

**Royal College of Nursing**  
**Budget submission to HM Treasury**  
**February 2020**

**Introduction**

With a membership of around 435,000 registered nurses, midwives, health visitors, nursing students, nursing support workers and nurse cadets, we are the Royal College of Nursing (RCN) - the voice of nursing across the UK and the largest professional union of nursing staff in the world. Everywhere there are people, there are nursing staff. We work in public services across the NHS, social care, public health and also in the independent sector. We promote patient and nursing interests on a wide range of issues by working closely with the UK Government, devolved governments across the UK and other national, European and international political institutions, trade unions, professional bodies and voluntary organisations.

As the largest part of the health and care workforce, our contribution to health and life outcomes in the UK is unique. We are advocates at work and within our communities, exercising our professional judgment in ways that support us to meet the needs of our patients, deliver health and care services and seek to sustainably address the wider socio-economic determinants of health. We are fundamentally committed to equality, diversity and inclusion. Our voices are crucial to health and care policy and its implementation in all four countries in the UK. We have a clear view of our aspirations for the new UK Government, at a time of unprecedented uncertainty and inequality - health and more broadly - across society.

The context in which this Budget will be delivered underpins an important point to our submission. Across the UK and particularly in England, there is a nursing workforce shortage, the impact of which is felt by nursing staff on their ability to provide safe and effective care for their patients - and also on the experiences and outcomes of people using health and care services.

**Our asks include, but are not limited to:**

For the United Kingdom:

- Exemption of all nursing staff from the Immigration Health Surcharge.
- Sufficient funding made available for an above inflation pay rise in 2021/22 for all staff providing publicly funded health and care services in the UK, and that this must include those staff working in social enterprises, outsourced services, wholly owned subsidiaries, joint ventures, and private contractors. Many of these staff have transferred onto Agenda for Change (AfC) terms and conditions; have their pay index linked to the AfC contract or need to be competitive with NHS pay rates.
- Alongside the long term funding settlement for the NHS, long term funding settlements should be established for public health and social care across the United Kingdom, based on population needs and with the workforce elements fully costed and funded.
- It is particularly important that our nursing community is supported to achieve adequate standards of living, including safe and adequate housing, provision of food and water, smart and equitable public transport systems and adequate support to safely and

reasonably reach places of employment. It is especially important that this is understood - and that our community is practically supported to achieve this - within the context of the existing lost value of nursing pay, and the need for a return to above-inflation pay rises.

- For our international workforce coming in to work alongside us in our health and care services, we also consider it particularly important that the UK Government explore long-term subsidized support to support our colleagues to achieve adequate standards of living - such as, but not limited to, access to safe and adequate housing.
- The proposed UK Shared Prosperity Fund must respect the devolution settlements and the role of the national governments as the developer and distributor of these funds in each country, to ensure effective policy and investment.

In England:

- A strategy for nursing workforce supply and planning which accounts for all publicly funded health and care services, based on a robust assessment of population needs, and makes use of all levers, including law and funding mechanisms, that are available to Government to ensure the provision of staff for safe and effective care
- Introduce a system of full tuition fee support (such as grants or loan forgiveness) and ensure that living grants are responsive to actual nursing student need for both undergraduate and postgraduate pre-registration students
- Continuing Professional Development (CPD) funding as part of national strategy which provides clarity on what Government and what employer responsibilities are, along with transparency in funding decisions, and also covers the inclusion of all NHS funded nursing staff in the CPD offer (e.g. those working in NHS and Local Authority funded but not NHS delivered services)
- The introduction of a Chief Nursing Officer role in Government to support development of public policy, focused on health and specifically including national workforce supply and planning strategies across sectors and settings
- A clear legal framework codifying in law the specific and clear accountabilities, roles and responsibilities for workforce supply and planning, for Government and across the health and care system at all levels
- A legal framework for the protection and support of frontline nursing staff when they exercise their professional judgement by registering concerns about patient safety and conditions for providing care, when they are working within systems affected by systemic factors which we have no control over (e.g. insufficient workforce to ensure staffing for safe and effective care)

## **Exempting nursing staff from the Immigration Health Surcharge (IHS)**

We call for an immigration system which is fair and transparent, and does not undermine the UK's commitment to recruit our international health and care colleagues in an ethical and transparent manner. Whilst the priority should be for Governments across the UK to ensure that appropriate numbers of nursing staff are generated domestically, international recruitment is the most efficient way of addressing gaps in the workforce in the immediate term while every effort is made to help us achieve sufficient growth in our domestic workforce.

When considering the international recruitment market, barriers for overseas nursing staff looking to work in the UK should be identified and resolved. One existing barrier is the IHS. The IHS was introduced in April 2015, and currently stands at £400 per annum for each individual from a non-EU country, plus £400 for each family member. The Conservative Party pledged in a press release issued on 17th November 2019 to increase the charge to £625 if elected, and for the first time to extend it to employees from the EU, without clear publicly available evidence and rationale.

Plans were also announced to spread the cost of IHS to individuals, over several months, from their pay packets. We explored rough considerations as to how long nurses on a range of different salaries might have to work until they reach the point in the year at which they would start being able to draw on their salary if the charge were paid upfront. For example, if the IHS charge is increased to £625 per employee and dependant, our estimates suggest that a nurse with two children from a non-EU country starting at a 'Band 5' post would have to work until the 4th of February, or 183 hours, before they saw any benefit from their salary.

This charge is unfair, and specifically, nursing staff should be excluded. It is an additional burden, unethical and unjust, given that these individuals are also already contributing to our health and care system but are charged to use it, as well as paying relevant taxes and national insurance. Additionally, this may dissuade nursing staff from choosing to come to the UK and work, despite the fact that there are huge shortages in the nursing workforce.

## **Sufficient funding for pay and good working conditions**

In 2018 the NHS Staff Council reached agreement on reform of the NHS terms and conditions of service in England, Wales and Scotland. These agreements resulted in three-year deals to reform the pay structure spanning 1 April 2018 until 31 March 2021. While the agreements do not make up for lost earnings over the period of pay restraint since 2010, they secured important structural reforms to the AfC framework as well as higher salaries for new starters to the NHS.

In Northern Ireland, a similar deal was not implemented in 2018. Moreover, due to decisions not to make the same pay awards as the rest of the UK prior to 2018, this meant that pay levels for staff in Northern Ireland had fallen significantly behind those for their NHS counterparts in Scotland, Wales and England. Following industrial action by us and other unions, a pay agreement is currently out for consultation which will bring pay rates up to the same level as those in England.

We urge the UK Government to work with the Northern Ireland Executive in order to ensure that all of the health-related commitments set out in the *New Decade, New Approach* framework

agreement are appropriately and sustainably funded. These commitments relate to pay parity for nurses and other health staff, measures to support safe nurse staffing, action on waiting times, hospital reconfiguration, and health and social care transformation.

Prior to these pay agreements, NHS nursing staff had suffered a cumulative, real terms drop in pay of around 14% since 2010; the pay uplifts awarded to staff therefore represented a significant step in the right direction. We are looking ahead to the end of the agreements and the need to continue the process of restoring lost value. This means ensuring both meaningful pay rises, and that jobs are properly evaluated and nursing staff are employed on bands that fully reflect their levels of responsibility, activity, skills and autonomy.

Pay rises should not be conditional or linked to any further changes to terms and conditions, such as annual leave or sick leave entitlements, unsocial hours payments or pensions contributions. With significant and rising vacancy levels across health and social care, such changes to terms and conditions would risk recruitment and retention even further and must be avoided. It is important that planning commences for 2021/22 and there is a return to above-inflation pay rises in order to address the following challenges:

- High and increasing vacancy levels being covered by bank and agency working, and staff working beyond their contracted hours. Our Employment Survey<sup>1</sup> shows that over three-quarters (79%) of nursing staff are working excess hours at least once a week and well over half (57%) state that these hours are usually unpaid. 66% say they are under too much pressure and 67% are too busy to provide the level of care they would like. A high proportion of nursing staff (65%) are dissatisfied with their pay.

These findings indicate that workforce morale and motivation are being severely tested and this in turn presents acute challenges to both recruitment and retention in service.

The equality and fairness of pay levels, employment terms and conditions will have an impact on the ability to deliver the Long Term Plan integration agenda and develop Multispecialty Community Providers, as significant differences in pay and working conditions exist across NHS partner organisations.

#### *NHS contracted community services*

40% of NHS community services are contracted to independent providers. This includes community nursing, sexual health services, walk-in or urgent care services. Most of the staff transferred to these employers on NHS AfC contracts, however only a minority of employers have been able to maintain NHS AfC pay rates and associated contractual terms with many staff suffering detriment to their pay, terms and conditions since their transfer.

Similarly local authority providers and commissioners of public health, such as health visiting and school nursing services have not been able to match NHS pay uplifts, leaving some services having to make decisions to cut professional leadership and development programmes to cover costs.

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<sup>1</sup> Royal College of Nursing. (2019). Employment Survey 2019. Available at: [www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2019/november/007-927.pdf?la=en](http://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2019/november/007-927.pdf?la=en)

Funding must be supplied to make up the difference in the losses suffered by these staff and ensure this year's settlement provides sufficient funding for staff to achieve the same NHS AfC pay levels and provide for the same AfC contractual terms as their colleagues employed by the NHS and whom they work beside every day.

### *General Practice Nurses*

General Practice Nurses (GPNs) are employed by independent contractors providing NHS services. However, their pay does not always reflect NHS AfC rates and most are employed on minimum statutory employment terms and conditions. We call on the Government to provide a settlement to include sufficient funding to GP contractors to award practice staff equivalents to NHS AfC pay and provide for the same AfC contractual terms.

### *Social Care*

Nearly 900,00 nursing staff working in residential and domiciliary care are employed by independent providers but provide some 60% of publicly funded care. Yet, most of these staff earn a few pence above the national living wage and a long way below their NHS colleagues, with annual pay uplifts that have fallen far short of inflation. The current Continuing Health Care (CHC) tariff of £165/week<sup>2</sup> is insufficient to provide staffing levels for safe and effective care, or provide for comparable pay and employment terms that reflects equivalence with nursing knowledge, skills and expertise in this sector.

A recent survey of 2,200 RCN members working for two social care providers found:

- 82% have considered leaving their jobs as they don't feel they are being paid appropriately and experience stress over unsafe staffing levels.
- 70% work at least an extra 12 hours a week to make ends meet and maintain nurse cover for the care home.<sup>3</sup>

The CHC tariff and Local Authority funding must be increased to reflect the true cost of nursing care and be sufficient to pay nurses and care assistants' wages and employment terms equivalent to their NHS colleagues.

These findings indicate that workforce morale and motivation are being severely tested and this in turn presents acute challenges to both recruitment and retention across health and care services.

Sufficient funding must be made available for an above inflation pay rise in 2021/22 for all NHS staff in the UK, and this must include those staff working in social enterprises, outsourced services, wholly owned subsidiaries, joint ventures, and private contractors. Many of these staff have transferred onto AfC terms and conditions, have their pay index linked to the AfC contract or need to be competitive with NHS pay rates.

## **Funding for health and care systems across the UK**

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<sup>2</sup> Department of Health and Social Care. (2019). NHS-funded nursing care rate announced for 2019 to 2020. Available at: <https://www.gov.uk/government/news/nhs-funded-nursing-care-rate-announced-for-2019-to-2020>

<sup>3</sup> Jacobs,C. (2019). 'Internal survey of 2,200 RCN members working in social care'. Royal College of Nursing

We are a UK organisation and work in a devolved context. We know that governments across the UK rely on funding from the UK Government. Sustained and sustainable investment is needed to improve lives, maintain and grow a skilled workforce and shape services to meet the needs of our population. The arrangements for funding settlements for Northern Ireland, Scotland and Wales are complex but investment in health and care services across the UK must rise in line with growing population need. In addition, greater transparency from the UK Government over methods for establishing funding for devolved administrations, and for allocations to accurately reflect and speak to the level of investment required to deliver quality implementation of effective policy and funding in each country is needed.

Following the UK's withdrawal from the EU, the loss of EU funding needs to be fully replaced by the UK Government so that the social infrastructure allowing people to access public services and underpinning health and wellbeing is not irrevocably damaged. Health, social care and public health are devolved matters in Wales, Scotland and Northern Ireland. The proposed UK Shared Prosperity Fund must respect the devolution settlement and the role of the national governments as the developer and distributor of these funds in each country, to ensure effective policy and investment.

### **Workforce strategies in the UK**

The World Bank<sup>4</sup> has stated that delivering care which is not of sufficient quality contributes to unmet health needs and may increase the likelihood of mortality and risk arising from poor health. It identifies that a lack of investment in health and care, including in the health and care workforce, 'exerts a substantial economic impact' both in terms of correcting preventable complications of care and patient harm, which it estimates accounts for 15% of hospital expenditure in high-income countries<sup>5</sup>, and lost productivity.

National workforce strategies must incorporate these factors in determining the value on return of investment. Inadequate investment in the workforce to meet the needs of the population directly impacts upon patient care, and upon population outcomes. Failure to invest is a false economy.

All decisions regarding staffing for safe and effective care, from national bodies through to local organisations, should be based on assessment of patient and population need, an up to date evidence base, workforce planning tools and the professional judgement of senior nurses. Health and care services should be promoted as a safety critical industry, and the adequate provision of staffing recognised as a critical requirement for the delivery of safe and effective models of care.

### **England - nursing workforce supply and planning**

This Government has made a clear and ambitious commitment to achieving growth of 50,000 more nurses. It is our belief that anything and everything must be done to achieve this growth -

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<sup>4</sup> The World Bank, the World Health Organisation and the OECD. (2019). Delivering quality health services: a global imperative for universal health coverage, p. 17. Available at: <http://documents.worldbank.org/curated/en/482771530290792652/pdf/127816-REVISED-quality-joint-publicationJuly2018-Complete-vignettes-ebook-L.pdf>

<sup>5</sup> The World Bank, the World Health Organisation and the OECD. (2019). Delivering quality health services: a global imperative for universal health coverage, p. 17. Available at: <http://documents.worldbank.org/curated/en/482771530290792652/pdf/127816-REVISED-quality-joint-publicationJuly2018-Complete-vignettes-ebook-L.pdf>

in terms of harnessing all possible levers for change across Government and sectors. This includes funding, law and implementation, guidance, standards and all measures which credibly address nursing workforce demand, supply, recruitment, retention and remuneration within the context of population need.

In order for it to be possible for Government to be equipped to achieve this aim, as well as to ensure sustainable resolution of demand, supply, recruitment and retention of the future nursing workforce that is needed to meet population needs, substantive measures must be committed to and progressed. This includes a range of end to end levers and investments, as there is no one intervention, in law, policy, funding or implementation, which can achieve sustainable workforce supply and planning. Development and administration of these measures will have long term resource implications, which should be understood and planned for at the outset if we are to achieve patient safety, as well as improvements in access, experience and outcomes.

In England, across the health and care system, and at various levels, there is currently a lack of clarity on roles, responsibilities and accountabilities related to the workforce<sup>6</sup>. This has resulted in fragmented and incomplete approaches to workforce strategy and planning, and these elements are often missing from individual strategies produced within the health and care system on specific aspects. There is a clear need for legislation which explicitly addresses staffing for safe and effective care in England. The NHS Long Term Plan Bill is the ideal opportunity for the Government to fundamentally set out accountabilities, roles and responsibilities for workforce planning and supply in England. There is a need for planned, phased implementation, given the scale of the work needed.

Within a clear legal framework Government should be accountable, overall, for sufficient provision of workforce to safely and effectively deliver taxpayer-funded health and care services. Government must create and maintain a labour market from which to recruit, retain, support and pay professionals delivering care to people living in England. This will require additional investment. The safety of our patients depends on it, as does the health and productivity of the whole population. There should also be a clear legal framework for the protection of health and care professionals, including nursing staff, when exercising their professional judgement to register concerns about safety and conditions for patient care during their working time.

Until recently, successive Governments, in part, managed short term domestic supply by taking from areas with greater supply and disproportionately relied on overseas recruitment. There is vastly insufficient domestic short term supply available, and this approach can no longer be relied upon to meet population needs in the long term.

A key driver for supply previously was that pre-registration education for professions was state funded from a fixed budget, and resource shifted between under-supply and over-supply areas. The current rates of applications and acceptances demonstrate that the healthcare higher education funding reforms of 2016 have not generated a sufficient rise in the number of nursing students, which was the stated aim of that change.

A new nursing workforce planning model should establish a baseline growth model for supply numbers entering the workforce each year, based on a set, constant percentage of the workforce. This should be calculated on predicted demand, including the number of people leaving the profession. The baseline growth calculation should be based on trend for joiners and

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<sup>6</sup> Royal College of Nursing. (2019). *Standing up for patient and public safety*. Available at: <https://www.rcn.org.uk/professional-development/publications/007-743>

leavers for the whole health and care nursing workforce in England, not only based on the establishment and vacancy rate for NHS provider trusts.

Crucially, it must be understood and taken into account that domestic nursing supply for all health and care sectors and settings comes from one pipeline. Any strategy for growing the workforce must consider the potential for a newly qualified nurse to enter not only the NHS, but also social care, public health, independent sector or any service where there is nursing care.

The tendency for workforce strategies to focus on NHS requirements, rather than the full requirements of the complex health and care system, is one of many reasons to introduce a Chief Nursing Officer role specifically within Government. We call for this role to be created and resourced adequately to support cross government workforce strategies, now and in the future. This role would also be best placed to support national workforce planning, making use of the current evidence base, professional judgement and credible tools and guidance to understand the size and shape of the workforce needed to deliver the health and care services designed to meet the needs of the population.

Government has a range of mechanisms available for administering investment to aim for sufficient supply, and to support retention, for publicly funded services, including via NHS and local authority commissioning routes. A costed strategy is required to create the best conditions for attempting to generate over supply, using all available levers for supply, recruitment, retention and remuneration. Use of levers for change such as funding, law and targets should continuously and repeatedly reviewed and considered in relation to meeting the needs of the population.

There are a number of aspects of growing the domestic nursing workforce which are not optional. The focus must, in the first instance, be to substantially increase overall supply, with an additional added focus on also addressing specific clinical shortage areas or geographies on top of increase in overall supply. Otherwise, there will continue to be shifting of a finite pool of staff from one crisis area to another, as well as placing newly qualified staff within extremely pressured service areas, compromising retention.

Creating new university nursing graduates is the fastest and most cost effective way to increase the size of the workforce at the necessary scale and pace. Currently, the numbers coming through this route are insufficient. We acknowledge the funding commitment made for universal grants to support living costs from the Government in December 2019. However, the scale and pace of growth required to address the workforce shortage means that there is a need for a fuller package of interventions.

It is essential that no one who wants to study nursing faces any financial barriers to study. There are two key aspects to funding for nursing students to address within the Budget:

- Funding for nursing students should include full tuition fee relief for all undergraduate and postgraduate pre-registration nursing students, regardless of commencement date or field of study.
- Maintenance grants should reflect actual student living costs. While a regular undergraduate degree takes 3,600 hours over the three years, to become a registered nurse it takes at least 4,600 hours, with half of that time in the classroom and half on clinical placements. This severely limits their ability to take on part time work. Clinical placements can also be in a range of locations, and students are required to cover travel costs upfront.

We commissioned London Economics to model two potential student funding options to demonstrate illustrative costs and benefits to HMT of providing these two elements of financial support. These models were created before the recent universal grants announcement. However, their illustrative use for HMT and the deficit remains. We outline these models and their costs in benefits in greater detail below.

We believe it is appropriate that alongside the introduction of loan forgiveness or tuition grants, that debt relief for education is also provided for all pre-registration nursing students - undergraduate and postgraduate - entering higher education through the student loan system following the reforms.

### ***Option 1: Moving to means-tested maintenance grants plus non-means-tested tuition fee grants***

Under this option, students receive upfront funding for tuition fees as a grant and all students receive a means-tested maintenance grant of the same value they would currently receive under the loan model. This could be up to £20,252 for each student per year, depending on where the individual lives in England and whether they live at home.

#### *Benefits*

Option 1 has been estimated to *conservatively* result in an additional:

- **8.5%** increase in the number of new graduates per cohort (**1,080** for this cohort size of 16,020; of which
- **850** qualified nurses entering the NHS post-graduation
- This would mean an additional **4,790** NHS 'nursing years' in the decade post-graduation. This would be part of a total of **61,020 total years** of NHS service per cohort.

All of this brings a net extra benefit to the exchequer of **£132 million (out of a total benefit of £1,677m)**, achieved through a reduced reliance on bank and agency staff in publicly funded services.

#### *Deficit impact*

The total impact on the deficit during the period of study, would be £743m, or a net £310m extra over the current student funding model. This is approximately £100-110 million per year during the period of study. However, a year ago, before Office of National Statistics (ONS) changes, this figure would have been approx. £250m-£280m per year during the period of study. Therefore the impact on the deficit has reduced substantially (by approx. £140-£170m) per year compared to when we first presented these models.

#### *Cost to the Exchequer*

The total cost to the Exchequer over the lifetime of the cohort is £700m, or an additional £403 million per cohort over the current funding model.

## ***Option 2 - Moving to non-means-tested maintenance grants, plus forgivable non-means-tested tuition fee loans – written off in instalments at 3, 7 and 10 years post-graduation***

Under this option students would get a non-means tested £10,000 maintenance grant to go towards their living costs each year. Nursing students would also be able take a tuition fee loan, however, on graduation and entering the nursing register, the Government would guarantee a job in publicly funded health and care services, for at least 10 years, alongside an agreement to pay off portions of the student debt at different points during this time.

The structure of the outstanding debt paid down by the Government would consist of a 30% write off after three years, 70% write off after seven years and the rest paid off at 10 years. This incentivises graduate nurses to stay working in publicly funded services, and would support students to complete their degree through to graduation.

### ***Benefits***

Option 2 has been estimated to *conservatively* result in an additional:

- **6.3% increase in the number of new graduates per cohort (830 graduates for this cohort size of 16,020); of which**
- **650** qualified nurses enter the NHS post-graduation
- An additional **6,850** extra 'nursing years' in publicly funded services in the decade post-graduation. This would be part of a total of **63,080 total years** of NHS service per cohort.

This model brings a net extra benefit of **£172 million (out of a total benefit of £1,717m)**, achieved through a reduced reliance on bank and agency staff in publicly funded services.

### ***Deficit impact***

The total impact on the deficit during the period of study, would be £678m, or a net £245m extra over the current student funding model. This is approximately £70-90 million per year during the period of study. However, a year ago, before ONS changes, this figure would have been approx. £150m-175m per year during the period of study. Therefore, the impact on the deficit has reduced substantially (by approx. £80-85m) per year compared to when we first presented these models.

### ***Cost to the Exchequer***

The total cost to the Exchequer over the lifetime of the cohort is £595m, or an additional £298m million per cohort over the current funding model.

### ***End to End investment***

Student funding is one piece of a larger package of 'end to end' investment. Investment in increasing nursing supply through university must be thought of as a strategic approach and not the result of a one off funding announcement. This stretches from ensuring there are no barriers for any demographic groups to choose a nursing degree, supporting them financially while they do so and enabling universities to offer as many student spaces as needed through funded

planning for higher education institutes (HEIs) and for the supply of clinical placements in health and care services.

Continual professional development (CPD) is essential to this package to make sure that a nurse's education doesn't stop at graduation and that newly graduated nurses feel valued - the existing CPD offer made in 2019 must be extended to nurses working in NHS funded but non-NHS provided services.

There is also a requirement for a fit for purpose, long term, national recruitment campaign designed to appeal to a wide a range of people as possible.

Note: We are ready to provide further evidence and contributions which inform our submission, and are happy to engage directly with HM Treasury to further share the evidence, knowledge and expertise reflected here in our overall positioning. We would value the opportunity to progress dialogue on the enclosed so that HM Treasury and staff have what is needed to address the needs of nursing, and the wider communities that we serve in our population within the UK.

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