Royal College of Nursing

Royal College of Nursing Submission: HM Treasury Comprehensive Spending Review (CSR) written representation

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Contents

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1. Introduction

A decade of lost investment

With a membership of around 450,000 registered nurses, midwives, health visitors, nursing students, nursing support workers and nurse cadets, the Royal College of Nursing (RCN) is the largest professional body and trade union of nursing staff across the UK.

Nursing is a safety critical profession, one that is vital to our country's wellbeing and to our health and care system. Research published in 2014 reported that every 10% increase in the graduate nurse workforce was associated with a decrease in the likelihood of a patient dying by 7%. Hospitals in which 60% of nurses were graduates were safer than those where only 30% of nurses were graduates.

Having enough nurses is key to safe and effective care. Research shows that an increase in a registered nurse workload by one patient increased the likelihood of an inpatient (undergoing common general surgery) dying within 30 days of admission by 7%.

The COVID-19 pandemic has shone a spotlight on the critical role undertaken by nursing staff across the UK on a daily basis. It has also highlighted that successive governments across the UK have consistently underfunded the nursing profession and wider health and care system over the past decade. Too few nurses have studied at university and joined the profession, too many have left their nursing careers, and of our colleagues that remain, too many feel overstretched and undervalued.

In our recent UK-wide membership survey, which sought to understand their experiences of working across different specialisms and settings during COVID-19, a worrying 37% of respondents are now considering leaving the profession. Furthermore, nine out of 10 are worried about the wellbeing of their colleagues, and just over three quarters (76%) reported an increase in their own stress levels. Their dedication to clinical excellence and patient care in a system which has survived on their good will for too long is taking its toll.

There has been a continual boom and bust approach to nursing supply as well as NHS and care funding. Emergency funding packages have become commonplace because the system's finances are left to reach a critical stage before action is taken. As a result, health and care providers focus on the immediate financial and safety concerns at the expense of taking a longer term, strategic approach. Patient care and outcomes inevitably decline when the health and care system is continually fighting to maintain the status quo, unable to develop the necessary capability to improve and innovate.

Across the UK, nursing workforce shortages in all specialisms significantly affect patient outcomes and staff productivity. Despite the shortages being well recognised, the pandemic has further highlighted the fragility of our health and care system; thousands of retired nurses came back into work, and nursing students across the country disrupted their studies to support the emergency to cover the workforce gaps.

Furthermore, ahead of winter and with the threat of a second peak of COVID-19 ongoing, it is no longer feasible to continue with insufficient health and care staff to deliver overstretched services. The focus must be on both attracting enough registered nurses

to close the workforce gap as well as on growing and developing an oversupply of nurses to sustain the workforce thereafter. Governments across the UK must tackle the existing workforce shortage and make sure nursing is an attractive, well-paid and meaningfully supported profession. That is how to equip services to provide safe care now and in future.

Nursing as a labour market stimulus

The UK is entering an economic crisis but investment in heath and care can play an important role in minimising the impact of a recession, as well as some of the poor health outcomes associated with increasing poverty.

As a graduate profession, nursing offers the chance for social mobility and a career path to higher wages for many as part of this investment. For example, the Resolution Foundation and the Health Foundation have called for a substantive increase in the number of social care workers as a way of stimulating the economy. But encouraging more people to study nursing requires the government to financially support them with their studies at this economically uncertain time. Despite rising levels of overall government debt, the government's borrowing rates are at record low levels.

As we near the end of 2020 - the World Health Organization's International Year of the Nurse and Midwife - this CSR must provide the investment and support required to enable health and care services to redesign care in a way that truly levels up our country and tackles health inequalities from the ground up.

The most important things the UK government must do in this CSR are:

- Ensure all public spending announced is reflected in the Barnett Formula and consequentials so that devolved governments and their populations also benefit.
- Increase pay for all nursing staff by 12.5% for all nursing staff covered by Agenda for Change terms, as part of a one-year deal that applies equally to all pay bands. We expect this to be the case for every country in the UK.
- Prepare the UK for the continued fight against COVID-19 by supplying adequate personal protective equipment (PPE), increasing testing capability and by funding support for the mental health impacts of the crisis. The unequal impact of the pandemic on black, Asian and minority ethnic (BAME) communities must receive particular support.
- Introduce accountability for provision of workforce in legislation in England to avoid future situations where we do not have enough staff to provide safe and effective care. A workforce plan based on future population need is essential to this process.
- Increase the supply of registered nurses through additional commissioning of places, increasing the financial support with maintenance grants that reflect the true cost of living and abolishing student-funded tuition fees, for all nursing students in England. We have modelled the costs of a new student funding system in England as supporting evidence. However, all students across the UK should be financially supported to study.
- Remove financial barriers to international recruitment throughout the UK by ensuring that health and care employers are exempt from the International Skills Charge and the exemption for staff from the Immigration Health Surcharge is automatic for all.
- Invest in public health and prevention strategies and services throughout the UK to ensure that the health and wellbeing of our population is protected, and in order to reduce the reliance on acute care and treatment.

2. Barnett Formula

Nations across the UK have different populations, rurality and affluence and therefore have different health and care needs. We are aware that the way in which UK funding is distributed is via the Barnett Formula and all public spending should necessitate a transfer of consequential funding.

We welcome greater transparency from the Exchequer on how consequential funding is calculated, and transparency is also required for spending. This applies, in particular, to ring-fenced funding intended for workforce, including for pay rises, in any NHS funded services, including GP provided primary care and other independent providers.

3. Shared Prosperity Fund

Countries across the UK have benefitted greatly from the European Union (EU) Structural Funds which were funding allocations designed to support economic development and reduce disadvantage between regions and countries in Europe. Following the UK's departure from the EU, the UK government is proposing to set up a UK Shared Prosperity Fund which they have pledged to be 'at a minimum match to the size of the structural funds in each nation.' iii

The 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. The intention of this fund is to reduce inequalities between communities and in order to achieve this, the UK government must allocate the Fund based on an assessment of community need so that inequalities are not exacerbated and instead are tackled.

4. Pay for nursing staff across the UK

In July 2020, we - in conjunction with the thirteen other health unions representing members of staff working in the NHS - called for an early and significant pay rise for our members. Nursing is a highly skilled profession which deserves fair pay that reflects the complexity and impact of its contribution.

Pay for health and care professionals, particularly nursing staff, has not kept pace with increasing living costs over many years. Despite the 2018 round of pay increases, average earnings for registered nurses in England have dropped by 12.6% in real terms (against

the Retail Price Index (RPI)) since 2010 and average earnings for nursing support workers have fallen by 11.6% over the same period. Median weekly earnings (excluding bonuses) across the economy have fallen in real terms (against RPI) by 7.9%, demonstrating that NHS workers have been hit hard by public sector pay restraint combined with rising living costs since 2010.

A fair pay deal is not only good for current nursing staff but will increase the attractiveness of our profession - helping to fill the tens of thousands of unfilled posts, reach safe staffing levels and provide safe and effective patient care.

Our recent survey of around 42,000 members showed a worrying rise in those reporting that they are considering leaving the profession, with 61% of members citing pay, and almost half citing low staffing levels as a key factor. Nearly three quarters (73%) said higher pay would make them feel more valued. The public also support an increase in pay. In a poll conducted by YouGov in July of this year, 86% of respondents said they would support a pay rise for nursing staff. If the government is to meet its 50,000 more nurses target in England, then it must make a career in nursing attractive. Pay is one of the most important ways to do this.

In August, we launched the Fair Pay for Nursing campaign, aiming to secure a fully-funded 12.5% pay increase for all nursing staff covered by Agenda for Change terms, as part of a one-year deal that applies equally to all pay bands. This must not come from existing budgets.

Based on analysis of NHS workforce numbers and earnings data undertaken by London Economics, a 12.5% pay rise for all Agenda for Change staff working in NHS trusts and support organisations in England shows that the cost to the Exchequer would be approximately £4.25 billion extra per year. The Barnett consequential associated with a 12.5% pay demand is estimated to be an additional £802 million.

The economic disruption of COVID-19 has left the UK economy in recession, however government spending in the form of NHS pay rises could act as stimulus to boost the economy. Evidence from the Institute for Fiscal Studies shows that the NHS acts as an economic 'anchor institution' in areas of higher deprivation due to the job opportunities it provides, as it employs more people at a higher wage levelling up the local economy. Many of these more deprived areas are likely to suffer some of the worst economic fall-out from COVID-19.

NHS organisations are major employers in many towns and cities, and directly and indirectly support skilled jobs in health and social care and through supply chains. Investment in our social infrastructure therefore produces gains through a short-term economic boost as well as contributing to longer-term goals. In addition, the true cost of a pay deal could be minimised by several external benefits that would have a positive effect to the Exchequer. In theory, these incentives could include an increase in tax receipts, national insurance contributions, reduced costs of unemployment, or multiplier effects from extra spending of disposable income to the wider economy.

In the recent RCN survey, three quarters of respondents (73%) say higher pay would make them feel more valued . Morale and productivity are known to be correlated with job

satisfaction and feeling valued. One study suggests that a "25 percent increase in nurse job enjoyment over a two-year span was linked with an overall quality of care increase between 5 and 20 percent" . The same study says that "nurses' intent to stay increased by 29 percent". Similarly, research from the OECD shows that higher pay can increase the potential supply of new entrants to the profession.

The possible benefits of investing in nursing pay such as better morale, improved patient care and less staff turnover would have clear long-term benefits for the UK economy and wider society.

5. COVID-19

COVID-19 has fundamentally changed us as professionals and individuals, including not just how we live our lives but our expectations on how we rebuild an inclusive economy that promotes wellbeing, improves outcomes in public services and creates a fair society. The nursing workforce has been unstinting in their professionalism and agility as key workers to provide care throughout the pandemic. However, there were both immediate issues and deep-rooted problems that existed which affected nurses' ability to fight COVID-19. The health and care systems across the UK were not prepared for this emergency.

The two biggest concerns for our members in direct relation to COVID-19 were the provision of PPE and testing for health and care staff.

PPE

The shortages of PPE revealed serious problems with how the UK procures essential safety equipment. Some settings reported adequate PPE, for example intensive care settings in acute hospitals, but this has not been the shared experience for all staff in all settings. Those working in care homes were particularly impacted by problems with stock availability and the slow distribution of PPE, despite the government and health agencies knowing they needed to equip services with PPE in the weeks before the crisis took hold. Existing stocks of PPE, based on modelling for an influenza pandemic, were insufficient. Without adequate and proper PPE, nursing staff put their own lives, the lives of their families and patients, at risk. These supplies should be based on infection control guidance which reflects the latest available scientific and clinical evidence, and not dictated by cost.

PPE will be essential to cope with a potential second wave or localised resurgence of COVID-19, as well as for future infectious disease outbreaks. The government must adopt a longer-term approach to sustainably procuring and maintaining stockpiles of PPE as well as other medical equipment essential for staff and patient safety. This CSR should

harmonise procurement between government departments, and factor in additional resource to enable the expertise of clinical procurement staff to be part of the decision-making processes.

Testing

Sufficient testing infrastructure will be paramount in curtailing both COVID-19 and any future novel virus outbreaks. Testing for COVID-19 was too slow to reach the necessary scale for health care staff and the wider public and current capacity continues to pose challenges. At the peak, many nursing staff took the precaution of self-isolating when presenting with symptoms as they were unable to take a test. As a result, at the outset of the pandemic, some directors of nursing in London were reporting staff sickness rates of over 20%. This presented a significant staffing challenge and placed additional pressure on already overburdened staff.

Furthermore, startling discrepancies existed between testing for those working in the NHS and those staff working on temporary contracts in the NHS or outside the NHS completely. Members also told us that a lack of transport to remote testing sites prevented them from accessing testing facilities.

To truly plan and ensure that public services are equipped to respond to emergencies, the same speed, energy and focus applied to the COVID-19 response by frontline staff, must be used in national, regional and local planning, testing and investment to safeguard us all against public health emergencies.

Mental health

COVID-19 will have a serious impact on the mental health of our workforce and our population. The impact of lockdown may lead to increases in depression and anxiety, and nursing staff will also be likely to experience mental health issues, given the challenging circumstances in which they have provided care. Before the pandemic, nurses were already experiencing unacceptable levels of burnout and exhaustion leading to stress. We expect the UK government to support all employers by ensuring they have enough money and staff resource to offer confidential counselling and psychological support to all who need it.

The impact of government funded initiatives to support staff mental health during the first wave of the pandemic such as the “our frontline” helpline should be evaluated, including accounts from staff and employers who have used the services and an assessment of the level of take up. A new, fully costed package of care should then be made available for the continued delivery of counselling and psychological support. This costing should include promotion to all health and care staff across all settings to raise awareness of the resources available. It is vital that access to this specialist support is in place beyond the pandemic to sufficiently help staff in coping with delayed responses to trauma.

The crisis is not only having a huge impact on physical health of the population and physical health services, there is emerging evidence to suggest it is having an

unprecedented toll on the mental health of the population. Increased demand for support for depression and anxiety is likely to surge as a result of social distancing, and exposure to traumatic events.

Research from the Office for National Statistics in June 2020 revealed over two-thirds (69%) of adults were reportedly worried about the impact coronavirus was having on their lives, with 44% reporting that their wellbeing was affected. During the first two months of lockdown, mental health reportedly worsened by 8.1% with young people and women disproportionately affected. Care and services diverted towards dealing with the pandemic will impact on people who are already living with mental health conditions and could result in a detrimental health impact for those with severe mental health conditions such as schizophrenia and bipolar disorder, who have been identified as being at higher risk during the crisis. Prior to COVID-19 people with severe mental health conditions were already dying 20 years earlier than the general population.

The COVID-19 pandemic has exacerbated an existing workforce crisis and overstretched services do not currently have the capacity to support this increased demand. There is a need for a dramatically increased funding arrangement for these underfunded services, with a priority on retaining and recruiting registered nurses with expertise in mental ill health and learning disabilities. There will also be a need for funding infrastructure for service delivery.

Unequal impact of the pandemic

There were also wider socio-economic and structural factors, which affected society's resilience, and which saw different communities adversely impacted. We have witnessed the disproportionate impact of COVID-19 on BAME communities and clinicians who have been more affected than other groups. The lived experience and emerging research revealed early on that BAME health and care staff were at increased risk of contracting COVID-19, becoming critically ill as a result and dying. However, employers and governments were slow to respond with coherent strategies and actions designed to mitigate and manage these risks. This was compounded by a lack of data on death rates, including by demographic, which impacted their ability to understand the true picture and address root causes of inequality.

COVID-19 has not created health and structural inequalities; it has uncovered and exacerbated existing structural and institutional inequalities and barriers which exist across health and care, but also across wider society. The government must prioritise the reduction of health inequalities within recovery plans and deliver a national, funded cross-government strategy to tackle health inequalities and the social determinants of health with clear objectives, measurable targets and timeframes.

NHS England have published annual data since 2015, the Workforce Race Equality Standards (WRES), to highlight workplace inequalities and encourage action to close gaps in experiences between BAME and white staff in NHS Trusts and CCGs.

Often those employed at bands four to six are professionals providing care on the frontline, therefore, as BAME staff are overrepresented in these pay bands, they may be at increased risk of exposure to the viral load of COVID-19.

WRES 2019 data shows that just over one in every five of all nurses, health visitors and midwives in NHS Trusts and CCGs is from a BAME background. However, there is an over-representation at Agenda for Change band five and under-representation across all other pay bands. In 2019, there were 42,895 BAME nurses working at Agenda for Change band five, compared with 1,876 BAME staff working in management bands eight and nine.

Further, in 2019 there were 4,995 less white nursing staff in band five, compared to an increase of 3,064 BAME nursing staff in the same band that year. As the pay bands increase, data shows larger increases in the number of white staff at each pay grade, compared to the increases of BAME staff, which are much smaller the higher the pay grade. Looking at management band 8d for example, there were in fact four less BAME nursing staff in 2019, compared to an increase of 63 who are white.

The WRES data provides compelling evidence that BAME staff are over-represented in lower pay grades than their white counterparts but this data has not been utilised effectively to investigate and level up the experiences of BAME health care staff and patients.

6. Workforce accountability in legislation

Any nursing staff shortage in any setting, threatens the quality of care people receive. Prior to the pandemic, there were around 50,000 registered nurse vacancies in the NHS across the UK. This can be attributed to insufficient accountability at all levels of decision making across the system for the supply and provision of health care staff.

The Welsh government has set out legislation how decisions about staffing should be made and scrutinised. In Scotland, legislation has been passed but the implementation has been delayed due to COVID-19. We expect the Scottish government to focus resources on implementing this important legislation, including, but not limited to, any Barnett consequentials as a result of the CSR. Our members in Northern Ireland took industrial action, including strike action, earlier this year over safe staffing and pay parity. It is essential that governments in England and Northern Ireland introduce legislation to create clear roles and responsibilities for workforce planning throughout the health and care system without delay. The health and care system would have been in a stronger position to meet the challenges of the pandemic had this legislation already been in place.

Staffing for safe and effective care in England

Ambiguity about responsibility for policy and funding interventions for supply, recruitment, retention and pay has led to workforce shortages. There is currently no specific legal accountability for the provision of staffing for taxpayer-funded services. As a result, costed workforce planning is not done consistently or strategically; nor is it based on credible modelling of population health to meet patient demand. This could lead to missed care and patient safety being compromised.

At the highest level of accountability, policy makers are responsible for decisions about what health and care services can be delivered for the population through NHS-funded and local authority-funded care. There is currently a lack of political will to have this conversation transparently with the public, which means there is increasing variation in access to services and patient outcomes, exacerbated by the COVID-19 pandemic.

Health and care system leaders and frontline professionals are focused on requirements to demonstrate efficiency and productivity. These systemic pressures present conflict between the ambition of the health and care system to consistently deliver high-quality care, despite a lack of resources, such as an adequate workforce. Therefore, clarifying roles and accountabilities for workforce in legislation will provide assurance to all that there will be the right numbers of qualified nurses, in the right place at the right time to provide safe and effective care. As the population continues to grow and our workforce ages, staff shortages are set to increase so it is vital that action is taken urgently. The Conservative Party promised this legislation in its election manifesto; it is clear that the NHS Long Term Plan Bill is the best opportunity for this to occur.

While there is no question that meaningful action will require expenditure, investment provides a wider return in terms of population health, socio-economic mobility and national productivity. The workforce is also vital to health and care service delivery, and public health provision. This is key to improving population health – an important determinant of national productivity, high employment rates and low levels of sickness absence. In turn, this is critical to economic growth. Additional investment to provide staffing for safe and effective care should be based upon a robust assessment of population needs, then costed and funded to meet these needs.

In 2018 the NHS received a long-term funding settlement, but there have been no such packages for either public health or social care. The 2019 NHS Long Term Plan for the NHS was contingent upon there being stability within social care, so as not to put additional pressures on the NHS. Much of the funding for social care in England is through local authorities, the vast majority of which are having widespread funding challenges. In practice, this has led to higher thresholds for accessing care, meaning that people who need support for social care may no longer be eligible to receive it. We believe that a long-term funding settlement for social care in England is needed. The Health Foundation estimates that there needs to be an additional investment of £12.2bn on top of funding available in 2023/24 to restore 2010 levels of service and provide stability in the social care workforce . However, funding must be based on a robust assessment of population needs beyond 2010 levels, as health and support needs have changed across society.

Workforce data coverage and workforce strategy in England

There is no overarching health and care workforce plan or strategy in England. This limits the ability of the system to supply the necessary numbers of nurses and to plan for staff numbers in the future. Developing a credible workforce strategy for the longer term is challenging due to a lack of comprehensive data on current nursing staff working in all settings and the numbers of nursing students graduating, both within the NHS and the wider care system.

It is only with a full and complete picture of our health and care workforce that the government can be sure that we are equipped with the fully trained workforce required to meet current and future patient need.

With this in mind, the government must create and fund a workforce strategy in England that:

- determines current and future population need, based on open and transparent data and engagement with stakeholders
- includes future demand for all health and care services and not just the NHS, as was the recent case with the NHS People Plan
- sets targets for future workforce as the basis for funding the whole nursing supply chain, including relevant higher education public bodies.

7. Nursing education and supply of new graduates

All nursing students across the UK must have access to adequate financial support for tuition and the cost of living to support them during their studies. Every country across the UK will need to substantially increase their nursing workforce supply in order to put our health and care system and the nursing profession on a sustainable footing. Sufficient funding will be required to achieve this.

We also call for sufficient and dedicated funding for continual professional development (CPD) for all nursing staff, in all health and care settings, alongside pay progression and career development opportunities. Funding must be based on modelling on future service and population-based need as well as the skills mix required.

Student funding in England

There are not enough people studying nursing at university in England. The government reformed the way that nursing higher education was funded and planned in the 2015

CSR. Formerly, the government paid the fees directly to universities and gave modest bursaries to students to support their study. The 2015 changes moved from a centrally commissioned model to a 'market led' model where students pay their own fees, primarily through student loans, and, until recently, received no living grant support from the government.

The intended aim for the reforms was to significantly increase the number of people studying nursing. Whilst the number of people on courses has risen for this upcoming academic year 2020/2021, this equates to approximately 4,600 new students. This small increase in applications falls far short of how many nurses the government needs to close the vacancy gap and achieve its 50,000 more nurses target. We are only now seeing a rise to the levels of 2016, the final year of the directly commissioned model. This represents three years of lost growth.

We know that the prospect of debt reduces the number of people who choose to study nursing as this was a key finding from our research detailed in our report Beyond the Bursary: Workforce Supply. This is why we call on the government to:

- abolish self-funded tuition fees for all nursing, midwifery, and allied health care students
- introduce universal, living maintenance grants that reflect actual student need
- reimburse tuition fees or forgive current debt for all nursing, midwifery, and allied health care students impacted by the removal of the bursary.

Costed student funding models for England

We commissioned London Economics to model the illustrative costs of the first two of the above policy changes with two different costed models. We outline these models in detail in appendix one.

Nurses for all health and care settings come from the same supply pipelines. Therefore, government efforts to increase student numbers will have benefits across not just the NHS, but also in social care, cancer care, community nursing and the independent sector.

The government must not miss the opportunity to act

The government only has one more academic year to substantially increase nursing graduates in England to meet their target of 50,000 more nurses by the end of this Parliament. We expect bold action – above what has already been promised - to increase student numbers by removing financial barriers for those students applying for the 2021/22 academic year and to financially support and retain those already on courses.

The reforms to health care education funding in the 2015 CSR created a complex and interdependent system, where many of the levers for increasing nursing supply sit outside of the remit of health decision makers, either with the Department for Education or the education regulators.

This CSR must avoid replicating the fragmented approach to higher education funding that happened in the 2015 CSR. Instead, the government should take a strategic approach, setting out how many nurses England needs in the future and working backwards to fund all parts of the higher education supply chain – including education and health and care bodies – to meet this aim. This means, among other things, understanding the true cost of clinical placement provision, capital and teaching costs for both universities and employers.

CPD

Nursing education across the UK must not end at the point of graduation. CPD enables registered nurses to develop their careers, become specialists in areas of care such as cancer, as well as design and deliver innovative care models to meet changing population needs. Career development is key to keeping professionals supported within the workforce, essential for ongoing safe and effective practice, and for career progression; all of which contribute to retention.

Crucially, funding for CPD in England is essential for meeting the transformative care goals and clinical placement capacity expansion in the NHS Long Term Plan. However, the government cut the overall funding for CPD in England in the 2015 CSR; the Health Education England (HEE) budget for CPD for nurses was cut by 60%, over two years from £205million in 2015/16 to £83.49million in 2017/18. In contrast, the 'future workforce' postgraduate medical and dental budget was increased by 2.7% in 2017/18. This is a significant and unfair disparity between nursing staff and their medical colleagues which must be reconciled.

The government announced an increase of £150 million in the CPD budget for NHS nursing, midwifery and allied health staff in the 2019 spending round. While welcome, this represents approximately a £30million funding increase over the 2015/16 levels, despite years of staff growth, under-investment in professional development and inflation. The government must go further and develop a strategic approach to the levels of CPD required and fully fund it accordingly.

Finally, we remain concerned that government CPD funding continues to focus solely on NHS staff. This leaves out a significant number of nursing staff across publicly funded services, social care, community work and the independent sector, all of whom also need CPD. These staff struggle to access CPD through their employers and so the government must use this CSR to increase CPD funding for all nursing staff in all settings.

There are approximately 192,000 registered nurses in England on the Nursing and Midwifery Council register not currently employed by the NHS. Not all of these staff will be currently working. However, as a rough guide, parity with the government's £1000 fund currently only for each NHS worker would cost the Exchequer £192m per year for these non-NHS staff to be given the same opportunities as their colleagues.

8. Internationally educated nursing staff

International nursing staff have always played a vital part in sustaining our health and care services by providing patient care. The latest available data as of March 2020 shows that 12% of the UK's registered nurses were internationally educated, whilst a further 4% qualified in the EEA. However, the UK still faces critical nursing shortages and the government continue to create additional and unjust burdens on our much-needed international workforce.

The Immigration Skills Charge

International recruitment cannot be used as a substitute for domestic training and supply. However, given that it takes at least three years for new nurses to qualify, it is clear that international recruitment will have to rapidly increase in at least the short to medium term if the government is to reach its target of 50,000 more nurses in England before the end of this Parliament. The ongoing financial pressures on both the NHS and social care means there is a real risk that the Immigration Skills Charge will deter organisations from recruiting internationally, which will impact safe staffing levels and patient safety.

Currently, health and care employers are required to pay a fee called the Immigration Skills Charge of up to £5,000 when hiring an internationally educated individual from outside the EU; this fee will also apply to employment offers made to EU nationals once freedom of movement ends in January 2021. Medium or large sponsors are required to pay a fee of £1,000 for hiring an international health care worker for the first 12 months of their visa. This fee then reduces to £500 every six months after that for the duration of their Tier 2 visa.

For some organisations this can amount to millions over a few years as employers continue to rely on international staff to fill domestic gaps. Portsmouth NHS Trust for example has paid the government £2 million since 2017. We explored rough considerations as to how much the NHS in England will pay on average from recruiting nurses internationally. Overseas nurses make up around 25% of nurses joining the NHS each year, which roughly equates to around 3,465 individuals. This means that NHS Trusts alone will be paying over £3 million per year in order to fill registered nurse vacancies.

These fees are clearly untenable for a system already facing such financial pressure and will act as a significant barrier to recruiting the staffing levels needed for patient safety. It is also not appropriate to divert funding away from the budget for frontline health services and the training of health professionals in this way. Whilst it is claimed by government that this money is reinvested into the system, this has not been publicly evidenced and does not amount to new money to support health and care delivery.

Nursing shortages across the UK are evidenced and it is wrong to penalise employers for recruiting internationally into positions that our domestic labour market simply cannot fill. Employers do not have any levers available to them to recruit domestic nursing staff if there aren't enough nurses being trained in the UK. It is government's responsibility to deliver the workforce necessary to meet our population needs and in turn, it should therefore be the government's responsibility to meet the costs associated with recruiting internationally as a result of insufficient domestic supply. It is for this reason that we expect an exemption for all health and care employers across the UK from the Immigration Skills Charge and for this CSR to account for the costs incurred.

No recourse to public funds

Staff retention is essential for patient care and the sharing of knowledge and skills and therefore, retaining existing international staff is an important aspect of this. However, we are concerned that hostile migratory policies and policy development by the Home Office run the risk of forcing international staff to leave the UK prematurely. In particular, we are concerned that the no recourse to public funds condition applied to migrant workers is a key disincentive to retention and another example of failing to recognise the value they bring.

Anecdotally, our members have reported the impact that no recourse to public funds is having on their lives. Whilst British nationals unable to work whilst shielding or self-isolating due to COVID-19 have benefitted from the security of public financial support, we are concerned that migrant workers are being forced to choose between continuing to work despite being at risk, or otherwise staying at home and falling into destitution. This is wrong and will put staff and patient lives at unnecessary risk.

Both before and during the pandemic, internationally educated nursing staff have made an invaluable contribution to patient care as well as a significant financial contribution towards our public services through taxes and national insurance. This CSR is an opportunity to put right the barriers which international health and care staff face in accessing financial support and benefits, so that they are free from the fear of COVID-19 or further instances of their own ill-health impacting their status or employment in the UK.

The Immigration Health Surcharge (IHS)

We welcomed the government's announcement in May 2020 to automatically exempt health and care workers and their dependants from the IHS as a positive recognition of their contribution and value to the UK. This was an immoral fee as health and care staff were already contributing to our health care services by virtue of their work and through national insurance and taxes. Whilst this announcement was necessary, we are concerned about how this exemption will apply in practice, in particular the administration burden and fairness surrounding the reimbursement scheme.

Under current plans, only registered professionals eligible for the new Health and Care Visa will receive an automatic exemption, whilst all others – including international social

care staff who have already been providing patient care for many years - will still have to pay this charge upfront in full to be reimbursed in increments. This will disproportionately affect lower paid unregistered staff - particularly in the social care sector. With the IHS set to rise in October to £624 for adults and £470 for dependants, individuals will be expected to pay thousands of pounds, which will be unrealistic and financially debilitating for many.

Plans to reimburse key staff in six-month increments clearly go against the spirit of the government's initial announcement and simply do not go far enough to incentivise workers to stay in the UK. The administration and costs surrounding the reimbursement far outweighs the benefits of granting immediate and automatic exemptions to the surcharge for all health care staff. It is also another example of the fragmentation and disconnect between the NHS and our wider health and care services. We expect the government to automatically exempt care workers and their dependants, not just registered professionals, and all staff should also be eligible for the new health and care visa.

9. Public health across the UK

Health and wellbeing of a population is not solely dependent on access to acute hospital care. COVID-19 has clearly shown the vital importance of all health and care services including care in general practice, the community and care homes.

Even before COVID-19, life expectancy in the UK had stalled and in some areas was declining. Across all health indicators including obesity there are striking inequalities; people from deprived areas are more likely to live shorter lives and spend fewer years in good health. In the UK, smoking caused an estimated 115,000 deaths in 2015 , whilst alcohol caused around 7,700 deaths in 2017. This is despite government pledges to prevent ill health and reduce health inequalities. We call on governments across the UK to fully fund long-term public health strategies and the agencies who have been devolved the power to deliver public health services in our communities.

Public health funding allocations in England

Funding for public health services and interventions in England has not been consistent and has suffered under austerity measures. The public health grant has been cut by more than a fifth (22%) since 2015/16. Consequently, this has meant that local authorities are unable to provide vital functions that promote wellbeing and prevent ill health and the reductions in outreach services such as smoking cessation, sexual health and children's public health, impacts population health and life chances.

In the 2019 spending round, we welcomed the Government's decision to begin to reverse these cuts and instead increase the public health grant for 2020/2021. However, the

2.6% increase announced for 2020/21 was far short of the £1 billion per year estimated to be needed if we are to begin to restore services. Restoring the public health grant to previous levels is not sufficient and will not support a productive and healthy rebuilding of public health services in a post-coronavirus world.

These essential services have been further impacted by COVID-19 and many have been paused. Research from the Local Government Association estimates that local councils could face estimated financial challenges of nearly £11billion in 2020/2021 because of the pandemic. Whilst we recognise that the government made available £3.2billion in grant funding, the projected gap is still significantly substantial and damaging to the future of local authority commissioned services, many of which provide vital public health interventions. We expect parity between how the government funds and resources NHS services with all publicly funded services including those commissioned and led by local authorities.

Looking beyond COVID-19, without adequate and sustained investment in public health, the government risks falling short of achieving its own ambitions including to 'level up' health inequalities; those in the Prevention Green Paper; the Sustainable Development Goals and in the Government's recent initiative on obesity. The government must revisit previous calculations and intentions to marginally increase the public health grant, and instead use this opportunity to deliver an increased, sustainable, long-term funding settlement for local public health that meets demand and supports efforts to embed prevention and reduce health inequalities.

Public Health England

Furthermore, the government's recent decision to disband Public Health England is another example of government rhetoric on prevention not meeting reality, as it is a decision taken at a time when public health and health protection have never been so vital and requiring stability.

The plans for the new National Institute for Health Protection currently exclude vital public health functions including health improvement and prevention. There is a lack of assurance that services including sexual health, smoking cessation, health visiting and school nursing for example, will remain and continue to be a priority. In this indefinite space whilst we wait for leadership for public health duties, this makes it even more imperative that there is clarity for the long-term funding arrangement. The government must fulfil its responsibilities to support the health and wellbeing of our population; nursing staff are key to successful health protection and public health services, but they cannot do their work if their services are decommissioned and deprioritised. Public health nursing staff need to be supported in tackling issues like obesity, smoking and alcohol abuse, to ensure sustained long-term health improvements for the population.

The COVID-19 pandemic has added further impetus to the need for a policy making and funding approach which focuses on preventing ill health and levelling up society in the longer term. This is why we call for this CSR to set out a shared cross-government funding commitment to prevention and reducing health inequalities.

10. Further information

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11. Appendix

England costed student funding models

Option 1

Moving to means-tested maintenance grants plus non means-tested tuition fee grants: under this option, students receive up-front funding for tuition fees as a grant and all students receive a means-tested maintenance grant of the same value they would currently receive in loans. This could be up to £20,252 for each student per year, depending on where someone lives in England and whether they live at home. Our modelling shows that this will conservatively result in:

Benefits

- An 8.5% (1,080) increase in the number of new graduates per cohort generated by the funding alone; of which
    - 850 extra qualified nurses entering the NHS post-graduation
    - an additional 4,790 NHS 'nursing years' in the decade post-graduation – part of the new total of 61,020 total years of NHS service per cohort.
- A benefit to the Exchequer of £132 million achieved through a reduced reliance on bank and agency staff in publicly funded services as there are more staff available.

Costs

- The total impact on the deficit during the period of study would be £743 million; this is a net £310 million extra over the current student funding model. This is approximately £100-110 million per year during the period of study.
- The total additional cost to the Exchequer over the lifetime of the cohort is £403 million per cohort compared to the current funding model.

Option 2

Maintenance grants, plus forgivable tuition fee loans, written off in chunks at three, seven and 10 years after the student graduates: Under this option, students would receive a non means-tested £10,000 maintenance grant towards their living costs each year. Nursing students would also be able take out a tuition fee loan. However, this loan would be forgiven in return for working in publicly funded health and care services after graduation.

The loan would be written off in increments: the first 30% after three years, the next 40% after seven years and the full amount 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. Our modelling shows that this will conservatively result in:

Benefits

- A 6.3% increase in the number of new graduates per cohort (830 graduates for this cohort size of 16,020); of which
    - 650 extra qualified nurses enter the NHS post-graduation
    - an additional 6,850 extra 'nursing years' in publicly-funded services in the decade post-graduation – part of a total of 63,080 total years of NHS service per cohort.
- A net extra benefit of £172 million (out of a total benefit of £1,717 million), achieved through a reduced reliance on bank and agency staff in publicly funded services.

Costs

- The total impact on the deficit during the period of study would be £678 million, a net £245 million extra over the current student funding model.
- The total cost to the Exchequer over the lifetime of the cohort's loan is £595 million, or an additional £298 million per cohort over the current funding model.

We present these options as illustrative examples of the necessary investment to increase student numbers. They do not represent the full level of investment that is required. Without policy change, it is unlikely that the government will meet its 50,000 more nurses target – and the commensurate improvement in patient outcomes – by the end of this Parliament.

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