

CONTENTS

- Introduction
- No good growth without good health
 - Population health
 - Social care
 - Health and social care careers
- Investment in health and social care systems
 - Structural reform
 - Shift from acute to community health services
 - Social care
 - Devolution
 - Health and social care careers
 - Climate change preparedness
 - Artificial intelligence
- Nursing as an anchor workforce
 - Early years prevention
 - Nursing contribution to productivity
 - Sustainable nursing workforce
- Returns on investment in nursing
 - Domestic nursing workforce supply
 - Supporting newly registered nurses to enter the workforce
 - Disproportionate graduate debt
 - NHS nursing pay
 - Independent sector nursing pay
 - Costs of accessing work
 - Mental health support
 - Fair deal for internationally recruited staff
 - Nursing leadership
 - Global nursing

Introduction

With a membership of over half a million 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 United Kingdom and the largest nursing union and professional body in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes priorities for nursing and patient safety, works closely with wider professional bodies and trade unions, and lobbies governments and other bodies across the UK to develop, influence and implement policy that improves the quality of patient care.

The budget at the end of October will coincide with a rise in inflation, which will not only reduce the purchasing power of our members but also the real terms investment committed to healthcare in 2025 Spending Review. The new Prime Minister has set out an agenda with ambitious aims for the NHS, social care, education and the wider economy, to be detailed in the budget and upcoming 10-year plan for the country.

In this budget submission, we set out the case for seeing the nursing workforce as instrumental in achieving national growth. Not only through its role in enabling the wider population to contribute to good growth everywhere, but also its potential as an anchor career available to young people in every part of country.

As the largest professional workforce across health and care, nursing is fundamental national infrastructure and central to delivering these economic benefits. Nursing staff provide the continuous, person-centred care that improves population health, prevents illness, supports people to remain in work for longer, enhances productivity and safeguards patient safety across every part of the health and care system. Yet for too long, nursing has been treated as a cost to be managed rather than a strategic investment that delivers substantial economic and social returns.

It's the right time for government to recognise the returns resulting from investment in nursing.

Key Messages

- The government must place health at the centre of its economic strategy. There can be no "good growth in every postcode" without good health in every postcode. A high-performing NHS is not simply a public service; it is a driver of economic growth, enabling people to contribute productively to their communities.
- Improving children's health is not only a public health imperative, but also critical for progress towards broader government objectives to break down barriers to opportunity and drive economic growth and prosperity. To align with the goals set out in the ten-year health plan and the Best Start in Life strategy, the forthcoming ten-year workforce plan should include a strong emphasis on growing, retaining, and strengthening the health visiting and school nursing workforce.
- Shifts from acute to community provision, and from illness to prevention, require upfront investment to ensure transformation is successful and sustained.
- Adult social care (ASC) is also a critical component of the UK's social and economic infrastructure. Insufficient social care capacity limits labour market participation among unpaid carers, places additional strain on local authority finances, and contributes to wider regional inequalities.
- Current monthly data indicates that the economy could be on a path to the Bank of England's forecasted 'adverse scenario', where inflation rises to 4.1% CPI for the year to Q3 2027. A resulting rise in interest rates, already substantially higher over the last four years when compared to 2009-2022, will inevitably impact on healthcare delivery, across all sectors.
- Without an increase in healthcare productivity, the growing complexity of health conditions along with a growing population will put unsustainable pressure on the NHS and social care sector. Productivity gains through better approaches and technological support will have an impact.
- Ultimately, it is staff who deliver those gains, and ensuring staffing meets demand requires revenue spending. The RCN cautions that assumptions about the potential for productivity gains via artificial intelligence in healthcare must be firmly rooted in the understanding that AI can augment clinical practice, but it cannot replace it. Clinical decision making must rest with qualified professionals, which in the correct circumstances and using reliable tools, AI solutions can support.
- The nursing profession is inseparable from delivering care, but also carries the expertise to unlock productivity gains within the NHS. In turn investing in nursing can help accumulate healthcare capacity, alleviate long term

sickness and drive growth at a local, regional and national level by helping people access employment and using NHS resources more efficiently.

- Embedding and protecting nursing leadership throughout health and care reform will be critical to delivering the government's ambitions for modernisation, productivity and improved population health. Nursing leadership roles must be protected and supported at all levels.
- Long term nursing workforce planning requires a proactive and joined up approach to policy and funding across government. This must address the current issues to nursing recruitment and retention, throughout the whole education and career pipeline.
- In reality, the nursing workforce has faced over a decade of a boom and bust, an entirely reactive approach. Cumulative underinvestment in nursing and cuts to nursing education have hindered, and will continue to hinder, the delivery of successive governments in their aims in the health service and wider economy.
- This reactive approach creates enormous risk in the health and social care sector, as there is no predictability in national supply or retention of nursing staff. Unlike other countries competing with the UK for supply, there are few interventions within the control of health and social care providers to address this.
- Current UK government policies disincentivise new joiners to the profession, and push the current workforce out of the profession, or out of the country.
- Newly registered nurses have reported increasing difficulty securing their first registered nursing post, despite continued workforce pressures across the NHS. We are calling for an end to inappropriate job adverts, centralised relocation funding for those who want to move so they can access a job, for new graduates to be prioritised for bank shifts and for those graduates to then be guaranteed a substantive nursing role.
- Because nursing graduates earn less than most graduates, they are more negatively impacted by the student loan model, paying back more, for longer. In addition, freezing the threshold from April 2027 means that even though nurses pay will rise by 3.3% in nominal terms, any gains will immediately go to higher spending on student loans and the cost of living.
- In 2017, the Prime Minister stood at RCN Congress and called for a return of the nursing NHS bursary. Offering loan forgiveness in recognition of years of service within health and care would address this potential barrier to entry and support early career nurses' retention. The estimated benefit-to-cost ratio associated with this loan forgiveness model stands at 4.0,

(meaning that for every £1 put in by the government, an estimated £4 are returned), and a societal benefit of £1.07bn per cohort.

- The commitment from the previous Health Secretary to initiate the process for job evaluation, recognising the contribution of nurses aligns with Band 6 remuneration and responsibility represented a step in the right direction. However, the upcoming pay award must recognise the long-term pressures to retain nurses and the rise in the cost of living.
- It is also essential that policies ensure the UK is attractive to international nursing staff, and do not unfairly penalise them for coming to work in UK health or social care. Denying access to these public services when nursing staff are paying into a system after obtaining ILR is unjust and harmful.
- The devolution agenda offers opportunities for healthcare, but also creates risks to delivery. The government should set out more detail on how tax devolution will be implemented to ensure this spending takes into account regional health disparities.
- Proposals to strengthen alignment between education and employers at regional level clearly presents an opportunity to promote nursing and other healthcare careers, in every part of the country. The new pathways must have close alignment with the existing curriculum so that nurses are ready to enter the workforce upon completion.
- The government must take a more focused approach to adapting the NHS estate to climate related stress. NHS England Capital Guidance should be updated to specifically account for adapting to the climate crisis, building on plans for a Net Zero NHS by 2040.
- The UK cannot continue to turn its back on the health needs of low-and middle-income countries and shrug its responsibilities to help address the global health workforce crisis. The government must set out a path for returning the UK's spending on Official Development Assistance (ODA) to 0.7% of Gross National Income (GNI).

No good growth without good health

Population health

There can be no "good growth in every postcode" without good health in every postcode. A high-performing NHS is not simply a public service; it is a driver of economic growth, increasing labour market participation, reducing economic inactivity and enabling people to contribute productively to their communities, while also acting as an anchor institution that supports local economies through employment, procurement and investment.

In July, the Health Foundation released a paper examining the prospects for the UK economy if population health was restored to 2014 levels.ⁱ This would see a rise in living standards for the poorest households, a 2% rise in GDP and a £40bn increase in government tax revenue as a result of improved employment and productivity.

All the evidence points to the requirement for the government to place health at the centre of its economic strategy. However, it is clear, as indicated by the Office for Budget Responsibility's latest Fiscal Risks and Sustainability report,ⁱⁱ that without an increase in healthcare productivity, the growing complexity of health conditions along with a growing older population will put unsustainable pressure on the NHS and social care sector.

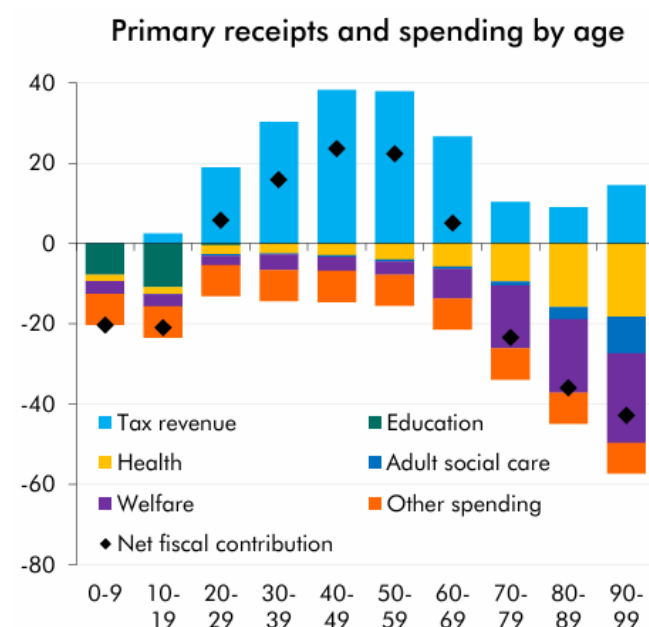


Figure 1 Source: OBR, Fiscal Risks and Sustainability Report July 2026

As the population ages, without changes to the existing tax regime, tax revenues will reduce over time whilst net expenditure on those over the age of 60 will increase as a proportion of public spending. Already health spending is by far the largest part of the government budget. Though that may be deemed a luxury for a

mature western economy, it is also a symptom of demographic shifts coupled with a failure to centre prevention in the health service over the long-term.

In 2023, The Health Foundation estimated that in 2040, 9.1 million people will be living with a major illness. However, looking at data trends since, could reveal a starker picture. The birth rate is falling in the UK faster than anticipatedⁱⁱⁱ whilst the effects of extreme heat will compound existing health issues.

These problems become more pronounced at a regional level, where NHS trusts in different parts of the country face different challenges. In 2010, the Marmot review looked at how health impacted productivity and the cost to the economy from poor health. In the intervening period, whilst there is some evidence for a limited, broad improvement in health, regional inequalities remain.

For instance, ONS analysis following the 2021 Census found^{iv} that whilst the level of people whose health was bad or very bad had decreased from 6% to 5.3% overall, there were few differences in the regional ranking, North East England still had the largest proportion of people in bad health, and the South East the fewest. A package of research into health in the North of England by the National Institute for Health and Care Research (NIHR)^v has found that if health in the North matched that of the rest of the country, an additional £18bn could be added to the economy. London has a much higher proportion of ‘Good’ and ‘Outstanding’ schools as rates by Ofsted, as compared with the rest of the country too.^{vi}

Social care

Adult social care (ASC) is a critical component of the UK’s social and economic infrastructure. Insufficient social care capacity limits labour market participation among unpaid carers, places additional strain on local authority finances, and contributes to wider regional inequalities.

The sector employs approximately 1.8 million people and supports hundreds of thousands of older and disabled adults each year, providing essential services that enable independence, dignity and safety.^{vii} Urgent reform is needed to build a sustainable system that allows everyone to access timely, high-quality care based on need.

The performance of adult social care is closely intertwined with that of the NHS and the wider economy. When ASC capacity is stable and well-resourced, hospital discharge is timely, avoidable admissions are reduced, and individuals are able to maintain independence for longer.

Conversely, when ASC provision is constrained or fragile, the NHS becomes the system of last resort, with rising pressure on emergency departments, delayed discharges and increased system costs.^{viii} Low pay contributes to poorer continuity and quality, increasing NHS demand. The Joseph Rowntree Foundation has conducted detailed research and modelling into the effect of low pay on social care outcomes, published in February. They estimate that 8% of emergency

admissions originate from care homes and 45% of ambulance callouts are for non-injury falls.^{ix} Low pay, according to their research significantly affects staff turnover, reducing staff continuity and historically leading to not just increased agency staff, but the handing back of contracts due to challenges facing recruitment.

Health and social care careers

The new government has set out its intentions to link local employers to schools, engaging 14–16-year-olds in 'technical education pathways' which provide experience and skills development, not limited to academic subjects. The intention is to invest in and promote non-university orientated careers.^x

Of the pathways, the new approach specifically references life sciences and health and care. Crucially, it sets out that 'the approach will allow areas to shape education around the industries that matter and are growing in their communities'.

Nursing is a diverse profession, with many potential career pathways. However, young people are expressing a current lack of interest in pursuing this path. RCN commissioned public polling in 2025 found that from a sample of over 2,000 young people aged 16-18 by YouGov^{xi} saw nine in ten (91%) say nursing has the joint highest value to society, alongside doctors. However, an almost identical number (88%) would not consider it as a career, with low wages (52%) and pressures in services (55%) top of reasons not to join.^{xii}

Along with the wider measures set out in this submission, this intended alignment between education and employers clearly presents an opportunity to promote nursing and other healthcare careers.

The new pathways must complement existing nursing education in each region, broadening access to nursing as a professional career. They must have close alignment with the existing curriculum so that nurses are ready to enter the workforce upon completion. There will likely be some difference in facilities and workforce supply from region to region, given the wide range of existing and planned regional authorities. Nurses must not miss out on valuable experience if they are from a region which has more limited scope to support their education. Therefore, DHSC needs to support the new pathway, coordinating the placement of students to access fair and timely education. Otherwise, the new educational pathway's potential may be under-utilised and an opportunity missed.

The model appears to be partially inspired by the Manchester Baccalaureate programme ('the 'MBacc') which was introduced in Greater Manchester, in the 2024-25 academic year. This scheme has seven pathways for education and workplace experience which combine academic subjects with vocational training, one of the pathways is centred on health and social care. These are delivered as 'T-levels' in partnership with NHS trusts in the Northwest of England.

A report released in June by the Gatsby Charitable Foundation^{xiii} into health and care T levels suggested that they had a return on investment of 1.81, meaning that for every pound spent then the investment would return 81% more back to the NHS in terms of value, even without considering wider societal benefit.

Government needs to develop more detail on how employers will be incentivised to participate, especially beyond hospital trusts. Whilst there is a model, looking at GM, there are clearly geographical limitations. Some more rural areas will not be able to provide access to a range of businesses and forms of employment.

In health and social care, there will be regional divides regarding the experience and opportunities to some as health needs and quality of services differ from place to place. Although that is the case in general for healthcare and is the case when nurses attend placements, it does mean there is a disparity of opportunity for those participating. This disparity will need to be addressed through the wider investment in healthcare and nursing detailed in this submission.

Investment in health and social care systems

Analysis by the Institute for Fiscal studies released last year^{xiv} highlighted that the gains in productivity in 2024-2025 did not see a drastic shift in the waiting lists, which have only come down very gradually. This may indicate a misallocation of resources, unsustainable growth in productivity, issues with measurement or increasing complexity in cases and/ or an increase in the number of interventions and appointments per item of care.

The RCN has been active in highlighting the corridor care crisis in the NHS. We are clear that it is symptom of fundamental capacity constraints in the system, caused by an inefficient allocation of resources. Corridor care is not only unsafe and undignified for patients, but also a drag on productivity within acute settings.

The cost of a bed per day is now £562, and delayed discharge is costing the NHS an estimated £2.7bn per year.^{xv} Such constraints on capacity can only be alleviated by an injection of additional resources, in the form of additional staff, an expansion of capacity and/or a reduction in patient admittance and throughflow.

Looking at the productivity data for NHS trusts made available since February, there are productivity gains being made throughout the NHS. However, it is unclear what the distinct drivers of those gains are, without access to deeper data relating to healthcare inputs.

There may be specific localised reasons for very high (above 20%) growth figures. For example, Leeds and York Partnership, is experiencing very high gains in productivity, but in May 2025 saw an equivalent figure of -25.5%, meaning that although growth is high, the trust's growth in productivity might rather be illustrating that the trust is simply catching up on previous reductions in capacity. With waiting lists stubbornly high and the workforce stagnant, a supply side intervention is limited. Capital investment to create space, alongside tackling existing backlogs in maintenance takes time. Productivity gains through better approaches and technological support will have an impact. But ultimately, it is staff who deliver those gains, and ensuring staffing meets demand requires revenue spending.

In order to assess the impact of government reforms, trust approaches to productivity improvements and staffing, we would like DHSC to provide a more transparent breakdown of underlying productivity data, as it relates to the metrics published.

Structural reform

We expect the long-term shift to care in the community and towards prevention previously set out to be followed through, and considered a key component in the

upcoming 10-year plan for the country. This requires aligning incentives between NHS structural reforms, workforce planning, devolution, long term social care reform and workforce education.

The government is undertaking the most significant reorganisation of the health service in more than a decade. The Health Bill, including the abolition of NHS England, reform to integrated care boards (ICBs) and the development of neighbourhood health services means that responsibility for planning, commissioning and delivering care is being reshaped across the system.

The spending review pledged a 3% CPI-based real terms investment in health and social care over the remainder of the parliament.^{xvi} The settlement included a 2% productivity rate from 2026-29, as reiterated in the Ten-Year Health Plan. The Darzi report highlighted several key productivity problems in the NHS, tying patient flow problems to a slowdown in healthcare output as beds are occupied by those needing to be transferred to other settings.^{xvii} According to the report, hospital productivity fell 11.4% between 2019 and 2024, as historical underinvestment in the NHS estate, COVID and changes in demographics have put extra pressure on patient flow.

The Bank of England's most recent set of economic forecast scenarios came in July^{xviii} before the break down in negotiations over the opening of the Strait of Hormuz. Their central scenarios, predicated on a steady return to normality estimated inflation would rise to just above 3% by the end of 2026, before gradually decreasing. However, as we enter the Autumn, there is no end in sight to the conflict, and we edge closer to their 'adverse scenario' where inflation rises to 4.1% CPI for the year to Q3 2027. The conflict has also put pressure on input prices which are beginning to feed through into the wider economy, for instance the Strait is the main global source of helium which is used in MRI scanners.^{xix}

This rise in interest rates, already substantially higher over the last four years when compared to 2009-2022, will inevitably impact on healthcare delivery. Primary care delivered in the community, via dentists, GPs, pharmacists and other contracted services (such as for vaccine contracts) operates out of small businesses. Many will hold debt or mortgage payments tied to interest rates. If these rise at the same time as other input costs such as energy, there is less money for healthcare and investment in staff.

Reforming adult social care will unlock the potential of our communities, but can only be achieved with a sustainable workforce and effective health care system. Facing the challenge of reforming Adult Social Care, following decades of government reviews, recommendations and inaction, is a noble ambition. Given its reliance on local authority delivery and strain on their finances, taking a national approach comes with the advantage of freeing up local leaders to focus on other issues.

Public health success is contingent on other determinants such as crime, housing, employment and education which in turn are delivered at a local level, within

communities. These are prevention in action, and a joined-up approach at local level can help us bring the NHS into the future, with a sustainable financial approach as our communities get older, and health more complex. None of this will be possible without investment in our nursing workforce, positioned at every juncture in a positively reinforcing circle, delivering in the community, as the first point of prevention, bringing down waiting lists and the cost of Adult Social Care.

Shift from acute to community health services

The shift to community care will take time and money, including workforce planning and investment for backfilling posts during transition. It requires detailed, long term workforce assessment and planning, along with substantial upfront investment. However, we are one year into the 10-year plan and it is unclear how the shift is progressing, without clear investment and implementation plans.

A reality that successive governments have failed to engage with is that a shift from acute to community provision in England requires upfront investment to ensure transformation is successful. Ireland and Denmark are examples of health systems which invested in shifting care from hospital to community settings. Shifting care in these cases did not mean cutting hospital budgets. Both systems are increasing overall health spending to aid the transition and aim to allocate a larger share of the budget to community services, expanding community capacity in parallel. The current reforms in both Denmark and Ireland also introduce substantial capital investment to community infrastructure.

The transition in Ireland required investment in workforce incentives, and a range of other measures. The Irish fiscal council estimates that annual costs of the scheme will total more than £3bn by 2027.^{xx} At just over 10% of the total Irish healthcare budget, this would be the equivalent of about £20bn pounds annually. The Danish example – dating from 2007 – also included a reduction in the number of administrative areas in order to help streamline decisions and management. Further reforms set out this year have pledged £3.2bn in capital investment, £2.5bn of which will go to updating Denmark's hospitals and £230m for scaling up digital health solutions. £410m will go to improving community care infrastructure.

The Danish program is also ongoing, predicted to cost around 2% of the overall health budget by 2030. If this applied to England that would mean just over £4bn annually. However, it is important to note that although there are many similarities, the health systems in Ireland and Denmark do also contain key differences with the NHS and apply to smaller populations.

These international examples demonstrate a clear understanding of the nature of transformation, and how it must be enabled through up front funding, in order to release benefits later. These should serve as examples for England, so that the

pattern of repeated failure to make this shift can be broken. Government must fund the transition to community carefully, including community nursing roles.

Social care

The social care system is heavily fragmented between different models of provision, creating numerous barriers to the deployment of additional social care capacity in cohesion with NHS care pathways. The RCN has recently raised this issue in the context of the government's commitment to eradicating 'corridor care', and advocated for the removal of unnecessary bureaucracy dividing health and social care systems.

In the absence of a more sustainable, long-term funding model this should include the introduction of a top up of social care funding so that NHS funded patients are financially viable for residential care homes, or home care, where needed, as well as the provision of additional funding to unlock available social care capacity and enable "Discharge to Assess" outside hospital, either in short stay residential social care, or in the home.

There are opportunities to bring health and social care closer together. This requires a better understanding in government of how hospital discharge is slowed by funding assessment rules and the interrelation between social care providers and other health care services.

Devolution

The devolution agenda offers opportunities for healthcare, but also creates risks to delivery. Devolved health ambitions are likely to be constrained by the wider fiscal environment. With the government committed to existing fiscal rules and facing competing spending pressures, there is a risk that structural reforms may proceed without substantial additional investment, raising concerns that organisational change could be used primarily to deliver savings rather than meaningful improvements in services.

In the Cabinet's recent briefing on 'rewiring the state' the government set out its ambition to devolve a proportion of income tax and increase business rates retention.^{xxi} The government should set out more detail on how this tax devolution will be implemented, an equitable approach to distributing tax revenues and work with us to ensure this spending takes into account regional health disparities. The new devolved spending framework may take many forms but could follow a similar path to the Barnett consequential funding settlement for the devolved national governments, alongside a methodology for providing a fiscal floor for ensuring that poorer regions receive a just settlement compared to those with higher tax receipts e.g. East Anglia vs London.

The additional funding could also be used as collateral to leverage increased private investment or borrowing for capital projects such as housebuilding, or

capital investment in health infrastructure. However, without a specific regulatory barrier in place, there would be no boundary to local mayors instead using the money to cut taxes. Regions with older populations will in some cases also be those with lower productivity and tax receipts,^{xxii} and higher health spending per capita. Those regions with more complex health needs must be taken into account when designing the system for devolved finances.

To ensure the success of the reform agenda to reduce the number of ICBs in England whilst devolving addition tax, education and health powers to, requisite incentives must be aligned.

The specialist Centre for Local Economies (CLES) think tank has examined how health inequalities affect, and are affected by regional economies^{xxiii} and how devolution might impact outcomes.^{xxiv} Their research suggests that investment in public housing and transport infrastructure could help to alleviate health inequalities. High costs and unreliable services contribute to poor mental and physical health. Crucially, regional transport investment can aid people in accessing healthcare services in more deprived, semi-rural parts of the country.

Their research has highlighted some of the approaches taken by mayoral authorities to join up policies relating to local employment and those struggling to find work with approaches to regional health outcomes. For instance, in the West Midlands, the mayoralty has adopted a ‘health in all policies’^{xxv} approach, recognising the importance of the wider determinants of health including housing, skills and the environment. Their Thrive into work^{xxvi} programme offers over 18s job support if they face health challenges. Geographical boundaries of power need to be as closely replicated across second tier authorities, ICBs and trusts and others to gain the most benefit from co-terminosity seen in Greater Manchester.

Greater Manchester

Greater Manchester (GM) is clearly a leading example for the Government’s wide-ranging reform agenda. It has experienced stronger growth and productivity than other regions since devolution in 2017, when measured using some metrics, but not all. The Productivity Institute has researched this, finding that even though it is not conclusive that GM was doing better overall, GM benefits from a kind of co-terminosity not applicable to all current or devolved regions.

In Oct 2024 The King’s Fund published an assessment of Greater Manchester’s approach to improving population health, they state that GM is seeing better than expected improvements in health outcomes and inequalities, and strong collaboration built on a shared and sustained vision and commitment to population health over time.^{xxvii} The King’s Fund found significant investment had been made in capability building including: *data and evidence, leadership and skills*, and in *learning and evaluation*. The Kings Fund caution that this model requires sustained commitment and investment over time, and that immediate pressures limit the ability to prioritise population health work. A study published

in the Journal of Public Health in July 2026, drawing on interviews with public health experts working in Greater Manchester, found that prevention work has in practice been treated as less of a priority than treatment-centred activity².

The government must also ensure that future spending decisions maximise value. Former Health Secretary Wes Streeting told the Parliament Health and Social care Committee that he was determined that health budgets would not be cut^{xxviii} to facilitate the £1bn increase in drug prices for the NHS as agreed in the trade deal with the United States.^{xxix}

An independent impact analysis by the Nuffield Trust^{xxx} of the UK-US medicines agreement has raised concerns about the impact of increased spending on branded medicines on its associated value. Medicines represent a large, important cost input to care, changing the NICE threshold of assess cost-effectiveness for specifically new branded drugs potentially could be money for extending existing methods for improving care which are in need of investment, for instance staffing or maternity care.

Climate change preparedness

The government must take a more focused approach to adapting the NHS estate to climate related stress. Figures from the UK Health Security Agency (UKHSA) show 3,000^{xxxi} heat-associated deaths during hot weather in May and June this year, equivalent to a small rural town, and that this year could see the highest number of heat-associated deaths on record. Recent intervention from the new Health Secretary Yvette Cooper stated that the NHS needed planning on a par with what is put in place for winter. A global study recently published by the lancet, updated projections for the impact of exceeding human heat tolerance, and the disproportionate impact on those over age 60.^{xxxii}

In a landmark report in May, the Climate Change Committee^{xxxiii} also called for all hospitals and care homes to have air conditioning within the next decade and advised the government to plan for at least 2 degrees Celsius of global heating by 2050. The risk to hospital structures, in many cases require existing repairs, from flooding, warping between high and low temperatures and the strain on the electricity supply in periods of extreme weather needs central planning. Currently the NHS has provides detailed guidance via its Green Plan^{xxxiv} on how to adapt NHS estates for climate change.

The New Hospital Programme incorporates the NHSs delivering a net zero NHS strategy, meaning that new hospitals will have to be net zero for 80% of 'direct' emissions by 2040 and net zero in entirety by 2045.^{xxxv} However, there is no coordinated central plan for supporting trusts to invest in adaptation, which requires planning over an extended time horizon.

Much of the existing NHS estate is decades old and already requiring ongoing repair and maintenance, compounded by concerns over the use of reinforced concrete (RAAC). The NHS, much like it does with pharmaceuticals, could benefit

from its position as a single buyer, pushing down the price of cooling equipment or contracts to adapt existing infrastructure. A decentralized, trust lead programme is likely to take more time.

NHS England Capital Guidance should be updated to specifically account for adapting to the climate crisis. The previous Chancellor allocated £750m^{xxxvi} per year to improve the NHS estate through the Estates Safety Fund. This should be strengthened at pace to incorporate specific climate risks related to high temperatures, with the commitment set out long term in the upcoming budget and following spending review.

Artificial intelligence

In the Ten-Year Health Plan, the government outlined its hopes for AI and other technologies to help in unlocking productivity gains, freeing up capital and labour to be used elsewhere. The RCN supports this endeavour, as long as nursing is at its centre. However, in order to facilitate technological shifts, work must go into understanding the potential risks associated with rushed implementation.

Underestimated upfront investment costs and misunderstood barriers to implementation across a fragmented system could pose difficulties to implementation. The amount of staff time required for training and adopting these tools needs to be well thought out, and planned carefully.

The RCN cautions that assumptions about the potential for productivity gains via artificial intelligence must be firmly rooted in the understanding that AI can augment clinical practice, but it cannot replace it. Clinical decision making must rest with qualified professionals, which in the correct circumstances and using reliable tools, AI solutions can support.

We are encouraged by the opportunity afforded by the creation of the AI Commission, by the MHRA, to provide advice to the gov about the regulation of AI and healthcare. This Commission will play an important role in navigating the balance between innovation and risk.

Nurses, on the front line of the health service are best placed to support the design of such tools to ensure the highest standards are adhered to. AI support technology needs to be cost-effective, accessible and appropriate for occasional fast moving, high pressure care settings. Consultation with the nursing profession is a necessity, if the health service is to make the most of developing technology.

Nurses must be at the forefront of efforts to develop and integrate new technologies into daily healthcare tasks to ensure maximum benefit for patients, whilst maintaining clinical excellence. Their knowledge and expertise are crucial to shaping how new technologies coexist with clinical practice, existing systems and how to leverage their abilities for improved outcomes.

However, nurses, along with other workers in healthcare, have a relatively low level of exposure to the potential changes artificial intelligence (AI) may make to the employment landscape. A 2023 Department of Education paper looking at job exposure to AI ranked both nurses and midwives in the bottom 10 out of 365 occupations ranked when considering several methods.^{xxxvii} The development of AI has moved quickly in the time since, and its potential for use in healthcare is somewhat clearer today. However, the risks it poses due to incomplete information have underlined the case that nurses work will be augmented, rather than replaced by AI. Given the 24/7 safety critical role of nurses they should be at the centre of designing AI initiatives.

While some administrative tasks may be optimised using technology, this is more likely to be useful in freeing up nurses to perform more complex tasks which require sophisticated decision making in a care setting. It should not be presumed that AI could replace any clinical nursing duties. The realities of AI infrastructure being primarily based in the United States, provided by private companies also poses risks for deployment in the NHS if for instance access were denied to the software, as has occurred in recent examples elsewhere.^{xxxviii}

For instance, regarding the NHS England's Federated Data Platform (FDP) and the proposed Single Patient Record. There are concerns about the supplier of the FDP, Palantir and its role in NHS England data systems, including accountability, transparency, vendor lock-in and compatibility with NHS values. We ask the government to consider these concerns seriously ahead of the break clause period prior to March 2027.^{xxxix}

Nursing as an anchor workforce

Early years prevention

Nearly one million young people aged 16 to 24 in the UK are not in education, employment or training (NEET),^{xi} and the NEET rate has only fallen below 10 per cent once in twenty-five years, during the Covid-19 pandemic. Eight of the ten English local authorities with the highest likelihood of individuals being NEET are in the North of England and the Midlands.^{xli}

The reasons for poor labour market participation among younger people is complex, with one of the strongest indicators for someone becoming NEET being earlier school absence, but there is also a health component. 45% of those who are NEET report having a disability, doubling from 2013/14. In the Milburn interim review, health was identified as not only 'central' to who becomes NEET, but 'one of the defining shifts in the data' over that time period.

The review has collected research which challenges the myth that young people not working do not have a desire to do so, with 54% of those surveyed wanting to work, and 69% saying it is worth getting a job.

Research by the Resolution Foundation^{xlii} has highlighted that the UK's NEET rate of 13% of 18-24 year olds is 'stubbornly' high compared to European peers, especially the Netherlands (4.6%) Denmark (8.6%) and Germany (9.4%). Their analysis suggests that education participation is a key driver, but the UK offers limited vocational pathways to employment compared with its peers. The report highlighted that in fact most NEETs face overlapping challenges, and they recommend improving 'young people's health, particularly through better mental health provision in schools and colleges to reduce the numbers becoming NEET due to ill health in the first place'.

In its Fit for the Future: The 10-Year Health Plan for England (2025) the Government made commitments to shift the focus from treatment to prevention, to 'raise the healthiest generation of children ever', and to 'get prevention right for the early years'. Improving children's health is not only a public health imperative, but also critical for progress towards broader government objectives to break down barriers to opportunity and drive economic growth and prosperity. A child who falls behind at 5 years old, is typically still behind at 16.^{xliii}

Health visitors and school nurses provide a range of universal and targeted specialist public health services to babies, children, and families and lead the Healthy Child Programme (HCP) in England. Their unique skills, expertise and community-based roles make them key agents for promoting public health, preventing illness, and reducing health inequalities. Through early intervention and health promotion, they improve physical and mental health and outcomes such as children's school readiness which in turn helps to build healthier more

productive future generations and reduces demand for acute services in the longer term.

Though workforce data is incomplete, health visitor population has declined significantly over the last decade.^{xliv} An RCN survey in 2025 found that 58% of health visitors thought that understaffing was leading to a reduced time for prevention and early intervention, numbers replicated by school nurses. However, both groups nearly unanimously (92% and 89% respectively).

The forthcoming 10-year workforce plan should include a strong emphasis on growing, retaining, and strengthening the health visiting and school nursing workforce, with clear targets and timelines. This must align with the goals set out in the 10-Year Health Plan and the Best Start in Life strategy.

The RCN called for more investment in health visiting and school nursing in our report published in May. It made the case for additional funding to restore the public health grant to at least its 2015 real terms value and ensure that funding for public health increases in line with population needs and supports the transformative shift to prevention.

It also called for increased and ringfenced funding allocations for children's public health services within overall public health budgets, to ensure that investment in health visiting and school nursing services is protected and sufficient, to offer a high quality health visiting and school nursing service for all children and families, and the full range of responsibilities outlined in the Healthy Child Programme.

A more joined up approach recognising the key interrelationships between education and health has the potential to improve outcomes in both areas and beyond. A study by the Institute of Fiscal Studies found that Sure Start centres generated £2.4bn for the public purse.^{xlv} Critically, as the centres brought together several different services supporting children and parents, shaping children's health, education and there is evidence it has a net benefit effect on increasing labour market participation and tax revenue. However, most centres were cut in the 2010s.

For example, current government affordability criteria used to determine pay are too narrow, failing to recognise the return to the exchequer of improved payⁱⁱ and the reduction in costs associated with lower workforce attrition as a result. Research from London Economics has demonstrated that 81% of a nursing pay uplift returns to the government through direct and indirect taxation.ⁱⁱⁱ

Nursing contribution to productivity

Unlocking the nursing workforce can bring gains in both health sector productivity and wider labour market participation. A strong nursing profession improves population health, enables people to live and work well for longer, in turn supporting economic growth and productivity.

A key factor in the ongoing delays to treatment and struggles of the NHS is the lack of growth in productivity over the medium to long term; 2024 was the first year to exceed pre-pandemic activity levels. The Kings Fund have identified a set of reasons for stagnant NHS productivity growth over the medium to long term including increased staff sickness absence and overall turnover, delayed discharges, lack of long term capital investment and the long term trend towards increased comorbidity and more complex needs.

There are leading examples of nursing practice demonstrating what can be achieved when nurses are recognised and supported. A meta-analysis of nurse-led triaging^{xlvi} from 10 studies found that when nurses were given more responsibility for triaging patients, patient satisfaction levels remained the same or rose, whilst length of stay was on average reduced.

A more stable workforce would reduce the need for agency and other forms of temporary spend, making gains in experience count, rather than losing staff knowledge from failures of retention.

Therefore, the nursing workforce, across all sectors, should be seen as an anchor workforce delivering good health and therefore good growth. They are vital to furthering devolution in health, education, employment, a vital link for communities and supporting local economies.

The success of health and care reforms, specifically, will not only depend on new structures, but also on whether the right clinical expertise is driving decisions. The government's ambition to improve NHS performance, strengthen prevention and move care closer to home cannot be delivered without the workforce that provides the majority of direct patient care. Increased NHS productivity can only be achieved via investment in the nursing workforce and their workplace.

Sustainable nursing workforce

Long term nursing workforce planning requires a joined up and proactive approach to policy and funding across government. This must address the current issues to nursing recruitment and retention, throughout the whole education and career pipeline. Inconsistent, short term approaches to workforce planning over the last 15 years have lead to uneven recruitment and a boom and bust cycle of recruitment which fails to recognise the importance of retaining nursing expertise over the long term. This ultimately drives up costs and drives down efficiency. There has not been a settled, joined up approach to workforce planning which takes into account international recruitment, higher education aims, and patient and population health demands. In addition to this, more recently, government policies on immigration have had a tangible impact on NHS staffing, without consideration for the impact on the workforce.

Nurse graduation rate data for 2022, the latest detailed international comparison, highlighted that the UK had a graduation rate matching the average across all OECD countries, of around 43 nurses per 100,000 population. While this rate has grown markedly since 2013, when it was about 31/100,000 it remains well below many countries that would normally be considered as comparators. It is only a third of the nurse graduation rate in Australia, and a little more than half of that in the US.

According to the latest UCAS data^{xlvi} across the UK, there are currently 18,350 accepted students to nursing courses, representing a negligible 0.2% increase compared with 2025 but a 13% decline compared with 2022, when 21,130 students had been accepted at the same stage of the admissions cycle. Most of the reduction occurred between 2022 and 2023 (-13%), after which the overall number of accepted students remained relatively stable, fluctuating between 18,300 and 18,450 acceptances.

This reactive approach creates enormous risk to health and social care sectors, as there is no predictability in national supply or retention of nursing staff. Unlike other countries competing with the UK for supply, there are few interventions within the control of health and social care providers to address this. They are reliant on UK Government policy and funding interventions to meet their workforce needs.

The International Council of Nurses has repeatedly warned that all governments need to be accountable for nursing workforce supply. Yet data from the OECD shows that the UK has become one of the most reliant countries on internationally educated nursing staff. Internationally educated nurses make up 23% of the UK workforce, the fourth highest proportion of OECD countries reporting data.^{xlv}

The current scenario is that UK government policies disincentivise new joiners to the profession, and push the current workforce out of the profession, or out of the country. Last year, 42% of internationally educated nursing staff the RCN surveyed told us that they are planning to leave the UK, many citing better pay and immigration policies as key drivers.

The approach of successive UK Governments to generating uneven workforce supply through international recruitment is unsustainable and when relying on red list countries, unethical. Over the last two years increasingly constrictive immigration and settlement policy reforms have driven an increasing outflow of internationally educated nurses.^{xlvi} This follows a large, targeted intake during the pandemic when 50,000 overseas nurses were recruited to support the NHS.^{xlvi}

This approach is indicative of short-term workforce planning, across government departments, whilst also undermining the value international nurses, who have settled here in the UK, bring to the health service.

Most student funding including the nursing NHS bursary was removed in 2017. This lack of long-term planning, rapid change in policy and drastic changes to

financial support have fuelled a boom and bust cycle in the nursing workforce over the last decade or more. There is currently no systematic and regular national workforce planning process focused on the supply of nurses in NHS England. The previous Long Term Workforce Plan (2023) was quickly deemed unrealistic and we are yet to see the upcoming 10-year workforce plan.

According to RCN analysis of NHS workforce data, if nurse numbers had grown at the same rate as doctors since 2009 there would be around 77,000 more full-time equivalent nurses in England today. This highlights the extent to which nursing workforce growth has failed to keep pace with demand and wider workforce expansion across the health service.

In Australia, a new National Nursing Workforce Strategy was recently set out,ⁱ with the specific intention to grow and retain the nursing workforce. The strategy was developed in partnership with state Chief Nursing Officers and incorporated consultation with nurses and nursing groups including sharing a draft strategy prior to publication. It also utilised an additional nurses supply and demand study which forecast nursing demand for the next 12 years.

In the UK, governments have not only failed to deliver the workforce needed to deliver a safe, let alone effective, health service, but policies over the past decade have actively eroded domestic nursing supply and retention. The evidence has been clear for a number of years, yet successive governments have chosen complacency and denial. Ultimately, this is a failure to deliver on duties to provide a comprehensive health service which meets the needs of the population. Without sufficient staffing, there is no health service.

In May, the NHS Alliance published a report looking at the financial impact on performance, including a survey results of trust leaders.ⁱⁱ More than half of trust and GP leaders are expecting to make cuts to their clinical and non-clinical staff this year – a significant increase on last year. Nearly all trust leaders surveyed said that this year would be more challenging for financial conditions than the year before.

Respondents suggested that there were cuts in the previous financial year to clinical posts, but 57 suggested more were to come in this financial year. The government cannot pursue its reform agenda whilst enabling the cutting of clinical positions due to financial constraints.

Government aims require investment in nursing growth, across all aspects of the supply and retention pipeline. This is true, despite the recent rhetoric that more can be done with the same, or fewer, nursing staff. To improve productivity, the NHS staff pipeline needs to be appropriately invested in and maintained.

Government views on nursing workforce are currently constrained by an artificial view of what is deemed affordable. Nursing is inaccurately seen as a 'cost centre', rather than the investment in an anchor workforce it really is. The government taking a wider view of affordability when determining costs and benefits of

investment in nursing pay. Changes were made this year to the Treasury's Green Book guidance^{lii} for appraising public investments, promising to move beyond binary cost benefit analysis to consider longer term benefits of investment, rather than affordability.

The forthcoming Ten-year Workforce Plan will only be meaningful if it reflects all the requirements set out here, is based on need rather than affordability, and provides additional funding to public services proportionate to the real healthcare needs of the population.

The nursing profession is inseparable from delivering care, but also carries the expertise to unlock productivity gains within the NHS. In turn, investing in nursing can help accumulate healthcare capacity, alleviate long term sickness and drive growth at a local, regional and national level by helping people access employment and using NHS resources more efficiently.

Investment in nursing is good value for money, underpinned by evidence. Investing in nursing is also cost effective for the government to pursue, with the potential to bring down length of stay whilst driving better care. A more effective health service can clear patients quicker, bringing down costs whilst those outcomes improve, allowing the government to tackle other health delivery challenges. However, the inverse is also true, reduced retention can also increase costs as trusts turn to temporary staffing and costly recruitment.^{liii} Lost efficiency from hiring new recruits can impact overall productivity, as can the reduction in morale and effectiveness for those who have taken the decision to leave.^{liv}

Safe staffing

The RCN endorses enforceable minimum registered nurse-to-patient ratios, ensuring staffing levels do not fall to dangerously low levels and helping protect patients and nursing staff from avoidable harm. Minimums are exactly that – a minimum that should always be exceeded – not a target.

There is a substantial and growing body of evidence demonstrating that registered nurse staffing levels have a significant impact on both patient and nurse outcomes.^{lvilvii} Extensive international research, including large-scale longitudinal studies within the UK, indicate that lower registered nurse staffing levels are directly linked with heightened risks of adverse patient outcomes including preventable complications, and increased in-hospital mortality.

Lower registered nurse staffing levels are associated with higher risks to patients and poorer quality care.^{lviii} Research published in the Lancet has indicated that an increase in nurses workload has an increase in the likelihood of mortality by 7%^{lix} A 2026 study published in BMJ Quality and Safety researchers at Southampton.^{lx} They tracked over 626,000 adult admissions across 185 wards in four NHS Trusts over five years, comparing days when a ward was understaffed against days when it wasn't. Eliminating understaffing was estimated to cost an extra £197 per admission in staffing, working out at roughly £2,778 per QALY gained – reflecting an estimated 6,527 avoided deaths over the study period.

The government since 2024 has made efforts to drive agency spending down in an effort to cut costs.^{lxi} A recent observational study of 626,313 admissions to 185 wards in four NHS hospitals found that use of temporary staff, whether bank or agency staff, was less effective than using permanently employed staff. Increasing permanent staff to avoid low staffing reduced the hazard of death by 7.7%, whereas using temporary staff reduced it by 4.1%.^{lxii}

Domestic nursing supply

The nurse training pipeline is under significant strain, resulting from pressures in the wider higher education sector, direct cuts to nurse funding and the financial burden upon students both during study and upon qualification.

The current financial pressures which uniquely negatively impact nursing student recruitment and retention must be addressed, in order to remove financial barriers to joining and staying in the profession.

Almost two-thirds of UK undergraduates run out of money before the end of term, according to new research by bank Santander.^{lxiii} The RCN has recently investigated the financial burden on nursing students. Many of the financial pressure on students stem from costs intrinsic to students' courses, including course-related materials, specialist equipment, placements, and travel to placement sites. Based on students' self-reported financial circumstances across the UK, the average monthly shortfall between income and essential living costs is approximately £381 per month. To address this gap, the financial support available to students would need to increase by around £390 per month on average, equivalent to roughly £4,680 over a calendar year.

Given that many students are experiencing financial shortfalls above this amount, and that prices are rapidly changing due to external factors, we calculate that nursing students across the UK need, at least, an additional £5,000 per calendar year. This amount should not be a loan, must be available universally, and should rise each year in line with inflation.

Cuts of nearly 3% to this year's strategic priorities grant^{lxiv} which supports nursing degrees and the nursing educator workforce are not aligned with a healthcare system which needs to train and retain nurses. Nor is the current student loan system, which leaves nurses with large financial obligations they are unlikely to ever overcome unless they begin earning a Band 8 nursing salary. The Augar review^{lxv} advised that higher education funding should be targeted towards courses with social value. It recognised that 'nursing and healthcare are examples of modestly paid but socially valuable professions'. The value in investing in nurse education goes far beyond a simple measure of cost and return.

We recommend that the Office for Students should have regard to economic and social value and consider support for socially-desirable professions such as nursing and teaching which do not command a significant earnings premium.

Supporting newly registered nurses to enter the workforce

In recent years, newly registered nurses have reported increasing difficulty securing their first registered nursing post, despite continued workforce pressures across the NHS.

A survey of final-year nursing students conducted in July 2025 found that 35% of students in England had applied for six or more nursing roles, while almost one in five (19%) had applied for 11 or more positions. Significant regional variation was also evident, with 29% of students in the East of England reporting that they had applied for 16 or more jobs.

The issue is now emerging again among the 2026 graduating cohort, with growing numbers of students contacting the RCN to report difficulties accessing suitable employment opportunities. Alongside concerns about the availability of entry-level posts, the RCN has also collected hundreds of examples of nursing vacancies that appear to be inappropriately advertised, including Band 5 roles that require post-registration experience or completion of a preceptorship. These trends suggest that newly registered nurses are facing increasing barriers to entering the workforce, even at a time when health and care services remain under significant pressure.

The NHS 10 Year Workforce Plan and Band 5 Job Review are critical opportunities to fund the right number of nursing posts, based on patient need. In the immediate term, we are calling for an end to inappropriate job adverts, centralised relocation funding for those who want to move so they can access a job, for new graduates to be prioritised for bank shifts and for those graduates to then be guaranteed a substantive nursing role.

NHS England should issue guidance to employers to address the widespread use of inappropriate nursing job advertisements, with a requirement for employers to regularly audit their own vacancies and application process to ensure that no band 5 vacancies necessitate prior experience, and to ensure that posts are banded correctly at the point of advertisement.

Newly registered nurses who cannot find a band 5 (or equivalent) nurse job within 30 miles from their home, or within one hour's travel time, and accept a job outside of this "reasonable commute" should be given relocation expenses up to a maximum of £10,000 (tax free) to support their relocation, on a par with the expenses available to resident doctors.

Funding should be provided through a centrally administered government scheme. Currently, employers faced with high numbers of applicants from other areas do not have any incentive to offer relocation funding. By offering national relocation funding, government can respond to regional workforce shortages and offer compensation for newly registered nurses who are required to move because of regional disparities in job availability.

To support greater availability of relocation funding, the DHSC should ensure that employers in harder-to-recruit-to areas should have access to a general

recruitment budget for outreach recruitment such as digital campaigns and face-to-face events at further-afield locations, such as university fairs outside of their local area of recruitment.

The budget could be used to fund “golden hellos”, including perks such as travelcards, as an incentive for newly registered nurses to relocate into roles that cover local/regional workforce shortages. This should be made available to publicly funded employers. It could be possible to make access to this funding conditional on providers demonstrating that all their band 5 roles (1) do not require any criteria which an NRN would not have and (2) include a preceptorship.

Disproportionate graduate debt

Nurses should be seen as a strategically important workforce, underscoring regional and national prosperity. Nursing is not a high paying job compared to other graduate careers or their medical and dental counterparts. However, nurses given their role, and number, play an outsized part in national prosperity. The supply of nurses cannot be left up to the higher education market alone, it must be supported by the state in line with wider strategic goals and incentivised accordingly.

In 2017, the Prime Minister stood at RCN Congress and called for a return of the nurses bursary. As a result of poor pay progression, nursing graduates are currently loaded with disproportionate levels of debt. A nurse qualifying a decade ago had the financial support, in the form of a bursary to train meaning they would accrue much less debt than the average student. This was removed, justified by the government at the time as necessary to fund more training places and expand the workforce. However, under the new system nurses will almost certainly not repay their student loans, essentially applying a graduate tax to their earnings.

Because nursing graduates earn less than most graduates, they will pay more, for longer. In 2022, London Economics were commissioned to look into student loan repayments, the potential impact of a loan forgiveness model and the associated costs and benefits to the exchequer and wider society. They concluded then, that ‘100% of all nursing graduates never fully repay the entirety of their outstanding loan balance’. Economic conditions since and incoming changes to loan repayment thresholds have not improved the likelihood of nurses paying their loans back.

The total debt at qualification for a nurse qualifying in 2016 would be £9,531 (including RPI-indexed interest). Equivalent to just over one year of tuition fees for the nurse who started after 2017. Given the expense incurred upon graduation, accrued interest and subsequent interest most graduates will never pay off the loan unless they earn substantially higher salaries than the UK average.

The further universal changes to student finance in England which came into effect for the 2023/24 academic year include lowering the student loan

repayment threshold to £25,000, extending the repayment period by 10 years, and removing real interest rates during and after study. Freezing the threshold from April next year means that even though nurses pay will rise by 3.3% in nominal terms, any gains will immediately go to higher spending on student loans and the cost of living.

As nurses rise through the Agenda for Change pay scale, they lose an additional 13% of their new earnings as the student loan repayments rise accordingly. Student loans are also taken into consideration as income for Universal Credit purposes, meaning that a Nurse with a Student Loan would receive the same amount in UC as someone without a Student Loan in the same financial circumstances, but would be worse off in terms of net income because of the loan repayment.

According to the most recent data release from the Department of Education, plan 2 borrowers would need to earn £63,600 to begin paying off their debt.^{lxvi} The average level of student debt in 2023 for those completing their nursing courses was almost identical to that for medical students (both around £41,000).^{lxvii} Nurses do not have the earnings potential of Drs, who can take on the burden of a large student loan and other expenses in the knowledge that once they complete their training they will already be paying off their loan.

In a recent RCN survey of around 1,500 nursing degree students in England (unpublished), 59% indicated that if tuition fees had increased during their course, it would have either 'definitely' (19%) or 'possibly' (40%) influenced their decision to study nursing, compared with 41% who said it would have made 'no difference'. This demonstrates that students are highly sensitive to unexpected financial changes once they have committed to a programme or profession.

Dependence on government financial support reinforces this risk: 83% rely on a 'maintenance loan' and 64% on a 'tuition fee loan'. If students believe that loan terms could change unexpectedly after they have started training, this uncertainty may deter future applicants, particularly those with limited alternative financial resources.

We have developed estimates of student loan payments and compared them to nurses pay. Taking a nurse on the middle pay point of Band 5 as an example, if the threshold is frozen then in 2028, they will be paying £658 per year in repayments, or £54 a month. If it rose with CPI as previously planned, that nurse would be paying £493 per year, or £41 per month.

However, it is the interest rate which has the biggest impact on the value of the loan over time. A nurse on plan 2, having qualified as the first cohort in 2020 would have paid £9,250. Not considering maintenance grants, that would mean £29,387 of debt at qualification. Today, that nurse's debt would £43,493.

Our proposed model is that 30% of the loans be forgiven after 3 years' service, 70% after 7 years and 100% after 10 years of service. Combining the societal benefit (£1.07bn) with the Exchequer cost (£271m), the estimated benefit-to-cost ratio associated with this loan forgiveness model stands at 4.0, meaning that for every £1 put in by the government, an estimated £4 are returned.

Offering loan forgiveness in recognition of years of service within health and care would support early career nurses' retention. It is estimated that if this policy were implemented for ten consecutive cohorts, starting with the 2025-26 cohort, then there would be an additional 12,015 nurses working in the NHS (equivalent to 10,755 FTE nurses) by the time the 10th cohort entered the workforce in 2037-38.

This represents 42% of current nurse vacancies. Analysis by London Economics commissioned by the RCN has identified that introducing loan forgiveness for nurses in England would provide a societal benefit of £1.07bn per cohort (in net present terms and constant 2025-26 prices).^{lxviii}

A similar loan forgiveness policy was costed and endorsed by the independent health think tank, the Nuffield Trust, who highlighted how other countries have been bolder in addressing the unacceptable attrition of early career nurses and suggested a loans forgiveness policy was "a clear and viable opportunity to make an immediate improvement to the outlook."^{lxix}

From 2007 the US government had a loan forgiveness model aimed at public sector employees at national and at state level. The Public Sector Loan Forgiveness (PSLF) programme^{lxx} entitled someone to loan forgiveness after 120 monthly payments, or 10 years in the public sector, to incentivise longevity. The US Department of Education's own commissioned economic analysis, published in 2025 reported that 'healthcare systems report PSLF as "key to recruiting nurses and hard-to-fill clinical positions".^{lxxi} There are also other state lead programmes in the US.^{lxxii} In Texas^{lxxiii} for instance, registered nurses can receive up to \$75,000 in loan forgiveness for urban sites, or \$100,000 for rural sites, in exchange for 3 years' service.

NHS nursing pay

Pay is not simply a matter of fairness, it is fundamental to maintaining workforce supply. The health and care system cannot afford continued losses of experienced nursing staff at a time of growing demand, increased complexity and ongoing workforce shortages. All nursing staff deserve fair pay and progression that recognises and values their skills, responsibilities and contribution to the economy.

With regard to the NHS, successive governments have failed to recognise nursing, a female dominated (88%) and racially diverse profession, as an economic investment. The profession has continually and consistently been weighted to the bottom of Agenda for Change. This continued pay erosion and

limited career progression sends a damaging signal that the skills, expertise and contribution of nursing staff are disregarded.^{vi}

Without urgent action on both pay and progression, including automatic progression from band 5-6 for NHS registered nurses after a period of preceptorship, the government will fail to achieve its ambitions.

As independent analysis has found, the average earnings of NHS nurses in hospital and community services fell by more than 10% between 2010/11 and 2025/26.^{iv} This represented a greater fall than seen for consultants (-9%) and resident doctors (-7%), even before the latest pay deal announcements which gave nurses 3.3% for 2026/27 compared to up to 7.1% for some resident doctors, who are also due to receive further structural pay increases over and above the annual pay uplift in 2027/28.

In addition, a recent RCN survey has found that more than a third (34%) of general practice nurses have not received a pay rise at all for 2025/26. The lack of recognition, along with challenging working conditions since the pandemic are fuelling a rise in nurses looking to leave the profession. Four in ten respondents to our 2025 Employment Survey were considering leaving their roles, driven by low pay, exhaustion, pressure and feeling undervalued.

The current AfC framework has not kept pace with developments in nursing practice since its implementation 20 years ago.^v Career progression for nurses remains slow and inconsistent, with only around 8% of newly qualified nurses progressing to band 6 within two years of qualification¹ compared with 84% of midwives who automatically progress after a year of preceptorship.

The cost-of-living crisis in the UK continues to compound the impact of cumulative pay losses for nursing staff. Energy bills are set to reach a 4-year high in October^{lxxiv} and if the Strait remains closed, the Bank of England and independent forecasts expect inflation to rise closer to 4% around the end of the year, remaining high in 2027 partially due to extreme weather conditions.^{lxxv}

This follows the peak in the cost of living in 2022 which still affects nurses living costs. Though there has been some softening in the labour market, the economy has so proved more resilient than first predicted when the Strait of Hormuz closed in March, still posting quarterly growth figures above the G7 average. This may mean that a rise in input costs may not translate to as big as related increase in consumer prices outside of transport, but it is inevitable that inflation will rise based upon the energy price cap and food production worldwide has been affected by several factors.

In February this year, the Pay Review Body reported in line with the pay award for 2026-27. For the first time in six years, this was delivered prior to the start of the relevant financial year. The PRB concluded, given the balance of evidence on affordability, delivery and workforce retention and recruitment that a higher pay award was more beneficial than a lower award.

In their view, a lower award would risk further damaging industrial relations, which would impact delivery. *‘In the case of industrial action, they (low pay awards) can also worsen the local and national NHS/HSC financial position, offsetting the immediate budgetary benefits lower awards.’* The pay uplift, as the RCN have previously pointed out, is considered by the PRB to be non-inflationary.

The government’s remit letter for 2027-28^{lxxvi} gave the PRB a mandate to include pay uplifts for both 2027-28 and 2028-29. Though that may make financial planning by government, providers and ICBs easier, it comes at a time of great uncertainty economically. The Government use a price deflator method to assess the cost of delivering government services, rather than Consumer or Retail price inflation. It therefore is a critical factor in assessing the supposed affordability of pay awards in the public sector.

The most recent GDP deflator estimates (June 2026)^{lxxvii} assume a rise in the price of delivering government services of around 3.5%, before dropping to around 2% in 2026-27. Given the developing rise in fuel, gas, commodity and as a result of climate related disruption in the UK and global agricultural sector, food prices, this cannot be deemed a likely scenario, implying higher costs for the NHS. The pay envelope as envisioned in the Spending Review put annual growth in NHS resource (non-capital) spending for phase 2 of the spending period (2025-2029) at 2.8%, 3% in England.

Both the SR and GDP deflator figures imply that costs now would need to be constrained at the end of the parliamentary period in order to meet the SR commitments. This would be a mistake, undercutting any intentions to support the existing healthcare workforce and delivery on the government’s agenda, as suggested by the Pay Review Body.

The forthcoming NHS pay award and discussions around reform of Agenda for Change therefore represent a significant opportunity. Investing in nursing pay is not only the right thing to do for a workforce that has experienced years of real-terms erosion. It is also a practical intervention to improve retention, reduce vacancies and strengthen productivity across the health service.

The commitment to the restructuring of Agenda for Change is incredibly important to progress, working with our trade union partners to ensure the best outcomes for nurses and other staff in terms of pay and conditions.

The commitment from the previous Health Secretary to initiate the process for job evaluation, recognising the contribution of nurses aligns with Band 6 remuneration and responsibility represented a step in the right direction. We believe that our nurses deserve automatic progression to Band 6, in line with their midwifery and paramedic colleagues.

Independent sector nursing pay

Appropriate pay and recognition must also extend to nursing staff beyond those on Agenda for Change pay terms. There are 16,705 FTE nurses working in general practice as of April 2026.^{lxxviii} General practice nurses (GPNs) do not receive the same pay, and terms and conditions as staff directly employed by the NHS, such as nursing staff working in acute care. According to a recent GPN pay survey by Nursing in Practice, more than a third (34%) of nurses working in general practice have not received a pay rise for 2025/26. Some 61% reported they had been awarded a pay rise for 2025/26 GPNs on average, receive £35,884^{lxxix} in annual pay, but those working at a band 6 level receive £36,443, more than £3000 less than a Band 6 nurse would receive in their first year on Agenda for Change.^{lxxx}

We strongly support the efforts by the government to not only secure a long-term Fair Pay Agreement in Adult Social Care. The recently stated ambition to build on this, bringing standards for pay, benefits and skills in line with Agenda for Change is the natural next step. However, in order for that to be equitable, the commitment must include parity for nursing staff working in other settings not currently on those terms and conditions.

Costs of accessing work

There are daily costs of working in the NHS which present barriers to accessing work for nursing staff. Car parking charges for staff working in hospitals as well as in the community can contribute significantly to the existing costs of living, and serves as a very clear indicator of how little healthcare staff are valued and enabled. Nurses outside of major cities are in particular more likely to drive. In the context of the cost-of-living crisis, aside from improved public transport, one of the most direct solutions to bringing down transport costs would be to provide free car parking.

Employers should ensure that all nursing staff can travel to work safely without financial detriment. We urge Government to ensure free car parking where available to NHS staff in England, alongside provision of funding for employers to expand sustainable and safe travel and parking options for staff as appropriate across the UK.

Mental health support

Nursing staff also need further support at work with their mental health. The rise in racism and wider evidence of poor treatment of staff^{lxxxi} demonstrates how the working environment has changed. Service pressures since the pandemic may have contributed, however the rates in staff turnover and sickness tell a story of a workforce facing burnout. Yet funding for staff support is unevenly distributed, wellbeing hubs for instance being cut almost entirely.

Though similar services are provided by trusts currently, before 2023 there was ringfenced funding for wellbeing hubs of £38.5m. Removal of government support, ICBs had to either identify short term funding solutions or close them.^{lxxxii}

This is despite the evidence that the return on investment for mental health support in health settings is between £4 and £5 for every £1 spent, following from the improvement in staff motivation, attendance and overall health.^{lxxxiii}

A fair deal for international nursing staff

It is essential that policies ensure the UK is attractive to international nursing staff, and do not unfairly penalise them for coming to work in UK health or social care.

In particular, the removal of eligibility for public services through the proposed application of a no resource to public funds condition to individuals with ILR status risks pushing nursing staff –and their dependents –into poverty and social exclusion. This is counter to the government's efforts to reduce child poverty and promote social integration among communities. Denying access to these public services when nursing staff are paying into a system after obtaining ILR is unjust and harmful.

Modelling from the OBR^{lxxxiv} has suggested that lower levels of migration equate to lower real GDP and lower real GDP per person, especially if a high participation rate is considered. As nurses who qualify for ILR include a substantial number who gained employment through work visas they can be assumed to have a very high level of labour market participation.

The RCN very much welcomed the exemption to the Immigration Health Surcharge for those entering the UK on a health and care visa, which was introduced during the COVID-19 pandemic. We hope to see this confirmed as a permanent measure given the vital role internationally recruited staff make to the NHS and social care systems in the UK.

Nursing leadership

Nursing staff work across hospitals, community services, primary care, mental health, public health and social care. Yet nursing leadership roles are increasingly vulnerable as the system responds to structural change, with ICB chief nursing roles under threat. The RCN is concerned that the erosion of nursing leadership is weakening the nursing voice at precisely the moment the government is seeking to transform services.

This matters because successful service redesign and improving performance depends on understanding how care is delivered in practice. Nurses are often responsible for coordinating care across organisational boundaries, identifying barriers to patient flow, supporting discharge, preventing hospital admission and leading the delivery of care in the community.

Embedding and protecting nursing leadership throughout health and care reform will be critical to delivering the government's ambitions for modernisation,

productivity and improved population health. Nursing leadership roles must be protected and supported at all levels.

Nursing is a distinct, safety-critical profession and the title ‘nurse’ should be legally protected. Patients should know who is treating them and have the confidence that when they are receiving care from a nurse, they are being treated by a regulated professional with the knowledge, professionalism and clinical expertise required to deliver safe and effective care.

Global nursing workforce

The WHO estimates that an additional 5.8 million nurses are needed to meet global demand.^{lxxxv} Official Development Assistance (ODA) is a critical lever for addressing the global health workforce crisis and other global health challenges. The UN recommends that all high-income countries spend at least 0.7% of their Gross National Income (GNI) on ODA. The UK previously met this target but in 2020, citing the impact of the COVID-19 pandemic, the government announced a ‘temporary’ reduction in ODA from 0.7% to 0.5% of GNI.

RCN research has shown that ODA to fund bilateral projects aimed at growing the health workforce in the most vulnerable countries fell by 83% between 2020 and 2023.^{lxxxvi} In 2024, the UK’s total ODA spend fell by £1.3 billion compared with the previous year. Cumulatively, the decision to reduce the in the ODA target from 0.7% to 0.5% of GNI has resulted in funding shortfall of £18.1 billion between 2021 to 2024. These cuts have consequently led to a cumulative loss to the health sector of nearly £1.8 billion.

The government previously announced that the ODA to GNI target ratio would fall further from 0.5% to 0.3% by 2027 to fund increases in defence spending. Estimates suggest that this will equate to a reduction in development financing of around £6 billion a year compared to the 0.5% target.^{lxxxvii} The government’s own impact assessment published in July warned that “reductions to health spending risk an increase in disease burden and ultimately in deaths, impacting in particular those living in poverty, women, children and people with disabilities”.^{lxxxviii}

The UK cannot continue to turn its back on the health needs of low-and middle-income countries and shrug its responsibilities to help address the global health workforce crisis. To meaningfully address critical challenges in global health, including the global health workforce crisis, the UK Government must reinstate the 0.7% of GNI spending target for ODA. Targeted funding must be made available to sponsor nurse education, recruitment and retention, especially in fragile, conflict-affected countries. By increasing the ODA contribution to expanding the global nursing workforce stock, the UK government can support sustainable health system strengthening in low-and middle-income countries and progress towards global health goals.

There is also a need for improved reporting of data on UK ODA spending. Within the OECD's Creditor Reporting System (CRS), there is currently no specific purpose code to accurately track investment in educating nursing personnel, though there is a specific code for medical education/training (CRS code 12181). The RCN recommends that member states work with the OECD to develop a nursing education code to improve workforce data collection and planning internationally.

2026 RCN Budget Submission

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