.

The Department of Health will continue to engage with the MAC on an ongoing basis and will endeavour to provide any additional evidence and analysis, when it becomes available and or is required.
Evidence on EEA nationals within the health and care system, focusing on England

In July, the Government commissioned the Migration Advisory Committee (MAC) to advise on the economic and social impacts of the UK’s exit from the European Union (EU) and also on how the UK’s immigration system should be aligned with a modern industrial strategy².

This report is the Department of Health’s written response to the call for evidence issued by the Migration Advisory Committee (MAC) on 4 August 2017. The report intends to assist the MAC to identify relevant evidence regarding EU nationals working within the health and adult social care system in England.

The overall picture

1. The health and adult care sectors employ nearly 3 million people - approximately 11% of the total workforce of all industries for England³. Information is not available on nationality for the entire health and care workforce however, it is estimated that over 150,000 of the health and care workforce are EU and EEA nationals (excluding the UK and Ireland)⁴,⁵ representing around 6% of all NHS and adult social care staff⁶.

2. NHS and social care workers perform a large range of roles requiring discrete and specialised skills. Many of the roles within this system have long education and training times (up to 16 years for some specialist doctor professions). There are existing shortages for certain key staff groups regardless of nationality, for example general practitioners, psychiatry and nursing.

3. Non-British nationals have been a significant proportion of the health and care workforce since before the creation of the NHS across all skill levels making valued contributions to the health and care of the UK population⁷. As of 2017, over 200 different nationalities are employed in our health and care services. A significant proportion, 6% of all Hospital and Community Health Service (HCHS) staff who as of June 2017 described their nationality as non-EU, non UK, i.e. rest of the world.

³ https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/datasets/headinelabourforcesurveyindicatorsforallregionshi00
⁴ This figure includes the total EU26/EEA nationals employed by the Hospital and Community Health Sector, estimates for General Practice Doctors and total (LA and Independent) Adult Social Care.
⁵ A number of data sources are examined in the following analysis. Where it is possible to exclude Ireland from the EU27 countries this is provided. EU26 refers to those EU nationals excluding Ireland and UK. EEA nationals include those from Iceland, Norway and Liechtenstein. Data excludes those working in GP surgeries as information is not available. Definitions of nationality are based on self-response and not an official migration status.
⁶ Children’s social care is the responsibility of the Department for Education so throughout this response social care refers to adult social care only.
Evidence from Professional Regulators

4. Professional regulation is mandated for 27 health and care professions in the UK. To work in one of these protected professions an individual must register with one of the 9 relevant professional regulators. Therefore the register can provide useful information on the size of the EEA workforce registered to work in the UK. Information is captured on who is regulated, where they qualified and their nationality.

Composition of the Registers

5. Nationality, country of training and/or country of initial registration are all relevant when determining registration requirements with the regulators. However, the identification of nationality is not straightforward from the register. There are a number of reasons for this e.g. nationality is not mandatory for some regulators, is unrecorded for historic individuals records, and nationality may be self-declared or may have changed after initial registration. In contrast, region or country of training is more robustly recorded but there will clearly be inconsistencies between this estimate and the actual number of EEA migrants on the register (See Annex A for further details).

6. There are clear variations between the regulators. The chart below shows the proportion of the current registers for each profession who are identified from the EEA using the region of qualification definition.

7. EEA qualified dentists and doctors represent a significant proportion of the total registrant base: EEA qualified dentists form over 15% of the register; EEA qualified doctors form 9.1%. EU nurses form a smaller proportion of the register (5.5%) but are significant in absolute terms at around 38,000.

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8 For example almost 67,000 doctors who joined the GMC register before 2004 have no nationality information recorded
i) Pharmacist data comes from the General Pharmaceutical Council (GPhC) this might exclude a small number registered in Northern Ireland.

ii) Data for opticians is as of 31 August 2016.

iii) Data from the General Chiropractic Council (GCC) is not included. The GCC report 7-8 EEA applications every year, the size of the register was 3,108 as of 31 March 2016.

iv) Data from NMC is based on country of initial registration.

8. Within certain professions the extent of EEA representation can also vary. Figure 2 below shows that over 20% of ophthalmologists are identified as qualifying in the EEA, whilst only 5% of GPs are identified in this group. This means that our reliance on EEA staff varies across specialities.
Figure 2: All Licensed EEA graduate doctors by area of practice, showing % of each area of practice that are EEA graduates

Source: GMC ‘Our data about doctors with a European PMQ’ Working paper 1 February 2017
Change over time for the five largest professions:

9. The five professions (dentists, doctors, pharmacists, nurses and midwives) with the highest proportion of registrants from the EU are currently eligible for automatic recognition of their professional qualifications under the EU Mutual Recognition of Professional Qualifications (MRPQ) Directive. The Directive means currently any professional in one of these groups with a specific qualification from an EU member state is eligible to have their qualification automatically recognised on an equal level with a UK professional qualification.

10. Figure 3 below shows how the numbers of EEA registrants in each profession has changed over the last four years. The main point to note is the rapid rise (more than doubling) in the numbers of nurses and midwives between March 2013 and March 2017.

Figure 3: Stock of EEA registrant base over time in the 5 automatic MRPQ professions as of 31/3/2017

<table>
<thead>
<tr>
<th>Profession</th>
<th>Mar-13</th>
<th>Mar-14</th>
<th>Mar-15</th>
<th>Mar-16</th>
<th>Mar-17</th>
<th>13-17 %age growth</th>
<th>Trend line</th>
<th>CV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses and Midwives</td>
<td>16,798</td>
<td>20,916</td>
<td>27,012</td>
<td>34,572</td>
<td>38,024</td>
<td>126%</td>
<td></td>
<td>33%</td>
</tr>
<tr>
<td>Dentists</td>
<td>X</td>
<td>6,440</td>
<td>6,318</td>
<td>6,406</td>
<td>6,324</td>
<td>-2%</td>
<td></td>
<td>1%</td>
</tr>
<tr>
<td>Doctors</td>
<td>23,459</td>
<td>23,767</td>
<td>23,429</td>
<td>21,752</td>
<td>21,550</td>
<td>-8%</td>
<td></td>
<td>5%</td>
</tr>
<tr>
<td>Doctors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Dec-13</td>
<td>Dec-14 Dec-15 Dec-16 Sep-17</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>2,966</td>
<td>3,093</td>
<td>3,304</td>
<td>3,596</td>
<td>3,474</td>
<td>17%</td>
<td></td>
<td>8%</td>
</tr>
</tbody>
</table>

Source: DH analysis

CV is the coefficient of variation. It is designed to be read in conjunction with the trend line as the trend lines are not to scale. A very small CV means there has been very little fluctuation in the numbers, such as in the case of dentists.

11. The numbers on the register at any point in time will depend upon the number of joiners and leavers.

Doctors joining the register:

12. Figure 4 below shows how the number of EEA doctors initially joining the register has changed over time. EEA applications and number of joiners remained reasonably steady over the period to May 2014 when there was a considerable increase followed by a drop back to a lower steady level. This change happened at the time that the GMC introduced language checks for EEA doctors wishing to register to work in the UK. In the period to May 2014 a little over 200 per month
joined the register. In the period after May 2014 the numbers joining has dropped to around 100 a month.

Figure 4: EEA Applications and Joiners to the GMC Register

Source: DH analysis, 2017

Nurses joining the register:

13. Figure 5 below shows how the numbers of EEA nurses initially joining the register has changed over time. In July 2016 the NMC introduced language checks for EEA nurses. A similar pattern can be seen in the data as for doctors. There was an early increase in applications followed by a considerable reduction.
14. It is likely that the introduction of the language test has made a significant difference to the numbers joining from the EEA. Figure 6 below sets an index at the date of language tests. By indexing the applications, it can be seen that nurse, doctors and pharmacists (who set up a similar language test in November 2016) follow similar patterns of change. Although both Pharmacists and Nurses show significantly higher rates of reduction.

Source: DH analysis, 2017
15. The NMC is currently reviewing its approach to language testing in order to ensure it is both proportionate and sufficient to protect the public.

Specifically, the NMC is considering:

- widening the language assessments it accepts to include other tests; and
- aligning language requirements for EU/non-EU applicants so that nurses who have completed a recent pre-registration nursing programme taught and examined in English OR have two years of registered practice in an English-speaking country will not be required to take a language test.

While it is not yet possible to determine the precise impact of these changes, it seems likely to increase the number of applicants who pass the test.

**Summary of evidence from registration data**

16. Registration data shows that there are significant differences in the proportion of a professional group in the UK who are trained or first registered in the EEA. In recent years nurse numbers from the EEA have increased significantly, although the numbers still form a relatively modest proportion (around 5.5%) of the overall nursing register. More recently following the introduction of language controls and the referendum, the number of nurses joining from the EEA has reduced significantly. Numbers of doctors from the EEA reduced on the introduction of language controls but has remained relatively stable since the referendum.
Detailed breakdowns of health and care sector employment

17. The health and care system employs some 2.6 million people where nationality can be identified from available data. Work can range from highly specialised highly paid individuals who have trained and worked for many years, to roles which require little formal qualification, paid at the minimum wage, and are of a temporary nature.

18. There are seasonal fluctuations in workloads, but on the whole activity is required across the year. There are also some differences in demands across localities depending on the local population and there is some specialisation of services in London and larger cities, but again the types of activity demanded are reasonably similar across the country.

19. This section considers workforce issues across 3 important sectors:
   - Acute/Secondary care and Community settings – mainly hospitals but also CCGs and community health services - known as Hospital and Community Health Services (HCHS) within NHS Digital datasets
   - Social care – mainly funded by Local Authorities or privately, but overwhelmingly privately provided;
   - Primary care – mainly general practice.

The permanent workforce:

20. Within each sector there are many different professions/occupations, but the main ones are set out in the table below with an estimate of the sizes. To note that nationality data for GPs is based on country of Primary Qualification. Other data is based on the nationality that individuals record rather than their specific immigration status.

Table 1: NHS Hospital and Community Health Service (as at June 2017) and Social Care (as at March 2017) key staff groups by nationality, headcount and percentage

<table>
<thead>
<tr>
<th>Sector</th>
<th>Staff group</th>
<th>UK (and Ireland)</th>
<th>EU &amp; EEA</th>
<th>Other countries</th>
<th>Unknown</th>
<th>All nationalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Hospital and Community Health Service*</td>
<td>Medics/Doctors</td>
<td>81,445 (72%)</td>
<td>8,607 (8%)</td>
<td>17,696 (16%)</td>
<td>5,571 (5%)</td>
<td>113,192</td>
</tr>
<tr>
<td></td>
<td>Nurses</td>
<td>253,474 (80%)</td>
<td>17,156 (5%)</td>
<td>25,990 (8%)</td>
<td>20,166 (6%)</td>
<td>316,725</td>
</tr>
<tr>
<td></td>
<td>Support to Doctors and Nurses</td>
<td>239,332 (84%)</td>
<td>9,019 (3%)</td>
<td>16,250 (6%)</td>
<td>19,321 (7%)</td>
<td>283,884</td>
</tr>
<tr>
<td></td>
<td>Ambulance</td>
<td>16,853 (80%)</td>
<td>274 (1%)</td>
<td>610 (3%)</td>
<td>3,368 (16%)</td>
<td>21,100</td>
</tr>
<tr>
<td></td>
<td>Scientific therapeutic and technical</td>
<td>132,331 (87%)</td>
<td>4,817 (3%)</td>
<td>5,398 (4%)</td>
<td>9,439 (6%)</td>
<td>151,908</td>
</tr>
<tr>
<td></td>
<td>Other (e.g. Ancillary and admin staff)</td>
<td>79,968</td>
<td>1,671</td>
<td>2,277</td>
<td>5,538</td>
<td>89,450</td>
</tr>
</tbody>
</table>

13
<table>
<thead>
<tr>
<th>Sector</th>
<th>Staff group</th>
<th>UK (and Ireland)</th>
<th>EU &amp; EEA</th>
<th>Other countries</th>
<th>Unknown</th>
<th>All nationalities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(89%)</td>
<td>(2%)</td>
<td>(3%)</td>
<td>(6%)</td>
<td></td>
</tr>
<tr>
<td>Managers</td>
<td></td>
<td>19,961</td>
<td>271</td>
<td>452</td>
<td>1661 (7%)</td>
<td>22,345</td>
</tr>
<tr>
<td>Total HCHS</td>
<td></td>
<td>981,921</td>
<td>49,300</td>
<td>75,681</td>
<td>79,126 (7%)</td>
<td>1,185,599</td>
</tr>
<tr>
<td>Total General Practice Doctors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctors on the General Practice register</td>
<td></td>
<td>54,732</td>
<td>11,087</td>
<td>3,125</td>
<td>n/a</td>
<td>68,975</td>
</tr>
<tr>
<td>Social Care (Local authority and independent sector)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct Care</td>
<td></td>
<td>813,000</td>
<td>69,000</td>
<td>103,000</td>
<td>n/a*</td>
<td>985,000</td>
</tr>
<tr>
<td>Regulated Professionals (e.g. nurses, social workers, occupational therapists and registered managers)</td>
<td></td>
<td>48,000</td>
<td>7,000</td>
<td>9,000</td>
<td>n/a*</td>
<td>64,000</td>
</tr>
<tr>
<td>Other (e.g. Ancillary and admin staff)</td>
<td></td>
<td>156,000</td>
<td>11,000</td>
<td>9,000</td>
<td>n/a*</td>
<td>176,000</td>
</tr>
<tr>
<td>Managers</td>
<td></td>
<td>107,000</td>
<td>3,000</td>
<td>6,000</td>
<td>n/a*</td>
<td>116,000</td>
</tr>
<tr>
<td>Total (LA and Independent) Adult Social Care</td>
<td></td>
<td>1,123,000</td>
<td>90,000</td>
<td>127,000</td>
<td>9%</td>
<td>1,340,000</td>
</tr>
<tr>
<td>All Sectors</td>
<td></td>
<td>2,159,653</td>
<td>150,387</td>
<td>205,806</td>
<td>79,129 (3%)</td>
<td>2,594,574</td>
</tr>
</tbody>
</table>

Sources:

NHS Digital HCHS Workforce Statistics- June 2017

Social care – Skills for Care workforce estimates for the local authority and independent sector in 2016/17 using the National Minimum Data Set for Adult Social Care, as at March 2017.

Skills for Care estimate the adult social care workforce size and nationalities by applying weights to the National Minimum Data Set for Social Care. This method is used to establish total nationalities therefore no unknowns are reported. Figures are rounded to reflect the level of estimation and total may not sum due to rounding.

**The temporary workforce:**

21. In addition to the permanent workforce the health and care sector makes significant use of a temporary workforce. However, this is not well quantified in terms of nationality as data on this characteristic of agency staff is not available. What we do know is that total expenditure on agent staffing in the NHS has decreased from £3.7bn in 2015-16 to £3bn in 2016-17.
22. At regional level, the expenditure rate (agency as a percentage of total staff costs) is generally higher than average in the East of England, London and Kent. It is relatively low in the North-East and Wessex. The level of change in the last three years has not followed a clear geographical pattern. During last year there have been decreases in all regions; the largest decreases were in East of England, Thames Valley and NW London.

23. Agency expenditure is highly variable between Trusts. Variation between Trusts within regions is far greater than variation in the average between regions. In 2016-17 the regional median average varied between 2.4% and 9.2%, and the Trust rate ranged from 0.1% to 20% of staff costs. This suggests that agency expenditure is driven principally by individual Trust-specific factors.

**Hospital and Community Services Setting**

24. Table 1 shows how the numbers of EU26 workers will differ according to profession. This section discusses what is known about the key NHS workforce groups: doctors, nurses and those in Bands 1 to 4 (including support to doctors, nurses and midwives, support to ambulance staff, central functions and hotel, property and estates staff).

25. 4% of permanent staff working in the Hospitals and Community settings state that they are from an EU country (excluding the UK and Ireland), this equates to some 49,300 staff (NHS Digital, June 2017).

26. Using Electronic Staff Records (ESR) it is possible to monitor how the numbers of EU staff have changed over time. Numbers before 2015 must be considered with caution. In earlier years a more significant number of staff did not declare their nationality on their records. The analysis below is based on DH analysis of ESR. This data is not cleaned and refined by NHS Digital and may therefore not be entirely aligned with officially published statistics. Nevertheless it is robust enough to provide a better understanding of recent trends.

27. The chart below shows how numbers have increased considerably over the last five years⁹.

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⁹ Note the number of staff not reporting nationality has reduced from 94,000 to 79,000 over the period Sep-2015 and Jun-2017, and this might account for some of the apparent growth in numbers.
28. The chart below shows how the number of EU26 doctors has increased by more than 2000 since 2012 and now form some 7.3% of all doctors working in the NHS (excluding General Practice). In the last year the numbers of EU26 doctors has stabilised at a little over 8,500.

29. The chart below (Figure 9) shows numbers joining on a monthly basis has distinct seasonal fluctuations based on junior doctors’ rotations in August, 2014 and 2015.
saw the highest number of joiners. Numbers of joiners have now dropped back a little, but continue to form over 10% of all joiners (a little over 150 staff per month).

Figure 9: NHS Hospital and Community Health Services: EU26 doctors joining NHS Trusts and CCGs on a monthly basis between July 2012 and June 2017, headcount and percentage

Source: Electronic Staff Records Management Information

30. The absolute numbers of EU doctors leaving will increase naturally as there are now more EU doctors working in the NHS. Again there are clear monthly fluctuations; however the rate of leaving remains similar year on year – some 2% of EU doctors leave each month (under 200 per month).

Figure 10: NHS Hospital and Community Health Services: EU26 doctors leaving NHS Trusts and CCGs on a monthly basis between July 2012 and June 2017, headcount and percentage

Source: Electronic Staff Records Management Information
Nurses working in Hospital and Community Health Services (HCHS)

31. The chart below shows how the number of EU26 nurses has almost trebled since 2012 and now form some 5.2% of all nurses working in the NHS (excluding General Practice). In the last year the numbers of EU nurses has stabilised at a little under 18,500.

Figure 11: NHS Hospital and Community Health Services: EU26 nurses working in NHS Trusts and CCGs, as at 30 July 2012 to 30 June 2017, headcount and percentage

![Chart showing number of EU26 nurses](chart)

Source: Electronic Staff Records Management Information

32. The chart below shows numbers joining on a monthly basis, 2015 and 2016 saw the highest number of joiners. The numbers of EU26 joiners has now dropped back, but continues to form over 9% of all joiners (a little under 300 staff per month). It is interesting to compare this to numbers joining the register as set out earlier which showed a much more significant drop in new registrants from the EEA. The difference may be due to those newly employed in the NHS already being on the register and working in the UK elsewhere, or returning after a break.
Figure 12: NHS Hospital and Community Health Services: EU26 nurses joining NHS Trusts and CCGs on a monthly basis, between July 2012 to June 2017, headcount and percentage

Source: Electronic Staff Records Management Information

33. The absolute numbers of EU nurses leaving will increase naturally as there are now more EU nurses working in the NHS. Again there are monthly fluctuations; however the rate of leaving remains similar year on year – some 2.5% of EU nurses leave each month (under 500 per month).

Figure 13: NHS Hospital and Community Health Services: EU26 nurses leaving NHS Trusts and CCGs on a monthly basis between July 2012 and June 2017, headcount and percentage

Source: Electronic Staff Records Management Information
Agenda for Change (AfC) Band 1-4 working in HCHS

34. AfC Band 1-4 staff are those providing support functions within the hospital setting. Work ranges from porter to cleaner to Healthcare Assistant supporting doctors and nurses. The chart below shows how the number of EU26 staff has increased by more than 5,000 since 2012 and now form some 3.6% of all AfC 1-4 staff working in the NHS (excluding General Practice). Unlike the medical professions, numbers in this group continue to grow.

Figure 14: NHS Hospital and Community Health Services: EU26 AfC Band 1-4 staff working in NHS Trusts and CCGs, as at 30 July 2012 to 30 June 2017, headcount and percentage

Source: Electronic Staff Records Management Information

35. The chart below shows numbers joining on a monthly basis, 2015 to 2016 saw the highest number of joiners. Numbers of joiners continue to form over 5% of all joiners (almost 400 staff per month).
36. The absolute number of AfC Band 4 staff leaving should increase naturally as there are now more working in the NHS. Again there are monthly fluctuations; however the rate of leaving has reduced recently – some 1.6% of EU staff leave each month (a little under 250 per month).
Regional Analysis:

37. Analysis by region shows that the distribution of EU workers is not evenly spread. But the relative distribution is similar across the professions. London shows the highest concentration of EU27 staff, followed by the South and East. Figure 17 shows the regional patterns.

Figure 17: Proportion of employees in NHS trusts and CCGs who are EU27 nationals, by HEE region, headcount at April 2017
Salaries:

38. The salaries of EU workers in the NHS will depend upon their profession, expertise and experience.
   - The basic salary range for a doctor in training is between £26,614 and £46,208 (as of January 2017).
   - Salaries for the most senior doctors, consultants, depending on experience ranges from a basic salary of £76,761 to £103,490.
   - The starting salary for a Band 5 nurse outside of London is £22,128.
   - The basic salary for those working in Agenda for Change bands 1-4 range from £15,404 to £22,683.

Adult Social Care

39. Skills for Care estimate the size and composition of the adult social care workforce based on the National Minimum Data Set for Social Care (NMDS-SC). The total size of the adult social care workforce is estimated at 1.58m. Nationality information is estimated for jobs in the statutory local authority sector and the independent sectors only. The information on the adult social care workforce is more limited than the NHS. Nevertheless some key evidence is of interest.

40. The total number of jobs within the local authority and independent sector in adult social care is estimated at 1.34m. Nationality is recorded at the individual worker level in NMDS-SC and it is estimated that 83% of workers overall are British, with 7% EEA nationals (95,000) including Ireland, and 9% non-EEA nationals (125,000).

41. Jobs are grouped into four overall categories, which encompass a wide range of roles. The overall picture of international reliance in the local authority and independent sectors is shown in the figure below.

Figure 18: Nationality of adult social care role groupings

![Nationality of social care role groupings](https://www.nmds-sc-online.org.uk/Get.aspx?id=1049339)


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10 Jobs for workers employed by direct payment recipients are not included in nationality analysis. Those working in social care in the NHS will be captured in the previous analysis.
42. This overall picture obscures some of the absolute and relative international reliance of specific roles. Viewing selected social care roles it is clear that there are both regulated roles with lead in times for domestic inflows from training for which there is a high proportional reliance (such as Registered Nurses) and a large absolute international reliance on roles which have on the job training, such as Care Workers. The turnover rate across all adult social care roles is 28% and the vacancy rate is 7%, and there is a historical reliance on international inflows in social care.

Figure 19. Nationality of selected Adult Social Care roles

![Nationality of selected social care roles](source)


43. The nationality trend for all jobs in the statutory local authority and independent sectors in adult social care shows that there has been a growing reliance on EEA workers in percentage and absolute terms (Figure 20), with the overall stock of EEA workers growing by 32,000 between 2012/13 and 2016/17.

Figure 20: Nationality trends in Adult Social Care

![Nationality trends in the LA and Independent sectors in ASC](source)

Table 4: Nationality trends in Adult Social Care

<table>
<thead>
<tr>
<th>Year</th>
<th>Total jobs</th>
<th>EEA (non British)</th>
<th>Non-EEA</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>1,276,000</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>2013/14</td>
<td>1,295,000</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>2014/15</td>
<td>1,320,000</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>2015/16</td>
<td>1,340,000</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>2016/17</td>
<td>1,360,000</td>
<td>5%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Source: Skills for Care (2017) Adult Social Care workforce estimates. Available at: https://www.nmds-sc-online.org.uk/Get.aspx?id=1049339

44. The nationality composition of the adult social care workforce varies by region. Regionally, London and the South East have the greatest reliance on non-British nationals.

Figure 21: Adult Social Care jobs by region and nationality

45. The table below shows the mean annual pay for a full-time equivalent worker across the four overall categories of job roles in adult social care. Many Direct Carers are paid at the minimum wage, 30% are on zero hour contracts. Vacancy rates in 2016/17 were 7% for all jobs in the statutory local authority and independent sectors, and at 9% and 7% for the regulated profession and Direct Care job role groupings respectively (SfC, same source as above).
Education and training - students studying / faculty teaching health and care courses within England

46. Healthcare courses in England can be undertaken by students from across the world. This section provides a breakdown of the current and prospective student population as well as information on the academics and lecturers who teach them.

47. Where possible data is presented for 3 main subject areas:
   - Medicine and Dentistry (Group A)
   - Nursing and Midwifery (Group B7)
   - Subjects Allied to Medicine (Group B)

Student Population

48. The Higher Education Statistics Authority (HESA) collects data on the domicile of students on higher education courses in the UK.

49. In all cases there has been very little change in the student breakdown of these courses. Medicine has the highest proportion of students from outside the UK, with 4% from the EU and just over 10% from the rest of the world. Under current rules the Higher Education Funding Council for England (HEFCE) determine the intake control targets for each university. Providers can choose to offer up to 7.5% of places to those who pay international tuition fees. As EU students are treated as home students for fee purposes they are not included in this restriction.
50. Nursing and Midwifery courses attract the fewest non-domestic students. In the most recent year 98% of students on nursing and midwifery courses were from the UK. Of the 1% from the EU a majority came from Ireland with a small number from the rest of Europe.

Table 6: HESA nursing and midwifery student domicile

<table>
<thead>
<tr>
<th>Nursing and Midwifery</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>98%</td>
</tr>
<tr>
<td>EU27</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Non-EU</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Student count</td>
<td>126,475</td>
<td>122,000</td>
<td>123,900</td>
<td>126,470</td>
</tr>
</tbody>
</table>

Source: HEFCE analysis of HESA data

51. Other healthcare courses are covered in the wider “Subjects allied to medicine” category. This includes the Allied Health Professions which include other regulated professions such as Radiographers, Physiotherapists and Speech Therapists.

52. Around 4% of students on these courses are from the EU27 and this proportion has been consistent for the past 4 years. Around one quarter of those from the EU27 are Irish.

Table 7. HESA subjects allied to medicine student domicile

<table>
<thead>
<tr>
<th>Subjects Allied to Medicine</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK</td>
<td>88%</td>
<td>88%</td>
<td>88%</td>
<td>88%</td>
</tr>
<tr>
<td>EU27</td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Non-EU</td>
<td>8%</td>
<td>8%</td>
<td>8%</td>
<td>8%</td>
</tr>
<tr>
<td>Student Count</td>
<td>104,995</td>
<td>103,470</td>
<td>103,605</td>
<td>107,995</td>
</tr>
</tbody>
</table>

Source: HEFCE analysis of HESA data
Clinical Academics & Other Teaching Staff

53. The Higher Education Statistics Authority (HESA) collects data on academic staff working at UK Universities funded by the Higher Education Funding Council for England (HEFCE) including those who teach healthcare students.

54. For healthcare staff data is available on the current academic discipline of members of staff – this is the area the staff member was working in during 2015-16. Data are available by the level of the person ranging from admin assistance to senior leadership. Across all medicine and healthcare courses 76% of academics are from the UK, 14% from the EU27, 8% from the rest of the world and the remainder of unknown domicile.

55. Demand for these staff groups is likely to increase as there is expansion to healthcare training programmes for both nursing and medical staff.

Medicine and Dentistry

Table 8 – Academic Staff covering Academic Roles in Academic Year 2015/16 (Medical & Dental)

<table>
<thead>
<tr>
<th></th>
<th>All Academic Staff</th>
<th>Academic Leadership</th>
<th>Professor</th>
<th>Lecturer &amp; Senior Lecturer</th>
<th>Research Assistant</th>
<th>Admin</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>16,390</td>
<td>310</td>
<td>2,300</td>
<td>11,245</td>
<td>2,335</td>
<td>200</td>
</tr>
<tr>
<td><strong>UK</strong></td>
<td>71%</td>
<td>84%</td>
<td>83%</td>
<td>71%</td>
<td>57%</td>
<td>53%</td>
</tr>
<tr>
<td><strong>EU27</strong></td>
<td>17%</td>
<td>11%</td>
<td>11%</td>
<td>17%</td>
<td>26%</td>
<td>25%</td>
</tr>
<tr>
<td><strong>Other Non-EU</strong></td>
<td>10%</td>
<td>5%</td>
<td>5%</td>
<td>10%</td>
<td>15%</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Unknown</strong></td>
<td>2%</td>
<td>0%</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
<td>13%</td>
</tr>
</tbody>
</table>

Source: HEFCE analysis of HESA data

56. In 2015/16 there were just over 16,000 academic staff working with medical and dental students. The most common job role was lecturers and senior lecturers who account for nearly 70% of all roles. There are similar numbers of professors and research assistants who make up most of the remaining roles.

57. Around 70% of all roles are held by people with a UK nationality with a further 17% coming from the EU27. In terms of the individual professions the proportion of non-EU workforce ranges from 16% (Academic Leadership) to 47% (Administration).
58. For courses in Medicine the Medical Schools Council produce an annual report into the numbers, and characteristics, of clinical academics\textsuperscript{11} in the UK. On an FTE basis the number of clinical academics declined by 2\% in 2016 and is down by 14\% compared to 2010. The reduction in numbers can be mainly attributed to a reduction in the number of lecturers as the total in the professor grades have remained relatively constant. This report does not include information on the nationality of clinical academics.

59. The number of domestic undergraduate medical training places will be expanded by up to 1,500 places per year starting in 2017 (500 new places in 2017 followed by 1,500 from 2018 onwards).

**Nursing**

Table 9 - Academic Staff covering Academic Roles in Academic Year 2015/16 (Nursing)

<table>
<thead>
<tr>
<th>Nursing</th>
<th>All Academic Staff</th>
<th>Academic Leadership</th>
<th>Professor</th>
<th>Lecturer &amp; Senior Lecturer</th>
<th>Research Assistant</th>
<th>Admin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>6,005</td>
<td>180</td>
<td>220</td>
<td>5,335</td>
<td>235</td>
<td>35</td>
</tr>
<tr>
<td>UK</td>
<td>93%</td>
<td>94%</td>
<td>91%</td>
<td>93%</td>
<td>87%</td>
<td>86%</td>
</tr>
<tr>
<td>EU27</td>
<td>5%</td>
<td>6%</td>
<td>5%</td>
<td>4%</td>
<td>9%</td>
<td>14%</td>
</tr>
<tr>
<td>Other Non-EU</td>
<td>2%</td>
<td>0%</td>
<td>5%</td>
<td>2%</td>
<td>4%</td>
<td>0%</td>
</tr>
<tr>
<td>Unknown</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Source: HEFCE analysis of HESA data

60. In total there are just over 6,000 academic staff in the field of nursing of which nearly 90\% are either lecturers or senior lecturers.

61. In line with the student demographics over 90\% of academic staff have UK domicile including 91\% of professors and 93\% of lecturers and senior lecturers.

\textsuperscript{11} Defined as someone registered with the GMC who holds both clinical and academic contracts/
Other Allied Health Professions

Table 10 - Academic Staff covering Academic Roles in Academic Year 2015/16 (Other Allied Health Professions)

<table>
<thead>
<tr>
<th>Other Allied Health</th>
<th>All Academic Staff</th>
<th>Academic Leadership</th>
<th>Professor</th>
<th>Lecturer &amp; Senior Lecturer</th>
<th>Research Assistant</th>
<th>Admin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>11,935</td>
<td>275</td>
<td>1,085</td>
<td>9,150</td>
<td>1,230</td>
<td>195</td>
</tr>
<tr>
<td>UK</td>
<td>75%</td>
<td>91%</td>
<td>80%</td>
<td>76%</td>
<td>63%</td>
<td>62%</td>
</tr>
<tr>
<td>EU27</td>
<td>15%</td>
<td>7%</td>
<td>13%</td>
<td>14%</td>
<td>22%</td>
<td>23%</td>
</tr>
<tr>
<td>Other Non-EU</td>
<td>9%</td>
<td>2%</td>
<td>7%</td>
<td>9%</td>
<td>14%</td>
<td>13%</td>
</tr>
<tr>
<td>Unknown</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
<td>3%</td>
</tr>
</tbody>
</table>

Source: HEFCE analysis of HESA data

62. There are nearly 12,000 academic staff working in the other Allied Health Professions with the greatest proportion (77%) working as lecturers or senior lecturers.

63. Three quarters of these staff have UK domicile with the majority of the rest coming from the EU. The proportion of lecturers and senior lecturers from the UK is lower than that for nursing but slightly higher than that for medicine and dentistry.

Population and life expectancy changes - the implications for the health and social care workforce

64. Population projections for the UK point towards significant increases in older age bands. By 2039, the number of people aged 85+ is expected to grow by 140%, increasing from 1.5m to 3.6m.
65. This change in population structure is expected to create greater demand across health and social care services which can be represented by different theories of population ageing such as a compression of morbidity, an expansion of morbidity, or a dynamic equilibrium of these two aspects (Fellows and Edwards, 2016).

66. A key component of this structural change is due to increases in life expectancy driven by advances in food supply, nutrition, hygiene and healthcare / medical fields. These advances have particularly improved survival levels to old age since the 1920s and 30s (Marmot, 2017).

67. With people living longer, the number of years in poor health (Annual Population Survey, ONS, 2012) has also increased mainly due to growth in the number of people living with multiple long term conditions.

68. In England, over 15 million people (c27%) were recognised as suffering from one or more long term conditions (LTCs) in 2015, making them one of the major sources of demand for health and care services (DH, 2015). Over the next decade these numbers are set to increase further as is an increase in the proportion of people who have three or more conditions at the same time.

69. These increases in population, life expectancy and living longer with multiple co-morbidities have significant implications for workforce requirements in terms of required numbers for the future. Therefore it is important that this overall demand position is considered when looking at supply requirements and necessary flexibilities to access different labour markets efficiently.

Source: ONS, 2015
Illustrative scenarios in projecting potential impacts of EU exit

70. Projecting workforce demand and supply is challenging and inherently uncertain. This section explores some simple projected scenarios which illustrate the workforce supply risks that must be managed as part of the UK’s exit from the EU, using directly employed doctors, nurses and direct care workers in adult social care as important examples.

71. For illustrative purposes, the projections in this section show the health and care system’s current reliance on EEA staff and how this stock may diminish after a change in the immigration system in the extreme position that it would completely preclude new EEA recruitment and if the current stock is subject to historical rates of EEA attrition. This scenario is used to consider potential supply risks and what this may mean for the immigration requirements of the system, by projecting a worst case position.

Directly Employed Doctors

72. Figure 22 below focuses on the directly employed medical workforce i.e. doctors in Hospital & Community Health Services (HCHS). It assumes a future where inflows of EEA doctors, other than those from Ireland, are no longer possible. It then illustrates a worst case scenario by showing the reduction in workforce supply, as the existing EEA stock reduces in-line with historical attrition.

73. Initially, the stock of EEA doctors declines by around 1,500 per annum, but the rate of decline slows as the stock decreases. After five years, the cumulative risk to supply is around 6,000 EEA doctors. This increases to over 8,000 doctors after ten years.
74. It takes at least 5 to 6 years to train a doctor and longer to train to specialty level. The expansion should generate around 3,000 new doctors by 2025, who will be in the early stages of junior doctor training. By 2030, the impact of the expansion would be around 6,000 to 7,000 doctors, and the majority of the extra workforce would still be in training.

75. If medics remain in the workforce longer this can also increase the overall size of the workforce. A reduction in the rate at which medics leave the workforce by some 1% (from 14.4%) could in ten years increase the workforce by some 9,600 staff.

76. It is important to note that the role of EEA workers will not be the only challenge on labour supply in the future. By simply considering population projections, and current age related need patterns, it might be expected that the demand for doctors could increase by around 0.9% annum. This would be equivalent to around 1,000 extra doctors per year. In addition, there could be specific shortages in certain areas of specialty or locality which might be more readily filled if there were a larger pool of possible recruits.

**Nurses**

77. Figure 23 below presents similar analysis for the nursing and midwifery workforce in HCHS. Again, it illustrates a worst case scenario by showing how the stock of EEA staff, excluding those from Ireland, would reduce if additional inflows were no longer possible and the existing stock left the NHS at historical rates.
78. Initially the stock of EEA nurses declines by around 3,000 per annum, but the rate of decline slows as the stock decreases. After five years, the cumulative risk to supply is around 12,000 EEA nurses. This increases to around 17,000 nurses after ten years.

Figure 23: Projected decline in EEA supply of Nurses and Midwives, assuming no EEA recruitment

<table>
<thead>
<tr>
<th>Year</th>
<th>Headcount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y0</td>
<td>0</td>
</tr>
<tr>
<td>Y1</td>
<td>-3,300</td>
</tr>
<tr>
<td>Y2</td>
<td>-6,066</td>
</tr>
<tr>
<td>Y3</td>
<td>-8,385</td>
</tr>
<tr>
<td>Y4</td>
<td>-10,329</td>
</tr>
<tr>
<td>Y5</td>
<td>-11,958</td>
</tr>
<tr>
<td>Y6</td>
<td>-13,323</td>
</tr>
<tr>
<td>Y7</td>
<td>-14,468</td>
</tr>
<tr>
<td>Y8</td>
<td>-15,427</td>
</tr>
<tr>
<td>Y9</td>
<td>-16,231</td>
</tr>
<tr>
<td>Y10</td>
<td>-16,906</td>
</tr>
</tbody>
</table>

Source: DH analysis, 2017

79. The Government is planning to increase nurse training places, which will help increase the supply of nurses in the future. The number of domestic nurse training places will be expanded by up to 5,170 places per year starting in 2018. It takes 3 years to complete a nursing degree so the first additional trainees will enter the workforce in 2021 and by 2025 around 15,000 additional nurses could be in the workforce. It is worth noting that not all newly qualified nurses may choose to join the NHS straight after training, this could reduce the amount of new available nurses.

80. If nurses remain in the workforce longer this can also increase the overall size of the workforce. A reduction in the rate at which nurses leave the workforce by some 1% (from 10.7%) could in ten years increase the workforce by some 28,100.

81. Again the role of EEA workers will not be the only challenge on nurse labour supply in the future. By simply considering population projections, and current age related need patterns, it might be expected that the demand for nurses could increase by around 0.9% per annum. This would be equivalent to around 3,000 extra nurses per year. In addition, there could be specific shortages in certain areas of specialty or locality which might be more readily filled if there were a larger pool of possible recruits.
Direct Care in Adult Social Care

82. The Direct Care group of job roles in adult social care accounts for an estimated 1.2 million jobs in the adult social care sector. Nationality is estimated for the 985,000 of these roles which are in the local authority and independent sector. Around 7% (69,000) of these workers have an EEA nationality (excluding Ireland). Direct Care is a diverse group of jobs, with the majority in the local authority and independent sectors being care workers (83%).

83. Direct Care workers in the local authority and independent sectors have an average time in role of 3.6 years, with 30% of current workers being in the role for less than a year. The high starter rate (38%) and leaver rate (31%) demonstrate considerable inflows and outflows of people into and out of these roles. There is also significant churn, with 68% of direct care workers being recruited from within the adult social care sector, and a vacancy rate of 7%.

84. Figure 24 below presents another similar projection where the existing EEA stock (minus Ireland) reduces at historical rates under a situation where there is no EEA recruitment. Assuming a static stock to the implementation date for illustrative purposes, five years after implementation we might see a supply risk of 28,000 fewer staff with this increasing to around 45,000 after ten years.

Figure 24: Projected decline in EEA supply for the Direct Care job group assuming no EEA recruitment

85. Recent trends have seen turnover rates increasing for direct care, from 26% in 2012/13 to 31% in 2016/17. A gradual reduction in the rate at which the existing stock of non-EEA Direct Care permanently leave the workforce by some 1 percentage point could, after 10 years, increase the workforce by some 20,000. This does not include additional pressures from increased demand. As context, the number of jobs has increased in the local authority and Independent sector by around 2% per annum since 2012/13 – which equates to around 20,000 staff per annum.

Source: DH analysis, 2017
Technical Notes:

Data Sources:
- NHS Digital data on headcount by nationality for nurses (including midwives) & Hospital & Community Health Services Doctors.
- NHS Digital data on headcount of joiners and leavers by nationality for nurses (including midwives) & Hospital & Community Health Services Doctors.
- Skills for Care job estimates by nationality for the Direct Care staff grouping in Adult Social Care.

Other notes:
- The Nursing workforce includes professionally qualified nurses (& health visitors) and midwives in HCHS.
- HCHS doctors include Consultants, Associate Specialist, Specialty Doctor, Staff Grade, Specialty Registrar, Core Training, Foundation Doctor Year 2, Foundation Doctor Year 1 and Hospital Practitioner / Clinical Assistant.
- Projections are based on headcount of staff.
- Where multiple data updates for a year were provided, data for September was taken to ensure consistent reporting periods.
- Irish nationals were excluded from the EEA cohort to reflect a position of a different immigration position for Irish nationals.
- The attrition (leaver) rate is calculated as the number of leavers between two years over workforce levels from the previous year.
- Joiners rate is calculated as the number of joiners between two years over workforce levels from the previous year.
- Methodology assumes no more EEA recruitment after 2021 and static rest of the world recruitment.
- Nurse training attrition rates have been assumed at the same annual rate as workplace attrition, calculated using leavers information.
- Doctor training attrition rates have been assumed at 1.2% per year over a 5 year training period, source: https://www.hesa.ac.uk/data-and-analysis/students/overviews?keyword=589&year=620&=Apply. Workplace attrition has been calculated using leavers information.
- Nursing trainees are assumed to enter the workforce after 3 years, HCHS doctors are assumed to enter the workforce after 5 years.
- To estimate a permanent leaver rate for Direct Care jobs overall the turnover rate for directly employed staff is applied to the percentage ‘churn’ or movement of staff within adult social care.
ANNEX A
Qualification versus nationality data from GMC

The following table, taken from GMC\textsuperscript{12} shows how the differences in identification using nationality or qualification data can affect the understanding of EEA migration patterns and workforce planning. 3,384 (15\%) EEA nationality doctors have qualified in the UK and 1,541 British nationals have qualified in the EEA. Almost 67,000 doctors (almost 30\% of registered doctors) have no nationality information recorded.

Table 1: GMC Licensed doctors by Primary Medical Qualification (PMQ) region and recorded nationality group, June 2016

<table>
<thead>
<tr>
<th>PMQ region</th>
<th>Nationality</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>British</td>
<td>EEA</td>
</tr>
<tr>
<td>UK</td>
<td>95,153</td>
<td>3,384</td>
</tr>
<tr>
<td>EEA</td>
<td>1,541</td>
<td>16,996</td>
</tr>
<tr>
<td>IMG</td>
<td>6,830</td>
<td>2,333</td>
</tr>
<tr>
<td>TOTAL</td>
<td>103,524</td>
<td>22,713</td>
</tr>
</tbody>
</table>

\textsuperscript{12}`The relationship between Primary Medical Qualification and nationality at the time of registration’, Working paper 2 GMC March 2017