Royal College of Nursing

The Economic Case for Investing in Nursing: the RCN's proposals ahead of the 2026 budget

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1. Key messages

- For the government to fulfil its stated aims on economic growth, improving and investing in the NHS must be prioritised. The nursing profession needs to be at the forefront of these investment decisions, and in particular, registered nurses need to be recognised as autonomous health care professionals in high pressure environments, paid accordingly at a band 6 level after a period of preceptorship.
- We recognise that, given the current financial challenges, affordability is a consideration for nursing pay and conditions, but to date has been done in a way which is both limited and risks exacerbating inequalities. It should not be overlooked that 81% of any additional pay for nurses is expected to be returned to the exchequer in additional tax revenue. Similarly to date, limited affordability arguments have counted against nursing given the size of the workforce which has hindered progress in reducing gender and ethnicity pay gaps.
- All nursing staff pay needs to be timely, above inflation and in line with the Retail Price Index (RPI). Nursing staff in general practice need to have their pay ringfenced to ensure earning parity across the profession. Nurses make up the largest group of NHS staff and efforts to improve pay for them will progress action on gender and ethnicity pay gaps.
- To support the ambitions of the *Ten Year Health Plan* the nursing supply pipeline and early career attrition must be addressed within the forthcoming *Ten Year Workforce Plan*. This should include building the government's graduate guarantee into workforce planning and alleviating the burden of graduate debt. These principles must be extended to our internationally educated nursing staff too, ensuring the pay structure reflects their needs.
- In addition, to support the implementation of the *Ten Year Health Plan* the shift to community must be fully funded and include an expansion of community nursing roles. A shift from acute to community provision in England requires upfront investment to ensure transformation is successful. Improving digital infrastructure must be prioritised to underpin digital advancements; and the technological innovation must be implemented with the guidance only nursing staff can bring.

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- Internationally educated nursing staff make an invaluable contribution to the NHS and broader health and care system; and without a robust domestic pipeline the NHS continues to rely on international recruitment. However, the recent increase to the immigration salary threshold for health and care worker visas has effectively closed international recruitment of band 3 nursing roles. A shortfall of £63 per year in England (excluding London) and Northern Ireland means staff are unable to renew their visas. To protect the stability of the workforce internationally recruited nursing staff on Agenda for Change (AfC) band 3.1 should be paid at least an additional £63 per year to meet visa requirements and future pay awards should ensure that roles eligible for sponsorship are in line with visa requirements.
- Access to continuing professional development (CPD) as part of career development is also essential for both individual nursing staff and service provision. The forthcoming *Ten Year Workforce Plan* must be supported by sufficient funding for CPD based on projections of future service and population needs. CPD should be factored into paid hours for nursing staff with funds to cover the shifts of those training.
- 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 UK government announced that the Official Development Assistance (ODA) to Gross National Income (GNI) target ratio would fall further from 0.5% to 0.3% by 2027 to fund increases in defence spending. Cuts to ODA by the UK must be reversed and plans to reduce spending further must be abandoned to ensure the UK appropriately contributes to achieving United Nations' Sustainable Development Goals.

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2. Introduction

With a membership of over 560,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the United Kingdom. It is also 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. It 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 government's number one aim is improving economic growth, unlocking prosperity and sustainable public services. However, the UK is faced with tight labour market conditions and an ageing population, which will both increase pressure on the health service and the exchequer's financial position in the years ahead.

Today, inflation is higher than the Bank of England target (Bank of England, 2025a), short-term interest rates on government debt are high, growth is below target (Gov.uk, 2025f) and the labour market is tight, although demand for labour has somewhat slowed (House of Commons Library, 2025a). This presents a set of financial conditions for the government to operate in which are difficult.

The RCN welcomed the pledge to increase spending for the NHS in the June 2025 Spending Review and changes to the assessment of government debt to help drive capital investment in the health service, as laid out at last year's budget (Gov.uk, 2024a). However, in early July, the Office for Budget Responsibility released its annual risks report, citing increased concerns for the public finances over the long term (Office for Budget Responsibility, 2025b). This report highlighted the growing importance of health funding to the exchequer, projecting borrowing above 20% and debt above 270% of GDP by the mid-2070s. This is unsustainable, especially given the widening net dependency ratio as the UK's population ages (ONS, 2025d), a not untypical shift facing western economies.

It has never been more crucial for policy making and investment across government to be based on joined-up thinking, and a clear understanding of inter-dependencies and inter-departmental impact. This is central to the mission-based approach of government. Population health, and the role of public services in enabling optimal health outcomes, is pivotal to the wider goals of government, including economic growth, and ensuring children and young people thrive in education. The right investment now will release wide-ranging benefits.

There are clear opportunities for government to make more strategic investments for long-term gains. The government has stated an intention to modernise the NHS, with the recently published *Ten Year Health Plan* confirming intended shifts from acute to community provision, illness to prevention, and analogue to digital.

Nursing staff need to be central to those changes. They are unique in their role across public services and settings that interface with every population and geography. When the nursing workforce is enabled and supported, they support the economy in multiple ways, including driving productivity in the wider population. They are working, earning and contributing to the economy through their own consumption of goods and services. It is cheaper to invest in nursing now, while we modernise the NHS, than as an afterthought. Timely, inflation-proofed pay awards, reducing the burden of student loan repayments and a workforce understood and supported will drive recruitment and retention.

The government's recent *Ten Year Health Plan* criticised the previous NHS *Long Term Workforce Plan*'s ambitions for workforce growth, signalling that modelling numbers will not be the focus of the new workforce plan. A junior health minister said in September that the government's *Ten Year Workforce Plan* will focus on 'a philosophical intent of what roles we need' rather than 'prescriptive numbers' on staffing requirements (HSJ, 2025a). We are clear that any credible workforce plan must include workforce supply and retention modelling based on health care needs of the population, and that this is made available in sufficient detail for the RCN and partners to scrutinise accordingly.

The forthcoming *Ten Year Workforce Plan* will only be meaningful if it reflects all the requirements set out here and:

- is based on need rather than affordability and
- provides additional funding to public services proportionate to the real health care needs of the population.

The RCN will continue to iterate estimations of costs and benefits of policy interventions needed to address the requirements of the nursing workforce and ensure the government's aims are realistic and achievable.

3. Economic growth and productivity

Improving health and employment outcomes

The country is suffering from a stagnant economy and tight labour market. There are several ongoing public health crises, affecting employment access and retention for the population, and ever-present inequalities and heath inequity. This is set to deepen with an ageing population. Supporting nursing staff through improved pay, conditions and professional recognition leads to better population health and economic outcomes, in time, contributing to economic and labour market stability. A more efficient health service is one which reduces elective waiting lists and prevents more people from developing conditions which keep them from work. A healthier nation is one where barriers to work from ill-health are reduced, fewer school and workdays are missed, and money is better spent on prevention and diagnostics.

Office for Budget Responsibility analysis suggests, as part of its financial risk assessment, that a work-limiting health condition is by far the biggest barrier to workforce participation (Office for Budget Responsibility, 2024a). Post-pandemic long-term sickness has risen to record levels, reducing the size of the workforce and tax base while adding extra pressure to services. In many cases, people will also be supported by family members in the role of informal, unpaid carers who will in turn suffer an employment penalty (Joseph Rowntree Foundation, 2025).

The government have already made clear that NHS performance is an economic issue, rolling out health and growth accelerator programmes in the north-east of England and the Secretary of State explicitly placing the health service at the centre of the government's growth mission (Gov.UK, 2025g). For a government whose number one aim is economic growth, one of its top three priorities is tackling elective waiting lists. This includes a commitment to meet the constitutional standard that 92% of patients should wait no longer than 18 weeks for elective hospital treatment by March 2029. A recognition of the importance of NHS in this context.

Research published in October by the Office of National Statistics (ONS) and NHS England (NHSE, 2025d) has looked at how tackling waiting lists for elective treatment might have an economic impact (NHSE, 2025). Preliminary results concluded that reduced waiting lists could have a follow-on effect of adding an equivalent 63,000 to person-years of national employment and therefore a contribution of over £1bn to HMRC in the five years to 2030/31. £2.7bn would be added to the economy through increased work-hours pay over the period. However, this will not be achieved without putting nurses and their expertise at the centre of investment, reform and modernisation of the NHS.

Addressing these issues also requires better use of funds in public health provision, currently the domain of local authorities rather than NHS commissioning. Nursing is central to public health, including obesity prevention and management, smoking cessation and sexual health services. Investment in nursing-led public health interventions will unlock growth, productivity gains, employment and national renewal. However, over time, the widening dependency ratio between those contributing to the tax base through work and those who rely on public services will widen considerably.

Safe nurse staffing levels in health care services also lead to better health care outcomes, particularly in managing long-term conditions, including those which create barriers for employment.

Research from the University of Southampton (Griffiths P et al., 2025) has looked in detail at the relationship between nurse understaffing, patient outcomes and cost effectiveness, measured against the number of Quality Adjusted Life Years (QALYs[1]) (NICE, 2024). The National Institute of Health and Care Excellence (NICE) cost-effectiveness thresholds compare the cost of treatment against money spent per QALY. A range of £20-30,000 is considered to represent good value for money for the taxpayer. Providing a metric to assess quality of life, they are a useful proxy for assessing economic impact of certain health interventions.

Individuals with a higher number of QALYs are less likely to need high-cost care but instead play active roles in their communities. Any treatment which results in increased QALYs will inevitably create a positive economic output as well. Savings came from reduced staff sickness, reduced re-admissions and reduced length of stay.

Their cross-sectional study looked at staffing and other NHS data between April 2015 and March 2019 across 138 trusts, using annual full-time equivalent (FTE) data per trust across all NHS staff groups to assess understaffing against the long-term ward mean. The study found that low registered nurse staffing on shift was associated with increased risk of both readmission (and the increased chance of developing certain conditions, such as deep-vein thrombosis) and avoidable death. In terms of affordability, eliminating low staffing cost £2,778 to each QALY gained, far lower in terms of cost than the minimum cost effectiveness threshold set out by NICE.

Even when agency staff were included, assuming agency staff cost 50% more than the cost of substantive staff, reducing low staffing with agency staff cost £10,980 per QALY. Investing in permanent registered nurse roles and filling current workforce vacancies to ensure safer staffing levels would therefore represent an exceptional investment in terms of value for money.

[1] QALYs assess both length of life gained from treatment and the impact on quality of life.

Staffing levels for safe and effective care in the NHS and other public services must therefore be central to any long-term workforce planning. The false economy of determining nursing workforce according to what is considered affordable in narrow terms must come to an end. Resource must be determined by need. The risks of failure to invest for safety are well evidenced. Studies examining missed care, show that when registered nurse staffing levels are low, more care is missed. And crucially, **when more care is missed, a larger number of patients die** (even when adjusting for case mix). Each 10% increase in missed care is associated with a 16% increase in risk of death (Ball J et al., 2018). The most up-to-date research also demonstrates that the registered nurse cannot be substituted by less qualified staff, and that such an approach will cost more in longer lengths of stay than is saved in staffing costs (Needleman J, 2024).

New evidence from NHSE in October 2025 indicates that the incurred cost of delayed discharges amounts to around £200m every month (HSJ, 2025b). Based on NHSE costings of £562 per day, 13,032 patients fit to leave hospital in September were awaiting discharge. Delays were caused by a range of factors including 'interface processes' where onward care was yet to be agreed, awaiting decisions on discharge or out of hospital capacity 'either in social care services, rehabilitation facilities, care or nursing homes'. All of which are directly related to staffing levels.

Evidence from a wide range of sources suggest that investing in the health care workforce can be linked to higher growth and economic stimulus (Tony Blair Institute, 2025). Recent modelling from the Tony Blair Institute indicates that preventative intervention in a number of health issues could lead to a 0.74% increase in GDP over a five-year horizon, or nearly £20bn per year (Yakusheva O et al., 2014). The work of health economist Dr Olga Yakusheva has suggested that specifically investing in nursing skills has a measurable effect on health outcomes, including length of stay in acute settings. This, alongside other studies have put forward the idea that nursing is in fact a value-added profession, and that investment in it can drive economic benefits.

As this evidence suggests, nurses, ubiquitous in care are perhaps the primary cost-effective method of investing in improved health care outcomes. Despite this, the number of nurses per doctor in hospital has fallen from 4.3 in the year 2000 to 2.8 in 2024, meaning that growth in this nursing workforce has increased over the long term at a slower rate than other staff groups (Nuffield Trust, 2025b). Compared to other countries, the hospital services in the UK are staffed by a significantly lower proportion of nurses. While international comparisons need to be treated with a degree of caution, it is notable that while 27% of hospital staff in the UK are professional nurses and midwives, the corresponding proportion in Germany (37%) and Ireland (38%) is around 10 percentage points higher (OECD, 2023).

Working conditions across public services are creating barriers to work for the nursing workforce itself, by creating intolerable, avoidable pressures and contributing to stress-related sickness absence, and attrition. In 2024, according to NHS staff survey data 45.5% of registered nurses and

Percentage of nurses and midwives working in hospitals

midwives felt unwell as a result of work-related stress in the past 12 months, compared to 41.6% of all staff (NHS England, 2024b). A nurse or midwife who missed three days of work for mental health reasons was 27% more likely to leave three months later than a peer with no absences (IFS, 2022). We have published very compelling testimony from nursing staff about the horrors of being forced to care for patients in unsafe and undignified non-clinical spaces, without access to equipment, beds or privacy (RCN, 2025c).

Ultimately, only investment to equip health and care services with the numbers and skill mix needed to meet the health care needs of the population will alleviate these pressures (see Section 4). While we maintain that the nursing profession is an inherently productive one, we also share government's ambition on improving productivity and efficiency across the NHS. We are discussing how we can support this shared ambition in more detail with the Department of Health and Social Care (DHSC) and the Chief Nursing Officer, particularly how we can work with the employers with the highest levels of nurse sickness absence.

Reducing these levels brings a multitude of professional, personal and patient advantages but also financial efficiencies with the immediate future and current Spending Review period. However, we do believe improving nursing career progression could also assist in reducing sickness absence levels. A consolidated period of practice at the beginning of a nurse's career and direct run-through to band 6 following this 'preceptorship' would reduce the likelihood of fitness to practice referrals and with appropriate support and guidance, reduce burnout that impacts turnover.

There are also smaller aspects of working life that 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 health care staff are valued and enabled. In the context of the cost-of-living crisis, **parking fees paid by hospital staff increased eight-fold from £5.6million in 2021/22 to £46.7million in 2022/23**, after the reintroduction of charges that

had been scrapped during the pandemic (Liberal Democrats, 2024). 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.

Driving growth through nursing career and pay progression

Career progression is essential for the retention of the registered nursing workforce and should be enabled by a pay progression structure that is aligned with the true clinical responsibilities of the registered nurse.

The reality is that opportunities for nurses are currently limited to management and specialist qualifications, meaning that once a nurse finds themselves at the top of band 5, their continuing development, knowledge and experience as a professional is not recognised or valued.

> **Nurses are willing to stay around two more years in roles which offer performance-based additional spine points relative to roles that do not**

Analysis by London Economics, commissioned by the RCN in 2025, (not previously published) used new methodology to estimate the retention benefits of a range of interventions. They found that on average, nurses are willing to stay around two more years in roles which offer performance-based additional spine points relative to roles that do not, which saves replacement costs of around £223m per year.

In addition, our own analysis of NHS England data suggests that band 5 nurses are 17% more likely to leave NHS hospital and community services than those at band 6, even after standardising for age.

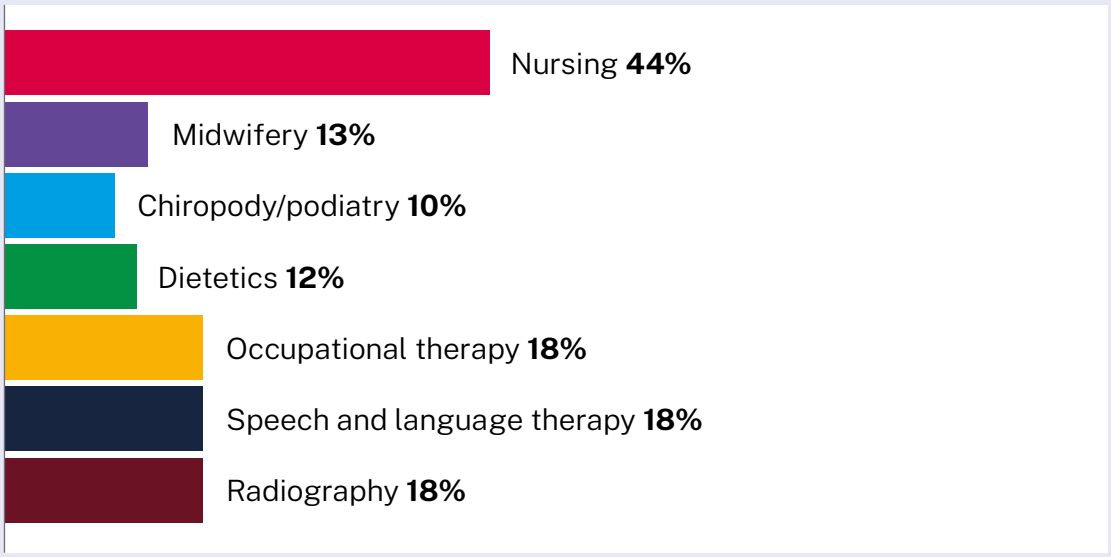
Other professions, such as pharmacists, paramedics and midwives, have career development funded and built into their roles, there is no such guarantee for nurses and career pathways are not clearly defined. This unfair structure fails to recognise nursing experience and expertise, and the ongoing focus on staffing models based on affordability rather than need is a barrier to providing safe and effective patient care.

The current AfC pay banding system for NHS staff has not kept pace with developments in nursing practice since its implementation 20 years ago. In 2018, the NMC undertook a review and revision of the Standards of proficiency for registered nurses, considering the changes taking place in society and health care, and the implications these changes had for registered nurses. No such review has been undertaken of AfC to assess whether it remains fit for purpose in recognising and rewarding nursing, considering changing expectations and practices. However, 83% of band 5 respondents to the recent *RCN Employment Survey 2025* (results to be published in December) said their current band was either inappropriate or very inappropriate.

It is also essential to highlight the institutional discrimination within NHS nursing career pathways and opportunities. Given nursing also has a high proportion of staff who are female (89%) and reporting ethnicities other than white (30%), addressing the barriers faced by nurses compared to other professions in achieving pay progression will contribute to closing the overall gender and ethnicity pay gaps.

Alongside this, there is currently an unacceptable disparity in career progression opportunities specifically between band 5 and band 6 for nursing and comparable graduates, professionally qualified health professions. Four in nine nurses (44%) are currently at band 5 which is at least twice the proportion as virtually every comparable profession (and for some four-times), including midwifery (13%), chiropody/podiatry (10%), dietetics (12%), occupational therapy (18%), speech and language therapy (18%), and radiography (18%) (RCN, 2025a). Equity would dictate a similar proportion of nurses at band 6 or above as the average across midwifery, paramedics, professionally qualified allied health professionals and other scientific, therapeutic and technical staff.

Health care staff working at band 5



In 2016, the DHSC, NHS Employers and ambulance trade unions agreed that paramedics were to be re-banded nationally from band 5 to 6. Meaning every paramedic would automatically progress from a band 5 to a band 6 following a period of consolidated learning (known as a preceptorship). This was in recognition of their practice as 'a modern paramedic'. Reasons for the change included paramedics increased responsibilities as the role had evolved since the implementation of AfC in 2004, requiring more clinical knowledge and advanced decision-making skills. Likewise, midwives also follow a similar model and progress to band 6 following a preceptorship period.

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As a profession, nursing has been subject to the same advances taking on significant developments in clinical practice and has advanced alongside innovations in health care and increased complexity of care to meet the needs of the population. The expectations of 'a modern nurse' have been clearly defined, and this equates with new band 6 nursing profiles recently published.

A nurse who does not progress to band 6 is potentially missing out on more than £7,000 in earnings per year

New analysis from the RCN conducted in September 2025 compared disparity in pay progression between health professionals on the AfC pay scale who follow a preceptorship pathway (midwives and paramedics) and registered nurses. Nurses, midwives and paramedics all begin on band 5 when they start working in the NHS. Our view is that government set a precedent for a predominantly male (and white) profession yet are resistant to implementing the same initiative based on the same reasons for a predominantly female (many of whom are from the global majority) profession notwithstanding their public sector equality duties and NHS employers' requirements under the Equality Act 2010.

The RCN's analysis looked at pay per year on each band and considered the existing timeline for NHS staff to progress in each band. An average annual uplift of 3% was applied to each pay point to give a realistic impression of how each pay band might develop in this time. We found that a nurse who does not progress to band 6 is potentially missing out on more than £7,000 in earnings per year, despite a large cohort having responsibilities and leadership qualities to warrant band 6 pay.

The evidence supports our view that nursing is a band 6 profession in the NHS and that a nationwide phased implementation of this model for existing band 5 nurses is fair and a proportionate means of recognising the complexity, skill and contribution of the nursing workforce as well as addressing institutional sex and race discrimination within nursing in the NHS. New registrants would be required to complete a time-limited preceptorship programme before moving to band 6 like paramedics and midwives.

This model should be fully funded and included in the *Ten Year Workforce Plan* due to be published in spring 2026.

Driving growth through fair nursing pay

Nursing is a highly gendered profession and 89% of nurses on the NMC register are female and 31% are from Black and ethnic minority backgrounds. The close association between nursing and traditional gender roles has direct implications for the demographics most likely to join the profession and has follow-on effects in terms of wages.

Nursing pay has not kept pace with the advancements in the complexity of the profession nor more broadly the growing societal recognition of structural inequalities facing women and ethnic minority groups. The pay inequality experienced by nurses compared to the rest of the public sector professions can be attributed to structural pay discrimination which does not properly compensate nurses for the responsibilities that they hold.

On top of this, nurses are burned out due to high vacancy rates and challenging working conditions, and this is driving problems with retention and recruitment when combined with pay erosion (Bimpong KAA et al., 2020). Sickness absence rates for nurses and heath visitors have been consistently one percentage point above the pre-pandemic average (NHSE, 2025c). This equates to more than 3,000 additional nurses not able to work at any one give time compared to the average before 2020.

Almost a third (29%) of nurses and midwives responding to the NHS staff survey said they **agreed or strongly agreed that they often think about leaving their organisation.** Additionally, an increasing number of nurses are leaving the nursing regulator's register early (before retirement), with nearly one quarter (24.3%) of nurses and dual registrants having left within their first 10 years of joining the profession.

A recently published academic paper (Mishra, Raman Pareek, Manish et al., 2025) looked at the 2024 pay award, attrition rates and employment sentiment in the NHS. It found that lower band (2-6) AfC staff showed a stronger relationship between pay satisfaction and intention to leave, possibly relating to their status as lower paid to begin with. Meaning that as dissatisfaction levels with the 2024 pay deal grow, their intentions to leave grow similarly.

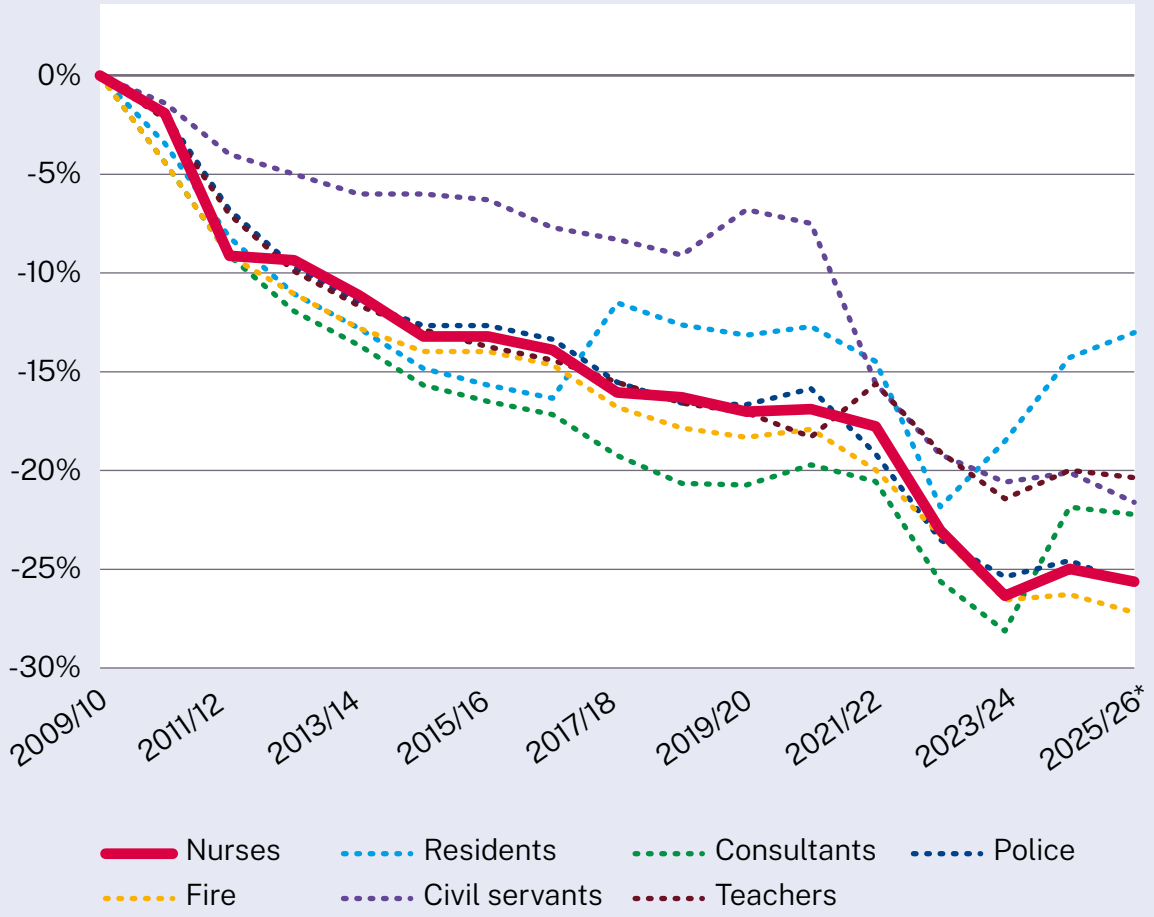
In the latest pay round, nursing and other AfC staff received by far one of the lowest uplifts in pay: 3.6%. For comparison, private sector pay growth has ranged between 4.8 and 6.3% over the last two years (ONS, 2025b). Following the announcement of the 3.6% pay award from the Westminster government in May 2025, the RCN undertook a consultation with members working in the NHS. In England, the turnout in the consultation reached 56%, with more than 170,000 nursing staff voting. **Nine in 10 (91%) said 3.6% was not enough.**

Nursing staff dissatisfaction with the most recent pay offer is understandable, given the ongoing problem of inflation. While in the aggregate, inflation is edging closer to the Bank of England's target, and it is below its 2021/22 peak, strong food price inflation remains consistent over the medium term (ONS, 2025c). Interest rates remain much higher than before 2022 (Bank of England, 2025b) and annual increases in housing costs are adding to income pressures for families. However, NHS pay for nursing

staff has been considerably undercut by inflation. **Analysis by the RCN has shown that the starting salary for a band 5 registered nurse would now be nearly £40,000 a year had wages kept up with RPI inflation since 2011 and is £8,324.12 behind what it would be had it risen with inflation (RCN, 2025b), a 21% real-terms drop, over that period.**

Further analysis, comparing experienced band 5 nurses with similar roles across the public sector[2] (chart 1, below) over the longer-term has demonstrated that nursing pay has experienced one of the sharpest rates in real terms decline. Only fire fighters, out of a range covering most of the public sector have had a worse set of uplifts since 2010, when considered along with inflation.

Real terms public sector pay 2011-2015



[2] We have used inflation data from the ONS to assess the purchasing value of nurses' wages and that of other public sector workers, for comparison over time. Using departmental pay circulars for information on pay at different grades, for different professions we have looked at how pay has fallen behind prices since 2010. The year 2010 has been chosen for comparison as a baseline year owing to the change of government, ushering in a period of 'austerity' in the public sector. the pay points used here were chosen for their combination of similar pay to a band 5 nurse at the top of the pay scale, along with a similar potential period of progression and similar or slightly lower level of responsibility.

The remit letter from the Secretary of State (Gov.uk, 2024b) set out the expectation that the envelope for public sector pay awards for 2026-27 will be within the current budget outlined in the spending review. This implies a 2.8% real terms (CPI) envelope for the phase 2 period of the latest spending review between 2025-26 and 2028-29. The prior pay award was set within an initial envelope of 2.8%, later topped up with savings from agency cuts and structural reforms to NHS England.

The recently released DHSC evidence to the pay review body suggested that, given AfC pay rises in 2026-27 'must be funded from departmental budgets and there will be no additional funding available above this for pay settlements', with their financial and delivery plans allowing for a 2.5% pay uplift which is broadly the same as forecast inflation. This compares to around a 5% increase in (nominal) overall funding.

We are of the understanding that the pay award envelope is partially derived from the government's GDP deflator estimates for inflation. We have concerns about the use of this approach for several reasons. The deflator is understood as how public sector budgets are affected by inflation, and therefore what they can afford in terms of pay as they contribute to the Treasury's understanding of the government's annual budget within the horizon of the current spending review period. The deflator is calculated taking into account growth and imports and exports. This can give a distorted, and inverse reading of inflation as compared with the Consumer Price Index, the Consumer Price Index with Housing, and the Retail Price Index which track the price of goods and services. This is best illustrated by the GDP deflator figures for 2021 (Gov.uk, 2025e) which indicated an inflation rate of 5.06% when CPI (0.9%) and RPI (1.5%) were much lower (ONS, 2021a).

Our concerns regarding the measurement of inflation also pertain to the use of CPI rather than RPI for assessing pay uplifts. Housing costs are not included in the basket of goods making up CPI. Housing is one of, if not the greatest outlay for most workers, including nurses. When captured as part of CPIH (including housing costs) a higher number is given, indicating their further importance in considering the cost of living. Yet when pay awards are announced, it is CPI which the government refer to. The government use RPI in other government services provision, for instance in the indexing of student loans for interest payments. We therefore dispute the use of CPI rather than RPI when considering nurses' current, past and future pay awards.

In 2022, London Economics also found that 81% of a pay rise for AfC staff would return to the exchequer through a combination of personal taxes, consumption related taxes, lower levels of student loan write off and recruitment and retention. Based on 2021 data, a 10% pay increase for staff then would have returned £2.74bn of the £3.4bn total cost of the uplift in exchequer benefit. Improved pay would create multiplier benefits in the wider economy, their improved savings and consumption supporting local economies and further employment, filtering through in additional taxation revenues via the more than 300,000 nurses on AfC alone.

Analysis by London Economics commissioned by the RCN in June 2025 (not previously published) found that around 41% of the cost of a salary increase is recovered through improved retention and lower recruitment costs. Taking an illustrative example, **nurses are willing to stay around four more years in a role that offers a 5% salary increase r**elative to a role that offers their current salary. This salary increase would add around £853m to the total pay bill for nurses and health visitors but it would lower recruitment costs by around £353m per year.

These findings demonstrate the importance of the government taking a wider view of affordability when determining costs and benefits of investment in nursing pay than is reflected by the GDP deflator.

We welcome the Secretary of State for Health and Social Care's pledge to improve the timeline for the annual pay review process. Timely and above inflation pay awards are essential for our members. However, delays in previous years have created financial hurdles for many whose costs are going up day by day. This is – in particular – an issue pertaining to Northern Ireland, and we implore the government to do all it can to enable the executive to sanction the latest, and all future pay awards in a timely manner.

In conclusion, in terms of NHS nursing pay (and other AfC staff), it is essential that this and successive governments take action to address long-term pay erosion impacting nursing staff so heavily. This must include investment in annual above inflation pay awards to meet the genuine cost of living.

Nurses who work in general practice have also suffered from behind schedule pay uplifts and low pay meaning that that many would fall even lower in the overall NHS pay distribution. Without national bargaining structures, many general practice nursing staff are left to negotiate for themselves, which adds to the disparity. Meaning that many would fall even lower in the overall NHS pay distribution.

In 2024 in England, where there are around 24,000 general practice nursing staff, only a fifth of staff employed directly by their practice received the 6% pay rise promised. Recently, the UK government confirmed a 4% pay uplift for all salaried general practice staff, including nursing staff, for 2025/26, as recommended by the Doctors' and Dentists' Review Body. We continue to call for ring-fenced funding for nursing pay in general practice to ensure it remains an attractive and sustainable career path, as there is currently no mechanism to ensure that the intended pay uplift is passed onto them.

The RCN welcomes the government's moves within the framework of the Employment Rights Bill to seek cross-bench agreement over social care system reform, led by Baroness Casey while also aiming to improve pay and conditions in social care (Gov.uk, 2025d). The most recent Skills for Care report on pay (2025, covering December 2024 data) suggests that the average care worker's pay amounts to £12 per hour in England and £12.19 in London (Skills for Care, 2025).

The pledge of £500m to cover the improvement package marks a significant investment, however the RCN would like the government to set out:

- further detail on the pay structure
- what proportion of the investment will be put towards pay and training
- how nurses are specifically affected.

We look forward to responding to the upcoming government consultation on the fair pay agreement in January, where we will set out some of our thoughts on reform in further detail.

The ambition to finalise a fair pay agreement for social care demonstrates that government clearly understands the necessity in improving pay and conditions for working people in the public sector as a key driver of both retention and improved outcomes. Recognising the contribution nurses in care make to the lives of so many people. It also illustrates what is possible when it comes to moving discussions over pay and conditions forward within a health setting, which incorporates the aims of various stakeholders.

4. An NHS fit for the future

NHS system modernisation

The government cannot deliver on its high-level goal of creating an NHS fit for the future, including reducing elective waiting times, without a realistic level of investment from government for the scale of transformation required, or without prioritising the central role of nursing. Across every plan for change in the health service, the government has made clear that reform and modernisation requires much more than investment. Productivity gains, be they through new practices or better use of technology, are only possible by investing in nursing and nurses' expertise, and relying on their understanding of the system, and patient needs, day-to-day.

These are not new goals, and successive governments have failed to plan and invest effectively to transform NHS delivery. A recent report from the Institute of Government (Paxton B and Davies N, 2025) on government procurement raised the issue that while the three shifts remain key to government reforms to the NHS, the government's milestone for the NHS is actually to bring down elective waiting lists. Having targets to both move to preventative, community-centred care and focus effectively on hospitals was sending mixed signals to industry and the public sector.

In addition to these goals, the government is also seeking to find significant savings through changes to the system architecture. Earlier this year, the government announced a requirement for integrated care boards (ICBs), the bodies responsible for funding and planning local services, to reduce their running costs by 50%. It also announced that NHS England would merge into the Department for Health and Social Care, with a 50% reduction in staff. While it is expected that this will generate £1bn of funding to reinvest into the frontline, many of these staff hold clinical leadership (rather than administrative) roles, and would be instrumental in implementing the objectives of the *Ten Year Health Plan.*

These changes therefore present significant risks to the success of the intended transformation, and that nursing functions throughout commissioning bodies are protected from the impact of cost-saving measures and reforms (RCN, 2025e). While it has recently been confirmed that redundancies will be centrally funded, it is unacceptable that so many nursing staff do not have clarity about the future of their jobs, so many months after the announcements were made. Public assurances about the safety and quality of health and care services are dependent upon nursing staff being key to decision making about funding, strategy and approach. In all aspects of this work, it is crucial that the value, impact and outcomes related to these functions and the roles associated with them is recognised, and a judgement is not made solely relating to their immediate cost.

These announcements have been made in the context of NHS services being forced to compromise on service quality to avoid closure. We are particularly concerned that NHS leaders are freezing nursing staff recruitment, despite

ongoing nursing vacancies. RCN student members recently raised the alarm that there are insufficient entry level roles in the NHS to accept nursing graduates across the country. The government made a 'graduate guarantee' recently and instructed trusts to fund an adequate number of band 5 (entry level) roles, as well as ensuring that advertised band 5 roles be uplifted to a band 6 if prior experience is required of candidates. We continue to hear concerns from student members and have intelligence that some trusts are simply unable to fund what has been asked of them.

The *Spending Review* (HM Treasury, 2025) pledged a 3% Consumer Price Index (CPI)-based real terms investment in health and social care over the remainder of the parliament. The settlement included a 2% productivity rate from 2026-29, as reiterated in the *Ten Year Health Plan*. The *Independent Investigation of the National Health Service in England* (Darzi, 2024), highlighted several key productivity problems in the NHS, tying patient flow problems to a slowdown in health care output as beds are occupied by those needing to be transferred to other settings. 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.

Analysis by the Health Foundation (2025) found a 10% increase in capital spending over the rest of the parliament is required, followed by 5.4% in the five years after to make up for the period of 2010-24.

Acute to community

A shift from acute to community provision in England requires upfront investment to ensure transformation is successful. Denmark and Ireland 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 such as a near £20bn in mental health support. The Irish Fiscal Advisory Council estimates that annual costs of the scheme will total more than £3bn by 2027 (Reed S, Lobont C, et al., 2025).

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.

These international examples demonstrate a clear understanding of the nature of transformation, and how it must be enabled through upfront 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 care fully, including community nursing roles.

The DHSC are yet to publish the *Ten Year Workforce Plan* which we expect will set out the modelling and deployment models needed to achieve the *Ten Year Health Plan*. The scale of investment needed in community nursing roles alone must consider that previous positions of nurses moving into the community would be vacant (for example, in acute care), yet demand would take time to fall. Filling these vacancies and paying the salaries in addition to the pay of the additional community nurses makes up the largest share of the cost of the community workforce expansion. As demand shifts away from hospitals into the community, fewer nursing roles will be required in the acute sector.

Analogue to digital

The RCN welcomes the government rollout of the NHS Online Hospital. Patients will hopefully benefit from the opportunity to get appointments more easily. Done effectively, this will mean people will get to the right specialist more quickly and reduce delays in referrals. This has the potential to reduce pressures on already overstretched GP services and cut the need for expensive stays in hospital.

Modernising services, reducing the need to go to hospital and bringing care closer to home are the right ambitions but they require investment in the infrastructure and crucially the nursing staff needed to deliver them. Central to the success will be ensuring there are the right number of staff to deliver online services while also not jeopardising capacity to deliver face-to-face care. Increasing the number of staff in primary and community services needs to be part of this. We hope the upcoming *Ten Year Workforce Plan* takes this into consideration.

Further digitising the health system will require much more than investment in the technology itself. A report by The Health Foundation (Hardie T, Hall J, et al., 2025) looking at this in detail before the election of the current government suggested that ongoing expenditure could total £8bn in capital spending, and £2bn in recurring annual investment. However new digital solutions for care will require training for staff and ongoing optimisation to maximise patient and health worker benefits.

Over the medium to long term, it should not be considered as part of the government's workforce strategy to replace nursing roles with artificial intelligence (AI). Clinical decision making should rest with qualified professionals, which in the correct circumstances – and using reliable tools – AI solutions can support. 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-supported 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, along with other workers in health care, have a relatively low level of exposure to the potential changes AI may make to the employment landscape. A Department of Education paper (2023) looking at job exposure to AI, ranked both nurses and midwives in the bottom 10 out of 365 occupations ranked when considering several methods. However, given the 24/7 safety critical role of nurses they should be at the centre of designing AI initiatives. Nursing's complex mix of skills mean that 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.

In the *Ten Year Health Plan*, the department 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 situated at its centre. However, 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 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 health care 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.

Health care workforce planning

For government to modernise health care and achieve the three shifts of the *Ten Year Health Plan*, it must generate a sustainable nursing supply pipeline in England, based on the health care needs of the population. The plan to deliver this must be detailed in the forthcoming *Ten Year Workforce Plan*, due to be published by the end of 2025.

NHS and social care workforce planning in England has been woefully inadequate over successive governments. The result is that the nursing workforce is in crisis with the most recent data showing that there were **25,107 vacant posts in the NHS in England alone**, and a vacancy rate of 5.9% (NHS England, 2025e). This is also potentially an under-estimation of the true vacancy rate, as it is based only on funded registered nurse posts, and not on any true number required for safely staffed health and care services.

The finance-driven nature of workforce planning has long been a subject of scrutiny, and an issue that government and NHS leaders have failed to come together to resolve. The resulting and ongoing nursing shortages (in relation to actual demand rather than affordable recruitment) is that registered nurses suffering from high rates of burnout and frustration at their jobs due to increased pressures and conditions. 45.49% of registered

nurses and midwives felt unwell as a result of work-related stress in the past 12 months, compared to 41.63% of all staff. Beyond burnout, nurses also experience frustration due to their working conditions. 37.03% of registered nurses and midwives said their work 'often' or 'always' frustrates them, compared to 35.47% of all staff.

45.49% of registered nurses and midwives felt unwell as a result of work-related stress in the past 12 months

The *Long Term Workforce Plan* (LTWP), published under the previous government in June 2023, aimed to address NHS workforce shortages through increased recruitment, training, and retention measures while improving productivity. The plan included projections to increase nursing numbers in the NHS from 350,000 (correct at the time of the plan's publication) to between 545,000–565,000 by 2036/37. However, these were not underpinned by transparent calculations for fields of nursing or specialist roles.

The LTWP was not released alongside costings nor detail on the required investment in education staff and infrastructure. £2.4bn was pledged by the previous government towards implementation, however it was clear immediately that this was not enough. The Institute for Fiscal Studies (Warner M and Zaranko B, 2023) concluded that, in order to fund the plan, VAT would have to rise by 7%, funding a 3.6% rise in overall health spending per year.

There was also insufficient detail on how LTWP funding commitments (such as the increase from £5.5bn to £6.1bn for education and training) would be allocated and delivered. The roles of integrated care systems and employers in delivering effective solutions were also ambiguous as there were no clear actions in the plan, which has made it difficult to scrutinise progress made since its launch in spring 2023.

While the LTWP recognised the severe workforce crisis in health and social care, driven by low numbers of domestic students, high attrition rates, and over-reliance on internationally educated staff, it lacked clarity on investment allocation and implementation, such as the interventions needed to expand the number of students.

The inadequacies of the LTWP must not be repeated in the forthcoming *Ten Year Workforce Plan,* which will only be achievable and realistic if it is fully funded. It should therefore include the level of modelling detail needed to establish investment costs and include specific details on the policy interventions and mechanisms that will be used to implement it. If this is not the case, the government cannot expect to create and support a workforce capable of delivering the *Ten Year Health Plan*.

Between 2021 and 2025, the number of applicants to nursing courses in England have fallen sharply, by 27%. There is a significant decline in the number of acceptances in 2025 compared to the peak in 2021, by 21%. This is concerning given an already understaffed health care system which is unable to meet the growing demands of patients and impacts heavily on patient safety.

There is also a high level of nursing staff turnover. Attrition analysis conducted by the Nuffield Trust (2023a) has found that 18% of new nurses left within the first two years of employment.

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Analysis from London Economics (2023), commissioned by the RCN has looked at the burden of student loan repayments. Taking the 2021/22 cohort, average debt on graduation per student in the cohort (including accumulated interest) was estimated to be £47,600. However, forecasted average repayments of only £24,400 and £10,700 for women, result in 100% of nurses in the cohort unable to repay their loan. The prospect of limited pay progression while paying off a loan the majority of nurses will never pay off acts as a significant disincentive to staying in their posts long term.

To support retention, the graduate nurses should have their student loan debt forgiven in exchange for working within a publicly funded health and care service for a set period. Under this model, nurses who work in the NHS or other publicly funded health and care services would have 30% of their loan written off after three years, 70% after seven years and the full 100% written off after 10 years. It is our view that this model would benefit recruitment, particularly amongst those with caring responsibilities, and for retention (RCN, 2025d). A similar loan forgiveness policy was costed and endorsed by the independent health think tank, the Nuffield Trust (2023a), 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'.

Modelling by London Economics commissioned by the RCN (2025d) can demonstrate that introducing this loan forgiveness model would significantly increase early career retention, unlocking a monetary societal benefit of £1.16bn per cohort (single year), based on an additional 65,000 additional nurse-years for the NHS. London Economics had previously estimated that the cost to the Treasury of £235m per year, a figure which 'pales in comparison to the long-term economic and social benefits'. The RCN joined the commissioning organisation, Million Plus, in sharing this estimate with the then Chancellor in a published letter (RCN, 2025g). Reducing the flow of early career nurses leaving the workforce would allow for some stability upon which plans can be made to work towards the three government shifts.

Access to CPD as part of career development is also essential for both individual nursing staff and service provision. The forthcoming *Ten Year Workforce Plan* must be supported by sufficient funding for CPD based on projections of future service and population needs. CPD should be factored into paid hours for nursing staff with funds to cover the shifts of those training.

Recognising the contribution of internationally educated nursing staff

International nursing staff (which includes nurses, midwives, health visitors, health care assistants, etc) have been integral to health and social care in the UK since the foundation of the NHS in 1948. Many of the Windrush generation have continued to be vital to our health and social care sector. Today, services simply could not run without our talented and dedicated colleagues from across the globe. From their initial recruitment to visa applications, from starting work to finding accommodation – internationally educated staff are confronted with unjust and unnecessary hurdles. Too many internationally educated nursing staff are facing racism and discrimination in the workplace, and this is playing an influential role in people's decision to leave their nursing careers in the UK.

There are more than 200,000 internationally educated nursing staff across the UK, making up 25% of the UK's total nursing workforce (NMC, 2025). These staff make vital contributions to the UK's health and care service each day, however government's immigration policy fails to recognise the value that these staff bring.

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The World Health Organization (2025b) estimates that, **globally, an additional 5.8 million nurses are needed**. In the context of global nursing shortages, it is imperative that all countries fulfil their obligations to create a domestic supply of registered nurses sufficient to meet current and future population health needs. It is also vital that internationally mobile staff that do choose the UK as a destination for their nursing career have the best experience possible.

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 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.

However, on 9 April 2025, the immigration salary threshold for health and care worker visas increased from £23,200 to £25,000, effectively closing band 3 roles to international recruitment in England (excluding London) and Northern Ireland. In the NHS, staff employed in England on the first salary point of band 3 are just £63 per year short of the new salary threshold. **Affected staff are unable to renew their visas, change employers, or change their visa type.**

A freedom of information request submitted by the RCN reveals that there are close to 15,000 non-British nursing staff on band 3.1 in NHS England alone. Limitations in Home Office data mean it is not possible to ascertain how many are on visas that would be impacted by these changes, it is therefore imperative that the government undertake their own assessment of the impact of the increased salary threshold.

However, RCN analysis suggests that an uplift in pay to allow them to reach the threshold would not be financially burdensome. When including an estimated 30% in employment costs, the outlay required in uplifting all internationally educated nursing staff on band 3.1 by £63 per year would be £1.2m. This is a very small sum by the standards of AfC.

	Total staff	Internationally educated staff
	40,000	**15,060**
Current pay of £24,937	Current cost: £1,296,724,000	Current cost: £488,216,586
With additional pay of £63 per year (£25,000)	Future cost £1,300,000,000	Future cost: £489,450,000
Required investment	**£3,276,000**	**£1,233,414**

Though we do not have perfect up-to-date data, a previous freedom on information request indicates that around 40,000 NHS staff are on band 3.1 (NHS England, 2024a). If the whole cohort were to see their pay increased by £63 per year, this would cost £3.2m total. To protect the stability of the workforce and ensure these vital staff are able to renew their visas internationally educated **staff on AfC band 3.1 should be paid at least an additional £63 per year to meet visa requirements**.

UK leadership on global health

Time is running out to achieve the United Nations' (2015) health-related Sustainable Development Goals by 2030. As the largest component profession of the global health workforce, nurses have a special role to play in advancing universal health coverage and meeting global health goals. However, the WHO (2025a) estimates that an additional 5.8 million nurses are needed to meet global demand.

Official Development Assistance (ODA) is a critical lever for addressing the global health workforce crisis and other global health challenges. The United Nations 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 (2025f) 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. 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.

Earlier this year, government 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 £6bn a year compared to the 0.5% target (House of Commons, 2025b). 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' (Gov.uk, 2025c).

Cuts to ODA must be reversed and plans to reduce spending further must be abandoned. 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. Targeted funding must be made available to sponsor nurse education, recruitment and retention, especially in fragile, conflict-affected countries.

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