Royal College of Nursing Submission to the NHS Pay Review Body: 2021/22 Pay Round

January 2021

RCN Submission to the NHS Pay Review Body: 2021/22 Pay Round

1. The RCN is making a pay claim of at least 12.5% for all Agenda for Change staff

1.1 The RCN's claim of 12.5% is based on a clear message from our membership. We have been undertaking continuing listening exercises with membership in order to understand the impact of the COVID-19 health crisis on their personal and professional lives. Many of their experiences of this pandemic only serve to reinforce the evidence of what was already known about the nursing workforce; one that was suffering from staff shortages, low morale and operating in an environment deprived of investment and resources, as well as real terms pay decrease.

1.2 A key part of our member engagement and consultation activity has been a large survey of nursing staff working across the UK in all health and social care settings undertaken in May and June 2020. This survey, which asked a wide range of questions about their working experiences since the start of the pandemic, received the highest ever response to any RCN membership engagement which illustrates the strength of feeling among our members. It is also noteworthy because it is the first time they have told us in clear terms about what pay increase they feel nursing staff should receive. It is because of this feedback that we take such a firm position in calling for an increase of 12.5% for 2021-22.

1.3 We call on the Pay Review Body to make its recommendations without being constrained by narrow definitions of affordability. An assessment of the long-term structural issues in the nursing workforce, highlighted and exacerbated by the COVID-19 pandemic, show the obvious need for the PRB to make the evidence-based recommendations necessary to tackle the recruitment and retention crisis. While we call upon the PRB to make the necessary recommendations to deal with the impact of a decade of real terms pay cuts, we also call upon the Governments to take the political responsibility for funding those recommendations.

1.4 Nursing is a safety critical profession, yet it cannot fulfil its role while there are such high vacancy numbers. Not only do vacancies compromise the delivery of safe and effective care, but they hinder nursing staff in driving forward service improvement and addressing those health inequalities that the pandemic has so harshly demonstrated to be at the heart of society. A fair pay award is necessary to recognise the skills, experience and responsibility demonstrated every day by every nursing support worker, registered nurse and nursing associate.

1.5 Our submission is made at the height of the COVID-19 pandemic. At this stage it is impossible to forecast how long the pandemic will last, or to foresee the longer-term impact on the UK economy, the population's health and wellbeing, the NHS or its workforce, although hopes are pinned on the successful roll-out of a vaccine. It is too early to ascertain the full impact, yet it is apparent that the pandemic has exposed weaknesses in the health and social care system that have restricted its ability to respond to the crisis. Chronic staff shortages, especially in emergency and critical care nursing have impacted on the system's ability to cope both with the pandemic as well as ongoing service demands. It has also exposed fundamental vulnerabilities and inequalities in our society. We understand that those people worst affected by the virus

are generally those with worse health outcomes before the pandemic and that tackling those inequalities will require sustained investment in public health and prevention.

1.6 Nursing staff have been directly involved in dealing with the health crisis, including clinical treatment, decontamination, isolation, communication, triaging, as well as psychological support of patients, their families and colleagues. All have been directly and indirectly impacted by changes in service delivery, with many redeployed into new roles, quickly adapting to new environments and roles. Nursing staff also face the risk of injury and infection, as well as anxieties and stress concerning their workload and the impact of the pandemic on their families.

1.7 At the start of the pandemic, the most pressing concerns were the shortage of PPE, medical supplies and the fear of infection, yet nursing staff continued to provide care in the face of fear and concerns about safety. These risks, which continue as the situation continues, are exacerbated by psychosocial impacts on the workforce. Nursing staff are experiencing stress associated with sleep deprivation, exhaustion due to heavy workloads and inability to take breaks due to demand and staff shortages. Psychological impacts are likely to have both short- and long-term consequences for individual nurses and nursing support workers. The pandemic has also had a major impact on staff training opportunities, as many programmes have been paused. This is likely to have an impact on career progression as well as motivation and retention.

1.8 During this time of crisis the nursing profession has finally been seen as the critical profession it really is. As Matt Hancock stated in March this year: “Nursing is the life blood of the NHS, pure and simple, without nursing, the NHS dies.” [1] But it should not take a crisis to value the nursing workforce.

[1] www.gov.uk/government/speeches/nhs-nurses-we-thank-you-for-your-service-as-we-get-through-coronavirus-together

RCN Survey and Member Intelligence

RCN Member Survey 2020

This submission draws on results from an RCN member survey undertaken in May and June 2020. All members were invited to take part in the research and the survey received 41,798 responses. This submission presents results from 28,666 respondents who indicated they work in the NHS. Of these respondents, 92.4% are registered nurses/midwives/health visitors; 0.9% are nursing associates or trainee nursing associates and 4.8% are nursing support workers.

In terms of employment status, 91.2% were in employment at the time of the survey; 4.8% were on either on sick leave or in self isolation due to the pandemic; 1.8% were either on sick leave (unrelated to the pandemic) or on maternity leave. A very small number (n=75) were on furlough.

RCN Member Engagement

The RCN has been undertaking extensive and systematic engagement with members, our accredited reps and senior nursing leadership throughout the health and social care system during the pandemic, in order to collect and respond to developments. As part of this engagement, we cross reference and verify any feedback so that we can build a credible picture of how services are responding to the pandemic and how this impacts our members at all levels of the workforce. In our submission to the PRB, we present this as internal intelligence to illustrate the emerging situation in the NHS.

2. The economic case for a pay rise

2.1 The remit letter for the 2021-22 pay round, subsequent to the November Spending review, which had identified £3 billion additional funding to support the NHS recovery in England, is highly disappointing. The Spending Review committed no additional funding for pay and the remit letter points to a return to public sector pay restraint. The combination of these two announcements will mean NHS organisations facing difficult choices between increased pay, jobs and service delivery.

2.2 The Spending Review announced further money for COVID-19 testing, PPE and vaccines and recovery. The detail of how this money will be used and against which priorities will be important. The RCN has always been clear that decisions around funding, service delivery and workforce must not be taken in isolation. Instead, comprehensive workforce modelling and an assessment of the services required to

meet local need must inform the funding granted to the system in order to deliver these requirements.

2.3 As an organisation which represents members from across the United Kingdom, we have called for the Government to ensure all public spending announced is reflected in the Barnett Formula and consequentials so that devolved governments and their populations also benefit We would welcome greater transparency from the Exchequer on the 2.6bn announced for devolved nations - 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.

2.4 Previous experience of recessions - particularly that of 2008/9 - provide clear evidence of the need to design a comprehensive stimulus package which boosts productive potential in the long-term. This includes the need to address the fundamental weaknesses in the UK's health, care and welfare systems which have been exposed.by the pandemic. Investment in health and social care – in infrastructure, technology and the NHS and social care workforce – must be a key part of the policy response. Investment in equipment, buildings, therapies and staff must be part of a comprehensive package to rebuild resilience in our health and social care sectors. Austerity has caused deep damage to the public sector and should not be repeated.

2.5 A substantial pay rise for NHS staff will not only help to redress the chronic underinvestment in the workforce, but will have provide a virtuous circle effect within a wider economic stimulus programme, serving to boost the whole economy. All would result in an increase in income tax and National Insurance contributions, as well as multiplier effects from extra spending of disposable income to the wider economy. This creates both further indirect and induced employment gains in other sectors and this is particularly important for those regions which were already struggling socially and economically. 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.

2.6 We support the Health Foundation's assessment that the NHS should commit to anchor workforce strategies which 'involve thinking not only about how the NHS can grow local workforce supply and widen access to employment for local communities, but also how it can be a better employer and place to build a career for more people[i]. It acts as an anchor not only in the number of jobs it creates, but in how it can support the health and wellbeing of its staff through good employment conditions and the working environment.' They go on to say, 'being an anchor means ensuring that the NHS provides secure employment and fair compensation so that all its staff can live with financial security, not least because in some areas the NHS is the largest employer.' Moreover, as an employer of a largely female and diverse workforce, it has both the responsibility and opportunity to advance social mobility.

2.7 The need for investment in the NHS as an anchor institution and the NHS as an anchor workforce has been highlighted as being particularly important in assessing the impact of the COVID-19 pandemic. The health crisis has exposed and reinforced the deep-seated spatial and societal inequalities which exist in the UK. The people who have been worst affected by the virus are generally those with worse health outcomes before the pandemic, including people working in lower-paid professions, those from some ethnic minority backgrounds and people living in poorer areas. In economic terms, the most deprived areas of the UK have suffered the most and will take longer to

recover. Investment in the NHS workforce is necessary to support local economies and populations.

2.8 There is a clear economic and social imperative to investment in the NHS workforce. The announcement of a public sector pay freeze in the Spending Review and clear reference to this in the Secretary of State's remit letter is therefore both alarming and at odds with the Government's commitment to level up the economy. A pay freeze will slow the wider economic recovery in those areas of the country which are at the heart of this agenda. A pay freeze will also hit a predominantly female workforce. This is even more stark for the nursing workforce, where a decade of pay freezes on top of historical undervaluation of the nursing role have resulted in a graduate profession which has limited access to career progression opportunities, is underpaid and undervalued.[2]

2.9 The argument that it is unfair to give public sector workers a decent pay rise when wages are not increasing in the private sector is illogical and poor economics. Essentially cutting salaries in real terms will result in less disposable income circulating throughout the economy, and the firms that are relying on a return to normality at the end of the pandemic will see consumers unable to make the purchases required to support businesses in the longer term. Public sector pay freezes will further destabilise the businesses the government is attempting to prioritise.

2.10 Having suffered weak economic growth as a result of austerity since 2010, a public sector pay freeze is simply repeating the same mistake. There will be those that suggest that the level of borrowing resulting from current government expenditure requires an immediate response; however, with interest rates at all-time lows, the burden of debt interest payments is lower than in 2010-11, despite levels of debt being higher. It is key that the government focuses on the affordability of the debt, rather than the current level of debt, and reducing debt levels can only occur through a thriving inclusive economy. The consequences of withdrawing much needed financial stimulus through public sector pay freezes would limit the economic recovery and would be self-defeating.

2.11 The government should be doing everything it can to support the recovery of the UK's economic and social health. This includes increasing the capacity and resilience of the NHS, and as a highly labour-intensive organisation, this must include investment in the workforce. All public sector workers, including the NHS have suffered real terms pay cuts over the last ten years and using the plight of private sector workers to justify further hardship to public sector workers is dangerous as it causes divisions and pits one sector against another.

2.12 The NHS workforce knows that all public spending is a political choice. Recent spending decisions including those on contracts to supply equipment and testing capacity to deal with the pandemic will inevitably be weighed against the pay decision in assessing how NHS workers feel valued.

2.13 We urge the PRB to undertake the review process quickly to ensure a timely pay award, to provide certainty to the NHS workforce and to ensure that financial support is afforded then to as soon as possible. As we near the end of 2020 - the World Health Organization's International Year of the Nurse and Midwife – all UK governments must provide the investment and support that the nursing profession requires in order to enable health and care services to meet the challenges of the COVID-19 pandemic and its aftermath including rehabilitation and clearing the backlog of care.

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[2] RCN (2020) *Gender and Nursing as a Profession: Valuing nurses and paying them their worth* www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2020/january/007-954.pdf?la=en

Modelling the cost of a 12.5% pay uplift

2.14 To support our PRB submission, Staff Side unions commissioned London Economics to undertake independent research on the net impact to the Exchequer of increasing pay for Agenda for Change staff.

2.15 The research undertook detailed economic modelling of the impact of a 5% and 10% increase in the total AfC pay bill (for AfC staff in England) as well as separate RCN commissioned additional research on the effects of a 12.5% increase which matches the RCN's claim for 2021-22.

2.16 It concluded that of the initial outlay (corresponding to £4.25bn associated with a 12.5% increase):

- The Treasury would recoup 47% (equivalent to £2bn of the additional pay bill cost through collecting the income tax and NI insurance contributions of AfC staff and their employers alone.
- The Treasury would recoup a further 26% (£1.1bn) of the additional pay bill costs through direct, indirect and induced taxation receipts resulting from the impact of AfC staff' spending of the additional disposable income throughout the wider economy.
- There would be a significant impact on recruitment and retention and reduced reliance on Bank and Agency staff over a 10-year period, resulting in overall cost savings to the Treasury corresponding to £0.16bn
- The research also modelled the impact of cost savings from a reduction in student loan write-offs (for a given cohort of English-domiciled students undertaking nursing degrees), which they calculated would generate an additional £0.17bn

In total, this means that increasing the AfC pay bill by 12.5% has a net cost of just £0.82bn to the Treasury.

Table 1: Exchequer costs and benefits associated with a 5%; 10% and 12.5% increase in total AfC pay in 2021-22

Impact on the Exchequer	5% increase on total paybill	10% increase on total paybill	12.5% increase on total paybill
'Headline' Costs	£1.70bn	£3.40bn	£4.25bn
Additional income tax and NI receipts from AfC staff	£0.79bn	£1.60bn	£2.0bn
Additional wider tax receipts from AfC staff's consumption	£0.44bn	£0.89bn	£1.1bn
Cost savings from reduced reliance on Bank and Agency staff	£0.06bn	£0.13bn	£0.16bn
Cost savings from reduced student loan write-offs	£0.07bn	£0.13bn	£0.17bn
Benefits	£1.37bn	£2.74bn	£3.43bn
Net Costs	£0.33bn	£0.66bn	£0.82bn

3. Impact of COVID-19: workforce numbers

3.1 At the start of the pandemic, emergency measures were put in place to expand the workforce quickly to meet the expected surge in demand. The NMC temporary register was launched in March 2020 to allow former registrants and overseas-trained staff in the process of applying for UK registration, to join the workforce. In addition, student nurses were invited to take on paid clinical placements.

3.2 As at July 2020, there were 14,243 people on the temporary register made up of three main cohorts: those who had left the permanent register in the last three years (66%), those who left the permanent register in the last three to five years (16%) and eligible overseas registration candidates (18%).

3.3 The NMC administered a survey to these people on the temporary register, with 9,433 (66%) replying. Of these respondents, just over half (56%) had not started working, practising or received an offer of employment at the point they filled out the survey; around a quarter (28%) had started practising as a nurse or midwife, and 11% had received an offer of employment but not yet started.

3.4 Just over a third (36%) said it was highly likely or possible that they would want to join the permanent register. Nearly a quarter (23%) percent) said it was possible, and 14% said they had not yet decided. Just over a quarter (27%) said it was highly unlikely.

3.5 While we do not have an overall picture for the UK, we have some data for the NHS in England and Scotland in this temporary workforce. Data for the NHS England workforce show that by July 2020, there were 147 registered nurses who had returned to practice working in the NHS (out of a headcount of 328,242) plus 10,036 students in employment within the nursing support workforce (making up 3.1% of a workforce of 328,242). These numbers, however, are likely to be higher as data do not record all staff that have returned to the NHS as part of the scheme. Many are likely to be recorded on contract types, for example fixed term, honorary or bank contracts, that are not fully accessible through ESR data. Many are also likely to have been employed via NHS Professionals.

3.6 Data for the NHS Scotland workforce shows that by June 2020, 2,423 nursing students were in employment within the nursing support workforce (making up 3.8% of a workforce of 63,178). [3] This data is an underestimate, however as some NHS employers added student details only to the NHS payroll system and not also to the NHS HR system, in order to progress induction at pace. NHS Education for Scotland exclude individuals not recorded on both systems from the NHS Scotland national workforce statistics. Nursing students in Scotland on Band 3 clinical placements left the workforce on 30 August and contracts for those on Band 4 clinical placements ended on 30 September. We therefore do not have a clear picture on the number of nurses who have returned to practice in NHS Scotland.

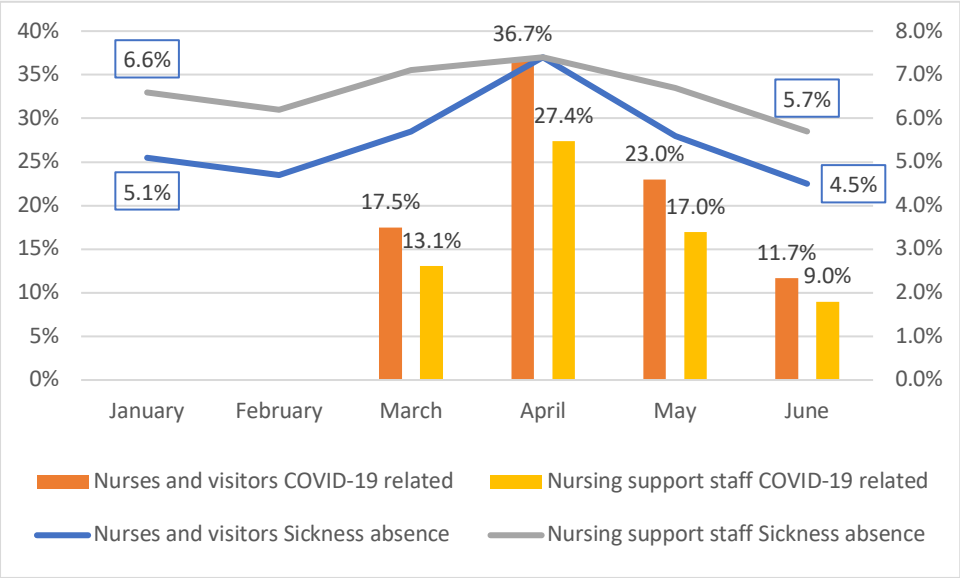
3.7 The King's Fund commented on the return to practice of health care professionals and described this collective action as impressive but stated that it also highlighted 'how thinly stretched the workforce was, even with a lengthy pause on elective health care.'[4]

3.8 The pandemic has also severely impacted workforce numbers through sickness absence and staff members self-isolating or shielding. The RCN receives regular reports on staffing pressures and one typical report from an Emergency Department in an England trust in December showed that it was a dealing with 4.4% of staff on sick leave due to COVID-19 related illness or self isolation, a further 3.5% off on non-COVID-19 related sick leave and 1.8% on maternity leave.

3.9 Figure 1 shows data for the England workforce, and that since the start of the pandemic, sickness absence rates among nursing staff were highest in April 2020, peaking at 7.4% for both registered nurses and health visitors and for nursing support staff[5]. Of those absences, over a third (36.7%) were COVID-19 related among nurses and health visitors, and just under a third (27.4%) among nurse support staff. The latest figures for June show that absence rates had dropped significantly. However, data for the whole workforce shows that absence rates have grown since June, and that around 38% of all absences are related to COVID-19.

[3] 01 September 2020 | Turas Data Intelligence (nhs.scot)
[4] www.kingsfund.org.uk/sites/default/files/2020-10/Health-social-care-select-committee-evidence-submission-workforce-burnout_0.pdf
[5] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates/june-2020

Figure 1: Sickness absence rates January to June 2020; COVID-19 related absence rates as proportion of sickness absence March to June 2020: England

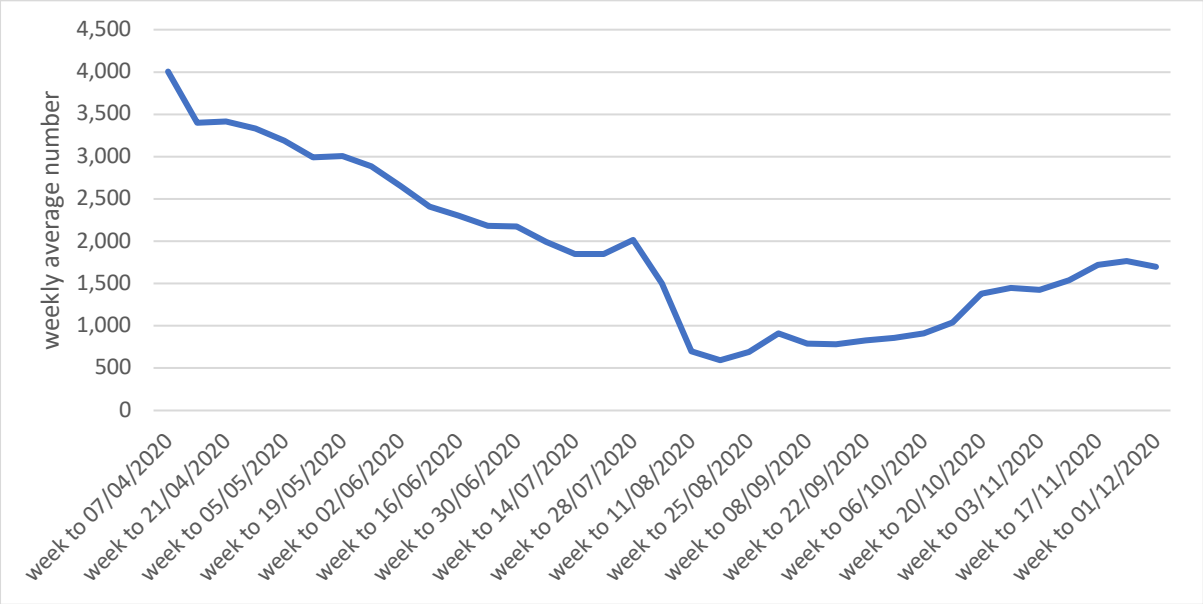


Source: NHS Digital

3.10 Data for the Scotland NHS workforce show the number of nursing and midwifery staff reporting absent due to COVID-19 was highest in April 2020, approximately equivalent to 5.8% of the headcount workforce. [6] The latest figures for December 2020 show that following an overall decrease to mid-August, reported absence from nursing and midwifery staff due to COVID-19 has been increasing.

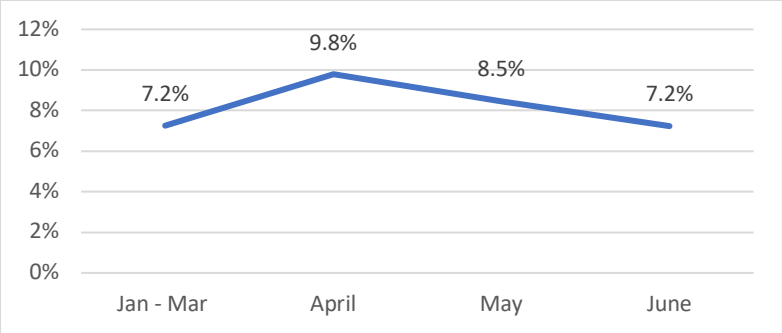
[6] https://www.gov.scot/publications/coronavirus-covid-19-daily-data-for-scotland/

Figure 2: Weekly average number of NHS Scotland nursing and midwifery staff reporting as absent due to COVID-19, April to December 2020



Source: Scottish Government

Figure 3: Sickness absence rates, January to June 2020. Nursing, Midwifery and Health Visiting staff: Wales



Source: StatsWales

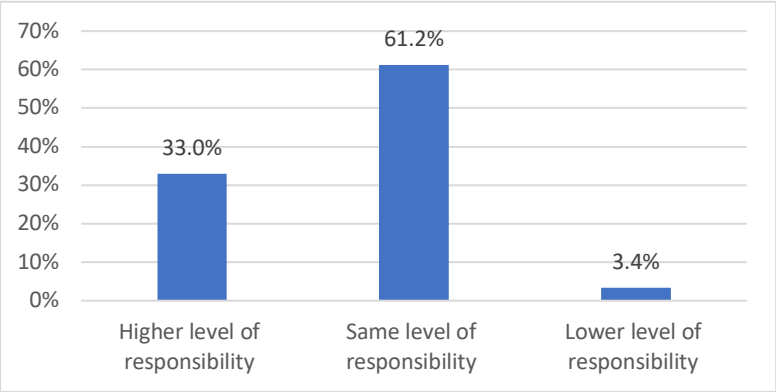
4. Impact of COVID-19: employment experience

4.1 While the COVID-19 pandemic has impacted on all nursing staff personally and professionally, a significant number have seen immediate changes to their employment, including moving to new roles, acquiring new skills and assuming higher levels of responsibility.

4.2 Results from the RCN's 2020 membership survey show that a third of all respondents working in the NHS stated they had been working at a higher level of responsibility during the pandemic as services and roles adapted to meet new demands. There was little variation among respondents working at a higher level according to AfC pay band, demonstrating the impact on working lives for all types of nursing staff.

4.3 Respondents were also asked whether this change in level of responsibility was remunerated. The majority (93%) stated they were not paid for this work.

Figure 4: Change in level of responsibility during the COVID-19 pandemic compared to before the pandemic

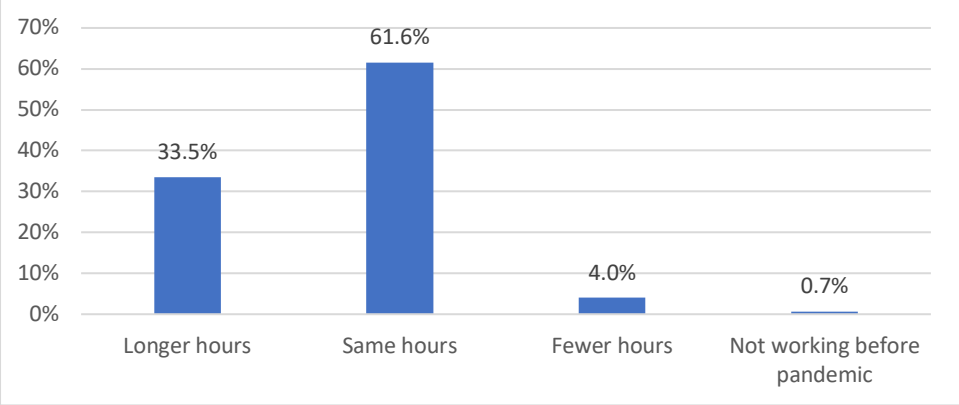


Source: RCN Pay and Working Conditions Survey 2020 NHS respondents

4.1 Working hours over the COVID-19 pandemic

- Six in ten state they are working about the same number of hours than before the pandemic
- A third state they are working longer hours
- A small proportion (4%) are working fewer hours
- Of those working longer hours, four in ten (41%) stated these hours were unpaid, while 19% stated they were only paid sometimes and 38% stated they were always paid.

Figure 5: Working hours compared to before the COVID-19 pandemic



Source: RCN Pay and Working Conditions Survey 2020

4.4 Long hours working has only exacerbated during the pandemic. The 2019 Northern Ireland HSC Staff Survey shows that 59% of nursing and midwifery respondents (compared to 50% of all occupations) work unpaid overtime and of those respondents just 17% describe this as acceptable. The 2019 England staff survey shows that 67.5%

of registered nurses and 32.6% of nursing and healthcare assistants worked unpaid overtime on a weekly basis (compared to 55.9% of all occupations).

4.2 Redeployment and temporary service change

4.5 In response to the pandemic, staff have been asked to temporarily work in a different or unfamiliar care setting. The quotes below from respondents to the RCN Member Survey encapsulate the impact on staff affected, both by being redeployed and being part of a unit where staff are deployed to and the changing emotions over the time of the pandemic.

> *"Since end of March/beginning of April we were overworked ITU. The situation has slightly improved now that the cases have decreased but we still have more patients than the staff can handle. Staff from other areas have been redeployed and we're really grateful for all their help but if you work with non-ITU staff sometimes they feel like more of a burden than help. If they've had prior ITU experience then it's fine and they could be a great help but if it's their first time you have to teach them a lot of things, in addition to the 2/3/4 patients you already have. A lot of them are also fed up and frustrated at being redeployed from their units and as a nurse I can't help but empathize with them and it's also taking a toll on me emotionally. Our management is in some ways supportive but opening too many ITUs at once has taken a toll on all the staff. And we never understood why they sent our staff to the Nightingale but they never sent patients there. We had to keep opening new ITUs. It's either send staff to the Nightingale and send a few patients there or open new ITUs and keep our staff to take care of patients in our hospital And despite all this, having to work 2/3/4 times our workload the government refuses our pay rise. As professionals I hope we get just compensation for the work we've done the past few months. I'm really tired and the lockdown hasn't really helped my mental state since I still can't visit my friends and family."*
>
> **Band 5 nurse, acute and urgent setting**

4.6 Other respondents told us that since the pandemic, they had been moved several times which was causing stress and uncertainty.

> *"Better communication from senior management about plans going forward for those of us originally redeployed to treat Covid patients and now being used like low cost agency staff moved from ward to ward on a daily basis."*
>
> **Band 5 staff nurse**

> *"We have no communication from upper management/matrons. Have no idea if we will return to the department we were redeployed from and it's causing stress and more mental health issues."*
>
> **Nursing support worker**

> *"Since the start of the pandemic, the team has been moved without consultation, over 4 times from different locations, finally to a community hospital 16 miles from their home base. During this series of moves they have lost their administrative support and faced changes to working patterns, again without consultation. The service has moved to 7 day provision, with*

many staff members regularly working 10 days straight shifts while covering for a number of staff required to shield or self isolate.

While staff have recognised the need to be flexible to meet the needs of an evolving health crisis this situation has, almost without break, continued for almost 10 months. The staff group report feeling jaded, burnt out and demoralised. They are aware that this situation is going to likely get worse before it improves but are still finding it a difficult situation to manage in a daily basis."

RCN workplace representative

5. Impact of COVID-19: workplace experience

"The experience of covid and the effect on the profession is not yet known…. I think the general feeling of hurt, anger and resentment amongst those put on the frontline will only get worse with time."

Band 7 nurse, acute and urgent setting

5.1 Through our wide-ranging membership survey and ongoing member engagement, it is clear that while nursing staff have stepped up to new challenges, the situation has exacerbated problems caused by low staffing levels and tested levels of morale.

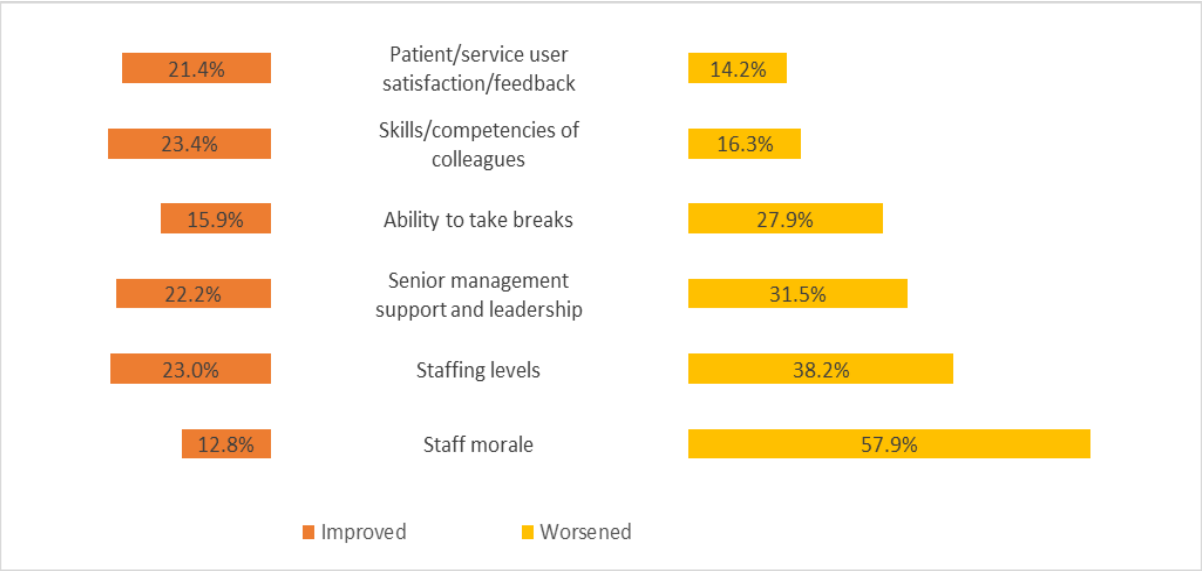
5.2 Respondents to the 2020 RCN membership survey were asked about their workplace experiences and whether their workplace has improved, worsened or stayed the same compared to before the pandemic. It is alarming to note that well over half (57.9%) reported that staff morale in had got worse, while only 12.8% reported it had increased. And in addition to long standing staffing shortages, which impact on staff morale and the ability of nursing staff to undertake their role effectively, almost four in ten state that staffing levels have worsened over the pandemic period.

5.4 As staff look to senior management support and leadership to help navigate and plan the NHS through the crisis, we find that only a quarter (22.5%) of respondents report that this has improved, while just under a third (31.5%) state it has worsened. Based on our regional intelligence, nursing staff repeatedly report to us that they have inadequate support from nursing leadership (including matrons, senior nurses and chief nurses) as a consequence of their roles having to change significantly due to the pandemic and as a result feel vulnerable. In parallel, the nursing leadership have told us they are frustrated and anxious about their inability to provide the level of support needed.

5.4 Further findings show that over three quarters report stress levels have increased since the pandemic, both among their colleagues (87.1%) and themselves (77.2%) while a high percentage (84.1%) stated they were worried about health and safety.

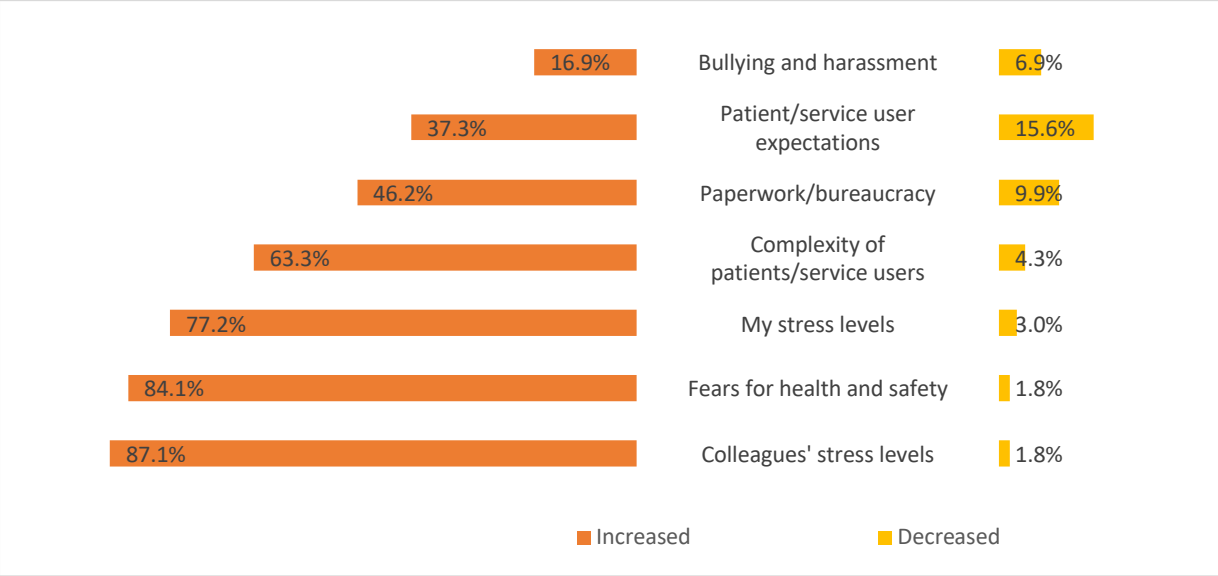
5.4 Almost two-thirds stated that patient or service user complexity had increased over this period, while just over a third (37.3%) stated that patient expectations had increased and a further 46.2% said that the level of paperwork had increased, reflecting the impact on service delivery and demand.

Figure 6: Compared to before the COVID-19 pandemic, have working conditions improved, worsened or stayed the same?



Source: RCN Pay and Working Conditions Survey 2020: Improved/worsened responses only

Figure 7: Compared to before the COVID-19 pandemic, have working conditions increased, decreased or stayed the same?



Source: RCN Pay and Working Conditions Survey 2020: Increased/decreased responses only

5.6 The 2019 England NHS Staff Survey found already high levels of work-related stress prior to the onset of the pandemic, with 44% of registered nurses and 40% of nursing and healthcare assistants agreeing that they had felt unwell as a result of stress in the previous 12 months (compared to 40.3% of all occupations). In addition, six out of ten (59%) registered nurses and 61.5% of nursing and healthcare assistants had gone to work despite not feeling well enough to perform their duties in the previous 3 months (compared to 56.6% of all occupations).

5.7 The 2019 Northern Ireland HSC Staff Survey showed a similar pattern, with 52% of nursing and midwifery respondents stating they had been unwell in the previous 12 months due to work-related stress (compared to 47% of all occupations). Around two thirds (65%) of nursing and midwifery respondents also stated that they had attended work in the previous 3 months despite feeling unwell due to pressure from managers, colleagues or themselves (compared to 61% of all occupations)

5.8 In the 2020 RCN Member Survey, further responses about the impact of COVD-19 on personal and professional lives show the deep concern felt about the health, safety and wellbeing of themselves and their colleagues. The majority of respondents (91.9%) are concerned about staff wellbeing, almost two thirds (60.3%) stated they were worried about their own physical health and over half (54.7%) worked about their mental health. Concerns about mental health are even more pronounced among staff (68% of respondents aged 35 and younger) and among those on lower bands (58% of those on AfC bands 1-4 and 60% of respondents on band 5).

5.9 Based on our regional intelligence during the first wave of the pandemic, we heard from RCN members that increased staff absence was having an impact of their ability to provide safe and effective care, as well as a significant impact on their own health and wellbeing. Registered nurses have been under strain from increased workloads, while nursing support workers report lower levels of supervision and feeling forced to work above their competency. This has only been exacerbated during the second wave, with nursing staff now displaying symptoms of PTSD. Chief nurses have reported to us their concerns about the ongoing impact of the pandemic on staff health and wellbeing and have real fears about the long-term impact of PTSD.

5.10 Survey responses also underline the deep-seated concerns about working environments which have only been exacerbated by the pandemic, with around six in ten (59.4%) stating that working conditions have got worse through work intensification and long hours working.

> *"[I would like] recognition that as nurses (and HCAs) we are missing breaks, working unpaid overtime, putting our own needs before patient care and clinical requirements - and we cannot keep absorbing additional tasks/complexity of patients/logistical changes."*
>
> ***Band 5 mental health nurse***

> *"Working from home has brought its own challenges and stress. Our job role has completely changed and increased the workloads we will have when we return to normal. No one is acknowledging that and have actually reneged on overtime payments."*
>
> ***Band 6 commissioning role***

> *"Throughout the pandemic the focus has been on acute care, the struggles and risks of those trying to manage in the community with a growing fear and shielding patients have not been recognised."*
>
> ***Band 7 clinical nurse specialist***

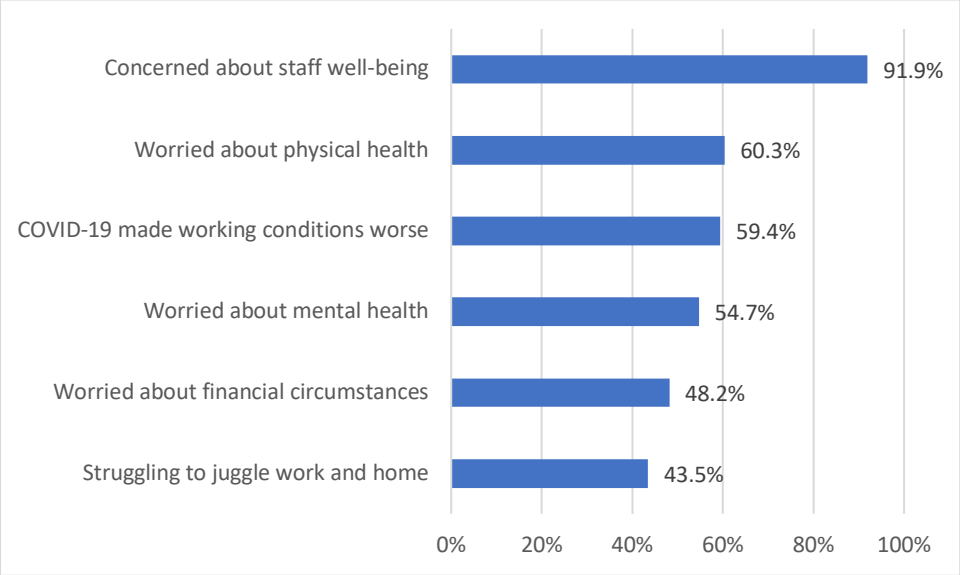
5.11 The impact of the pandemic to personal lives is also highlighted in the findings that just under half (48.2%) report having worries about their own financial circumstances and 43.5% report that they struggle to juggle work and home life.

"Pay is not good enough. When a qualified nurse leans on family financially before and after covid for basics like food is not acceptable. after I've paid my outgoings I have £200 for food, fuel, clothes, for a family of 4 for a month."

Band 6 senior nurse

5.12 Financial concerns are particularly acute among younger nursing staff (57% of respondents aged 44 or younger stated they were worried about their financial situation) and among staff from black or ethnic minority background (76% of black respondents and 74% of Asian respondents) as well as those employed on lower pay bands (59% of respondents employed on AfC bands 1-4 and 54% on band 5), highlighting the pressures felt by different groups within the nursing workforce.

Figure 7: Personal and professional concerns



Source: RCN Pay and Working Conditions Survey 2020: Respondents answering agree/strongly agree

5.13 Research undertaken by the Society of Occupational Medicine conducted prior to the pandemic concluded that nurses and midwives are at considerable risk of work-related stress, burnout and mental health problems such as depression and anxiety[7]. It states that: 'Rates of poor mental health appear to be increasing in response to rising demands, staffing shortages and diminishing resources. These pressures are often systemic in nature and require intervention at public policy and organisational levels' and that these problems are likely to have risen further 'due to the exceptional pressure that many nurses and midwives are experiencing during the pandemic and will likely increase for some time to come.'

5.14 The impact of COVID-19 on the physical and mental health and wellbeing of health care workers is of extreme concern, and reflected in ongoing research among the workforce, alongside the development of resources to support managers and staff in

7

www.som.org.uk/sites/som.org.uk/files/The_Mental_Health_and_Wellbeing_of_Nurses_and_Midwives_in_the_United_Kingdom.pdf

health and social care settings. Much of the anticipated impact is based on research on the workforce of previous SARS outbreaks and early findings from China. While the full extent of the impact of COVID-19 on the workforce in the UK is still emerging, early studies indicate the likely extent of harm to physical and mental health. For example, a survey of 1,000 health care workers undertaken by IPPR in April showed that half said their mental health had deteriorated since the Covid-19 crisis began, with the impact greatest on younger workers (aged 18 to 34). [8] In addition, around one third stated their physical health had deteriorated.

6. NHS response to the pandemic

6.1 Redeployment and service redesign

6.1 A major part of the policy response to pandemic has been the creation of temporary large-scale critical care hospitals across the UK in preparation for the anticipated strain on NHS services. The operating model for these Nightingale hospitals is generally for staff to be redeployed from trusts across the relevant areas, which potentially leaves those trusts vulnerable and unsafe.

6.2 Major changes have also been enacted in critical care, in response to an unprecedented number of patients, moving away from the requirement of one critical nurse per one critical care patient. We have seen examples of one critical care nurse caring for as many as six patients. Nursing staff have been supported by staff redeployed from other clinical areas, which in turn applied other clinical pressures to those clinical areas. Critical care nurses had to supervise all those staff that were sent to support them as well as overseeing the care of the critically ill patients.

6.3 Intelligence from RCN staff across the country shows that NHS trusts and boards have also responded to new demands in a variety of ways including:

- Local return to work campaigns
- Nursing staff provided with support and training to move from non-direct patient facing roles to clinical deployment or from areas where services have been temporarily paused to other areas
- Modifying and streamlining recruitment processes to allow staff to start more quickly in new roles
- Continued encouragement of staff to move away from agency work and register with local banks
- Allowing staff to directly book onto bank shifts
- Development of collaborative banks across different trusts and banks
- Nursing and midwifery students deployed into paid placements (first wave of the pandemic).
- International nurses supported onto the temporary register and transition into clinical practice

6.2 Support for workforce during the pandemic

6.4 During the first few months of the pandemic, the most immediate impact on the workforce arose through the lack of sufficient PPE for staff to do their job effectively.

[8] www.ippr.org/research/publications/care-fit-for-carers

The King's Fund described the early impact of COVID-19 on the NHS workforce and contrasted the way the public demonstrated its value of key workers with 'the system's inability to ensure basic personal protective equipment (PPE) necessary for a safe working environment, exposing staff to significant risk.'

> *"We are on the front line putting our lives at risk with PPE that is no better than a sandwich making kit."*
>
> *"[We need] adequate PPE for non-aerosol generated patients, not just simple PPE we use for other infections prior to Covid. How can this PPE protect health care workers adequately we are treating it as TB, MRSA, C DIFF, norovirus when this virus is killing thousands?"*
>
> ***Band 5 staff nurse***

6.5 The RCN undertook two surveys of members working across all health and social care sectors in April and May[9, 10]. The first survey received responses from 13,605 people, including those working in environments with possible or suspected COVID-19 but were not themselves undertaking high-risk procedures and others who were working in environments where high-risk procedures were being undertaken. Some of the findings showed that:

- Of those treating possible or confirmed COVID-19 patients in high-risk areas, around half (51%) reported that they were being asked to re-use items of PPE marked 'single use' by manufacturers. Of those treating COVID-19 patients elsewhere, over a third (39%) said they were being asked to re-use this equipment.
- Almost a third of nursing staff treating Covid-19 positive patients not on ventilators reported an immediate lack of face and eye protection
- One in ten nurses were relying on face or eye protection they have bought or homemade.
- 70% of respondents have raised concerns about PPE

6.6 The second survey received 5,023 responses and found that:

- 34% of respondents felt pressure to care for individuals with possible or confirmed COVID-19 without adequate protection. 56% of black and ethnic minority background felt pressure to work without the correct PPE.
- 44% of respondents said they were being asked to reuse single-use equipment.
- 58% said they had raised PPE concerns, but more than a quarter (27%) of this group reported that these concerns had not been addressed.

6.7 As efforts were made to manage the pandemic, staff reported difficulties in communicating with patients or colleagues when wearing full PPE and many have been working in unfamiliar clinical environments. NHS teams rapidly adjusted to new pressures to redesign services and ways of working which has often entailed greater delegation of authority and more flexibility in individuals' roles.

6.8 The NHS will not be able to meet the demands of the pandemic without more staff; there is an immediate need to deal with the backlog of work, reduce waiting lists and

[9] www.rcn.org.uk/professional-development/publications/rcn-ppe-survey-covid-19-uk-pub-009235
[10] www.rcn.org.uk/professional-development/publications/rcn-second-ppe-survey-covid-19-pub009269

waiting times and restore activity to previous levels. However, the pandemic has exposed the system's fragilities, and a greater investment in the NHS nursing workforce is necessary to address those fragilities and build back resilience.

6.9 Every member of the current and future nursing workforce is needed to deal with immediate pressures and to build up the required resilience in the system so that it can deal with future shocks as well as addressing the health inequalities so shockingly highlighted by the pandemic.

6.10 As evidenced by the show of public support, clapping for carers, the public value and support the work of frontline workers, particularly nursing staff. A recent poll conducted by the RCN and YouGov found that the public overwhelmingly support an early pay rise with 82% of those polled supported nursing staff receiving a pay rise this year. [11]

7. Morale and Motivation

7.1 Through previous staff surveys and member engagement, it was already clear that levels of morale and motivation were running low in the NHS. The second surge of COVID-19 is pushing staff to breaking point as they deal with the intensity of work and the impact of the crisis on their families, patients, service users and their own mental health.

7.2 Respondents to the 2020 RCN Member Survey were asked about feeling valued by different constituent groups and whether the level of value they felt from their colleagues, senior management in their organisation, the media, the patients/service users, the general public and the government in their part of the UK was higher, lower or unchanged since the start of the COVID-19 pandemic. The most striking findings are that while respondents clearly feel more valued by the public (76.4%), the media (60.6%) and patients (55%), very few (17.7%) feel more valued by the Government. While just over a third (36.5%) stated that the level of value is unchanged, a similar proportion (34%) stated they feel even less valued by the Government even at a time of extraordinary effort and demand on nursing staff.

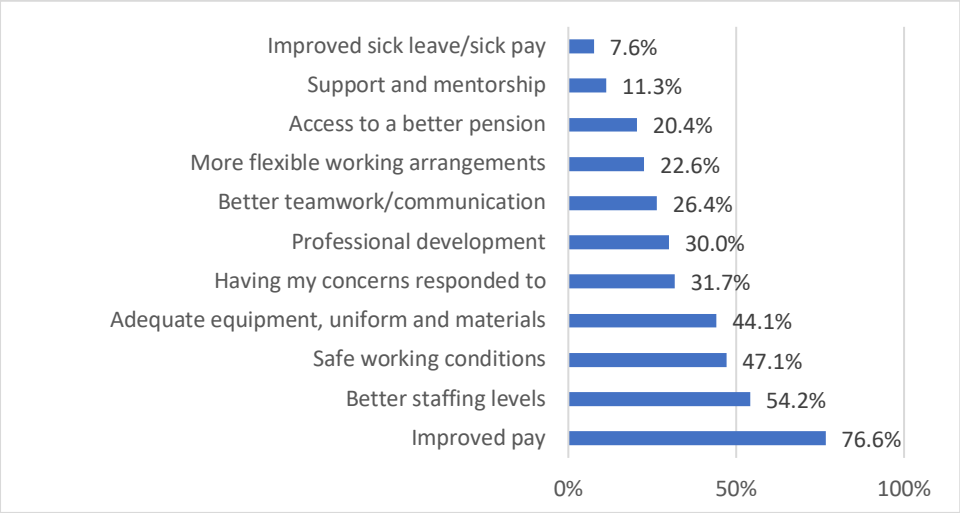
7.3 When asked about the factors that would make nursing staff feel more valued, it is clear that the major issue in their minds is that of pay. Just over three quarters (76.6% stated that higher pay would make them feel more valued.

7.4 Other responses reflect concerns about working environments, with similar numbers citing staffing levels (54.2%), safe working conditions (47.1%) and access to equipment, uniforms and materials to enable them to do their job properly (44.1%) as key factors which would make them feel more valued in their jobs.

7.5 In relation to pay, only around one third (36.3%) of registered nurses and a quarter (24.5%) of nursing and healthcare assistants agreed they were satisfied with their level of pay (38% of all occupations).

[11] https://www.rcn.org.uk/news-and-events/press-releases/public-support-for-pay-rise-overwhelming-says-royal-college-of-nursing

Figure 8: Thinking about your work, both during the COVID-19 pandemic and in general, what would make you feel more valued?



Source: RCN Pay and Working Conditions Survey 2020: Respondents allowed to choose up to 5 options

7.6 Respondents were then asked which *one* factor would make them feel more valued. Just under half (48.7%) highlighted improved pay as the main issue – far and above any other issue identified – underlining the significance of pay levels to nursing staff and their views of nursing as a career.

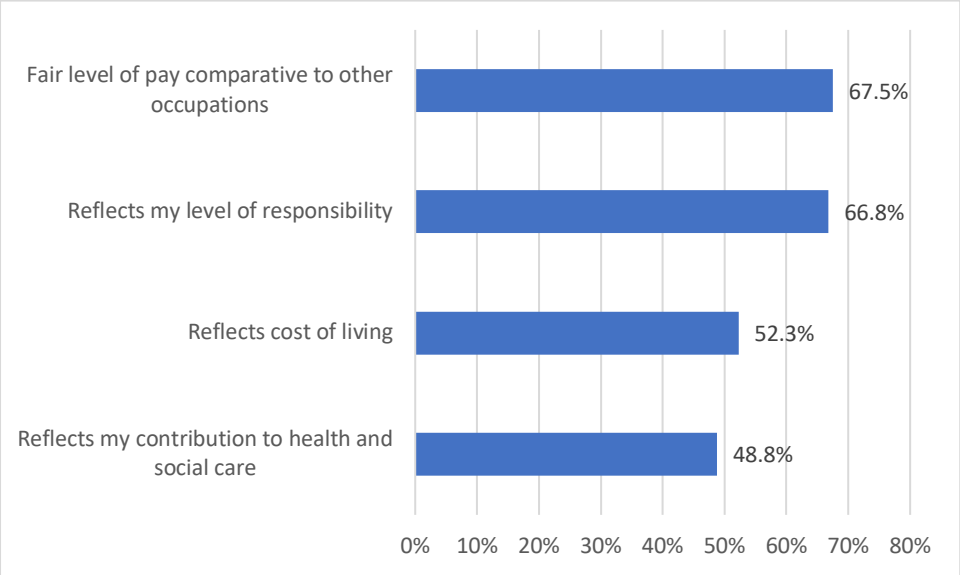
> *"Recognition in terms of pay for the hard work we do every day not just during the pandemic, we are over worked and under paid."*
>
> ***Band 6 sister/charge nurse***

> *"Nursing staff deserve to get a good wage. This is something I feel incredibly strong about. Since becoming a nurse I have felt nothing but disrespect from the government underpaying highly skilled nurses who are prepared to risk their own lives."*
>
> ***Band 5 staff nurse, acute and urgent care***

> *"I would like to see my extensive nursing skills and role reflected in my pay and respected by the government and media. I would like appropriate funding of the NHS so we can do our jobs for patients effectively."*
>
> ***Band 6 bank nurse***

7.7 Further findings show how feelings of fairness and value are central to views about current wage levels in NHS nursing. Around two thirds (67.5%) stated that improved pay was important in terms of comparability to other similar occupations while a similar number (66.8%) stated that their pay needs to better reflect the real level of responsibility they hold in their job.

Figure 9: Which aspects of improved pay are most important to you?



Source: RCN Pay and Working Conditions Survey 2020: All respondents who stated improved pay would make them feel valued (n=21,135). Respondents allowed to choose more than one option.

7.8 The 2019 England NHS Staff Survey also highlighted underlying issues around pay, staffing, materials and equipment. Only 28.6% of registered nurses and 31.8% of nursing and healthcare assistants (compared to 32.4% of all occupations) agreed that there are enough staff in their organisation to do their job properly, while barely half (55%) of registered nurses and nearly two thirds (62.8%) of nursing and healthcare assistants agreed that the had adequate materials, supplies and equipment to do their work (compared to 56.1% of all occupations).

7.9 The 2020 Scotland Health and Social Care Everyone Matter Pulse Survey reported that only 68% of NHS Scotland nursing and midwifery staff reported they feel appreciated for the work they do.[12]

[12] www.imatter.scot

8. Recruitment and Retention

8.1 The accompanying RCN Labour Market Review 2020 provides data on key trends and developments across the whole nursing workforce. On the face of it, the NHS nursing workforce looks to be doing well, with staff numbers having increased in the last year. However, the picture is complicated considerably both by the pandemic and the availability of data to be able to assess key trends in detail.

8.2 Firstly, the number of nurse support workers has increased over the last year by 11.1% in England, by 16.8% in Scotland and by 22.5% in Wales while there has been little change in Northern Ireland. This largely reflects the number of students employed on clinical placements in response to the pandemic. There has also been a growth in the registered nursing and midwifery workforce, but at a slower rate (4.5% in England, 1.7% in Scotland, 1% in Wales and 2.5% in Northern Ireland). At this point, it is not possible to ascertain how much this growth is attributable to nursing staff returning to practice.

8.3 Some data are available on vacancy levels, with for example, England having published a vacancy rate of 10% for the second quarter of 2020/21. As of September 2020, the vacancy rate in the NHS Scotland nursing and midwifery workforce stood at 5.1% (including 1.5% long-term) compared to 4.8% at September 2018 (including 1.6% long-term).[13].

8.4 However, according to RCN intelligence, the rate of bank working in England has also increased considerably over the period of the pandemic. However, this data has not yet been published or shared, in order to understand whether or not it presents a clear picture of bank/agency spend and fill rates, to what extent temporary and permanent staff are different or the same workforce, and whether local decision making on staffing is driven by safety and quality, and is sustainable for delivery of safe and effective care.

8.1 Government workforce strategies

England

8.5 In England, there are no assurances or plans from Government for how they will generate enough growth in the nursing workforce now. Demand is increasing, the workforce is ageing and too few nurses are entering the profession.

8.6 Last year the Government committed to an additional 50,000 nurses in the NHS in England by the end of this Parliament. However, there is no published strategy for the approach or any specified funding. Without transparency relating to these plans, we cannot have any confidence this will be achieved. No commitments or plans have been made for growth in the nursing workforce outside the NHS, yet additional capacity is urgently needed in social care, public health, primary care and the independent sector.

8.7 While in the last year there has been some additional growth in applications and acceptances to nursing degree courses, this is not at the scale to meet the workforce gaps (the numbers having dipped since the move to student loans in 2017) and will take several years to see any impact. Also, significant numbers of registered nurses leave the workforce in their first few years of practice. There is therefore no guarantee these prospective nurses – which due to the funding reform is also a younger cohort - will graduate or stay in the profession, as we know they are studying and will enter the workforce during highly pressurised time for health and care services.

8.8 There are several actions which the Government needs to take to address the challenges facing the nursing workforce. This includes a fully funded health and care

[13] Nursing and Midwifery | Turas Data Intelligence (nhs.scot)

workforce strategy, additional investment in nursing higher education supply and legislation to clarify roles, responsibilities and accountability for workforce planning and supply.

8.9 Each of these required actions will take several years to have any impact. With widescale shortages across the nursing workforce, increasing demand for health and care services and risks to international recruitment, the Government needs to act now to stabilise and grow the workforce. The only option, immediately available, not only to attract people into the recession, but also to retain those currently in the workforce, but feeling undervalued, is a fair and early pay rise for all nursing staff. This would have a significant positive impact on both recruitment and retention, both now and for the future.

Northern Ireland

8.10 The RCN has consistently highlighted over a number of years the absence of effective workforce planning for nursing, with the impact of this manifested in high levels of vacant posts, escalating expenditure on agency staff, and an inability to advance the strategic transformation of the Health and Social Care service because of shortages within the community nursing workforce upon which the refocusing of services is largely dependent. All of these issues have previously been noted by the NHS Pay Review Body, yet none of them have adequately been addressed by the Department of Health.

8.11 During late 2019 and early 2020, RCN members in Northern Ireland engaged in strike action to demand measures to promote safe and effective care, as well as pay parity with England. One of these measures was a demand for effective workforce planning. In response, the Minister for Health published a safe staffing framework, which included a commitment to "develop a costed action plan for the implementation of the health and social care Workforce Strategy 2026", including "full design of the optimum workforce model by 2023". However, there has been little discernible progress to date in delivering this undertaking. In addition, our demand for safe staffing legislation to which the framework also commits must be progressed within the current Northern Ireland Assembly mandate and must specify clear lines of accountability for the development and implementation of a workforce plan for nursing. The deficits within nursing workforce planning in Northern Ireland were identified and extensively analysed in two major reports published this year; the report of the Department of Health Nursing and Midwifery Task Group[14] and a report published by the Northern Ireland Audit Office on workforce planning for nurses and midwives[15]. The RCN commends both of these reports to the NHS Pay Review Body.

Wales

8.12 The recent publication Health and Social Care Workforce Strategy by the Welsh Government, though Health Education Improvement Wales (HEIW) and Social Care Wales (SCW) is a welcome development. However, our view is that this publication represents a list of aspirations rather than a comprehensive strategy.

8.13 The Welsh Government and/or NHS Wales fail to publish national figures for nursing vacancies in the NHS even though the vacancy rate is a critical indicator of the pressures faced by Health Boards and one published in the other countries of the UK. In

[14] www.health-ni.gov.uk/publications/nursing-and-midwifery-task-group-nmtg-report-and-recommendations
[15] www.niauditoffice.gov.uk/publications/workforce-planning-nurses-and-midwives-0

the absence of any official data, RCN Wales estimated there is a minimum of an estimated 1,612 nurse vacancies in NHS Wales. This is based on vacancy data found in Health Board, Audit Wales and Committee papers and is likely to be higher. This situation highlights the difficulty in presenting a true picture and the impact of vacancies on the workforce and patient care.

8.14 Commissioned places for nurse education are set by HEIW/Welsh Government, with no clear link to workforce strategy and no consultation with stakeholders or higher education. Nursing student places in adult nursing continue to rise but places for learning disability, children and mental health are in decline as do places for community post-registration qualifications. The Welsh Government has made no move to widen access by establish a national apprenticeship for entry to the nursing profession.

8.15 The 2019 RCN Wales publication Progress and Challenge examined Health Boards' activity in relation to workforce retention[16]. While most Boards acknowledge turnover as a significant issue, none have an agreed retention strategy. We have called on the Welsh Government to set out how the NHS in Wales will increase opportunities for flexible working as part of a national nursing retention strategy.

Scotland

8.16 The RCN is calling for work to restart on the implementation of the Health and Care (Staffing) Act, with a clear commitment to full implementation by the end of 2021. The Act places a duty on NHS and social care providers to make sure that there are qualified, competent staff working in the right numbers to ensure safe and effective care. While it was understandable that implementation was paused at the start of the pandemic, the reasons for passing this Act nearly two years ago have been made even clearer by the Covid-19 crisis, with safe and effective staffing being a key element of NHS recovery.

8.17 The Scottish Government 'Integrated Health and Social Care Workforce Plan' published in December 2019 contained some welcome measures, including commitments to increase the district nursing workforce and the number of places for student nurses in 2020/21. However, the plan is light on the detail behind how the overall projected workforce requirements were established. Since, then workforce planning policy direction has been interrupted by COVID-19 and Scottish Government has highlighted that planning assumptions need to be refreshed. Consideration is now needed as whether the integrated plan will be fit for purpose for the re-mobilisation and transformation agenda that is now being taken forward. The pandemic has highlighted long term failures in workforce planning and the need for workforce planning across health and social care to be a focus of recovery, particularly in light of the changed landscape for services and workforce.

8.2 International recruitment, Brexit and the new immigration system

8.18 Internationally educated nursing staff play a vital role in providing safe and effective care and contributing to our health and care workforce.

8.19 The accompanying RCN Labour Market Review provides an update on numbers of nurses, midwives and nursing associates on the NMC register. This shows that non-EEA registrants make up 12% and EEA registrants make up 4% of all on the NMC register.

8.20 However, many EEA nurses are choosing to leave the UK, and many others are choosing not to come in the first place. This is both likely due to uncertainty and hostility around immigration and the impact of COVID-19. Overall, since the EU

[16] www.rcn.org.uk/professional-development/publications/009-905

referendum, over 14,000 EEA nurses and midwives have left the UK workforce. A similar trend is reflected in the number of EEA registrants joining the register for the first time with a 91% reduction over the same period between March 2016 and September 2020 (from 10,179 to 938).

8.21 The number of non-EEA nurses and midwives joining the NMC register for the first time grew by 300% (from 2,389 to 9,545), and the number of non-EEA nurses leaving the UK also reduced by 37% from 2,090 to 1,318 over the same period, however this growth has not made up the shortfall in nurses from abroad since the referendum.

8.22 While the RCN is clear that international recruitment cannot be used as a substitute for a domestic workforce, overseas recruitment is vital and must continue so that people can receive safe and effective care.

8.23 Ending freedom of movement, coupled with the new immigration system from 1 January 2021, is likely to prevent many international nursing staff from coming to work in the UK, exacerbating current workforce shortages. The RCN has stated that the introduction of the new immigration system must not be used by the government to create arbitrary barriers which affect our ability to recruit much-needed international nursing staff. The planned changes to immigration policy will continue to leave the nursing profession fragile and will have particular ramifications for the social care sector.

8.24 The international workforce will only be able to enter the UK due to temporary exemptions to the UK's migratory policies. It is vital that nursing remains on the Shortage Occupation List and that the nursing profession continues to be exempt from the salary threshold of £25,600 on Tier 2 visas - any change to this policy would significantly undermine the supply of highly skilled internationally educated staff.

8.3 Recruitment and retention: workforce intentions

8.25 The 2019 NHS England Staff Survey found that 28.5% of registered nurses and 25.7% of nursing and healthcare assistants stated they often think about leaving their organisation (compared to 28.4% of all occupations). A fifth (20.1%) of registered nurses and 17.3% of nursing and healthcare assistants said they would probably look for another job in the next 12 months (21% of all occupations). In addition, 14% of registered nurses and 13.6% of nursing and healthcare assistants stated that they would leave their organisation as soon as they found another job (compared to 14.8% of all occupations). Of those indicating a wish to leave their job, the most common destinations are either another NHS organisation, another job within the same organisation or retirement.

8.26 The 2019 Northern Ireland HSC Staff Survey paints an even worse picture, with 41% of nursing and midwifery respondents stating that they often thinking about leaving (compared to 35% of all occupations). The main reasons for thinking of leaving are not feeling valued (58%) and levels of pay (46%).

8.27 While data on intention to stay is not available for Scotland, we know that turnover among nursing and midwifery staff has risen steadily over recent years, growing from 5.4% in 2011/12 to 7.2% in 2017/18 and remaining at 6.9% since 2018/19 indicating a high level of instability in the workforce.

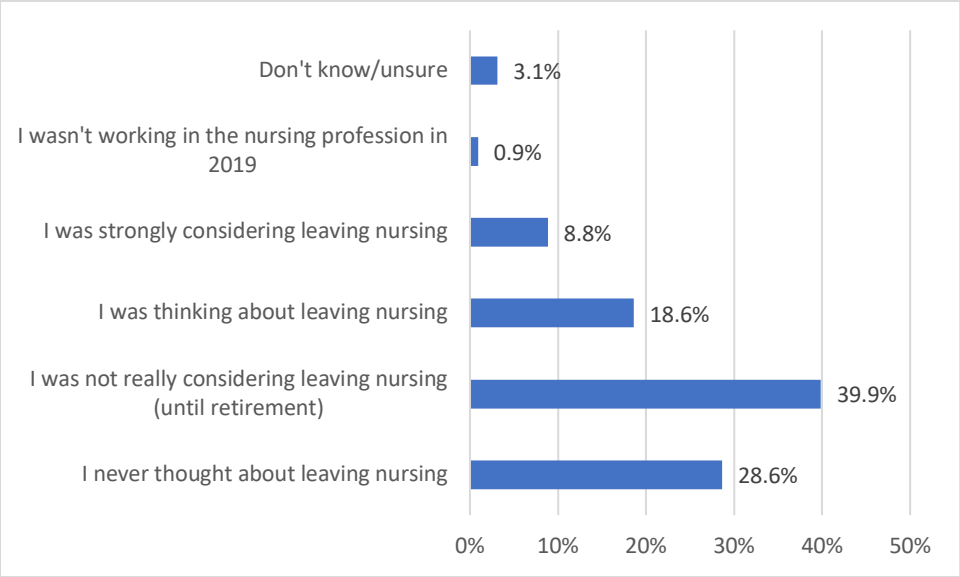
8.28 The 2020 RCN member survey also asked respondents about their feelings about staying in their job, both looking back to 2019 and looking ahead to the end of 2020.While just over two thirds (68.5%) were not thinking of leaving last year, around a quarter (27.5%) were considering or strongly considering leaving last year. Looking

ahead to later this year, just over half (52.5%) stated that they were planning to stay, while just over a third (36.8%) were thinking of leaving.

8.28 Among those who had temporarily returned to the register and the workplace, only 20% indicated a possibility they would stay beyond the length of the pandemic. While this group of staff have undoubtedly played an essential role during the COVID-19 health emergency, they do not provide a sustainable answer to staffing shortages.

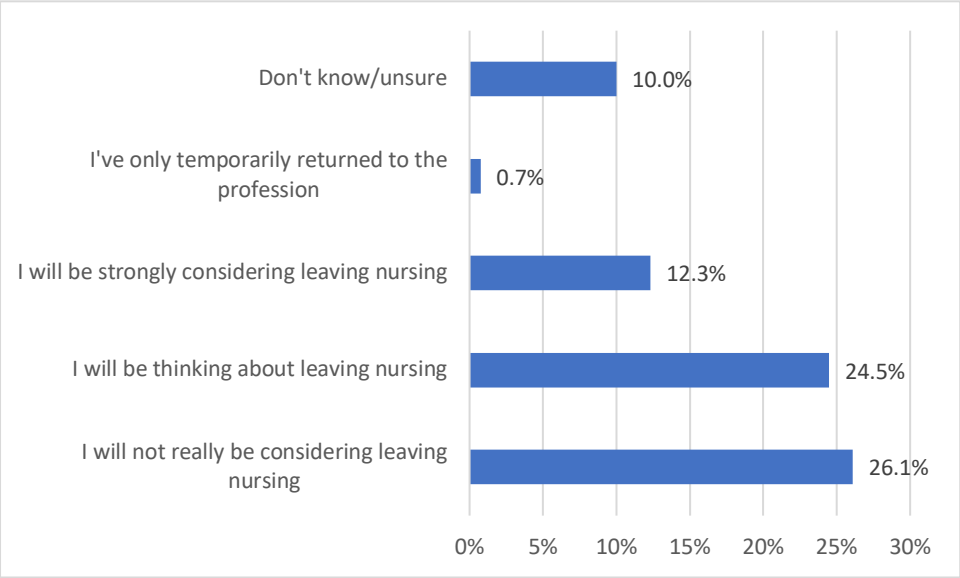
> *"I retired just before COVID-19, I have returned but I am considering leaving when the current situation returns to normal. I feel undervalued."*
>
> **Nursing support worker, acute and urgent setting**

Figure 10: Thinking back to the end of 2019, how did you feel about staying in or leaving the nursing profession?



Source: RCN Pay and Working Conditions Survey 2020

Figure 11: Which statement best describes how you expect to feel about staying in or leaving the nursing profession at the end of 2020?

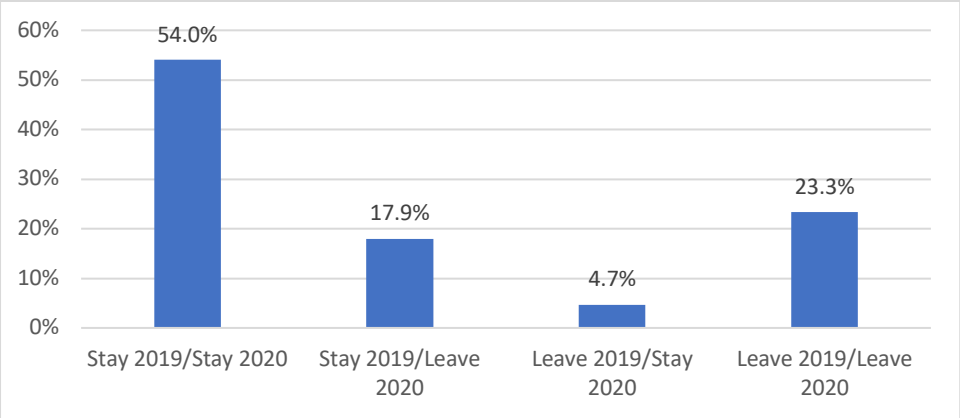


Source: RCN Pay and Working Conditions Survey 2020

8.29 Comparing individual responses around intentions to leave between 2019 and 2020 shows that:

- just over half of all respondents (54%) were not thinking of leaving last year and do not expect to do so this year
- 17.9% were not thinking of leaving last year but will do so this year, indicating the number of respondents who have changed their views about staying in their job over the last year
- a small number (4/7%) were thinking of leaving last year but intend to stay in 2020
- just under a quarter (23.3%) were thinking of leaving last year and are still considering doing so suggesting a deep level of dissatisfaction among a significant number of respondents

Figure 12: Matched results showing respondents' answers regarding feelings about intention to leave in 2019 and expected feelings about leaving in 2020.



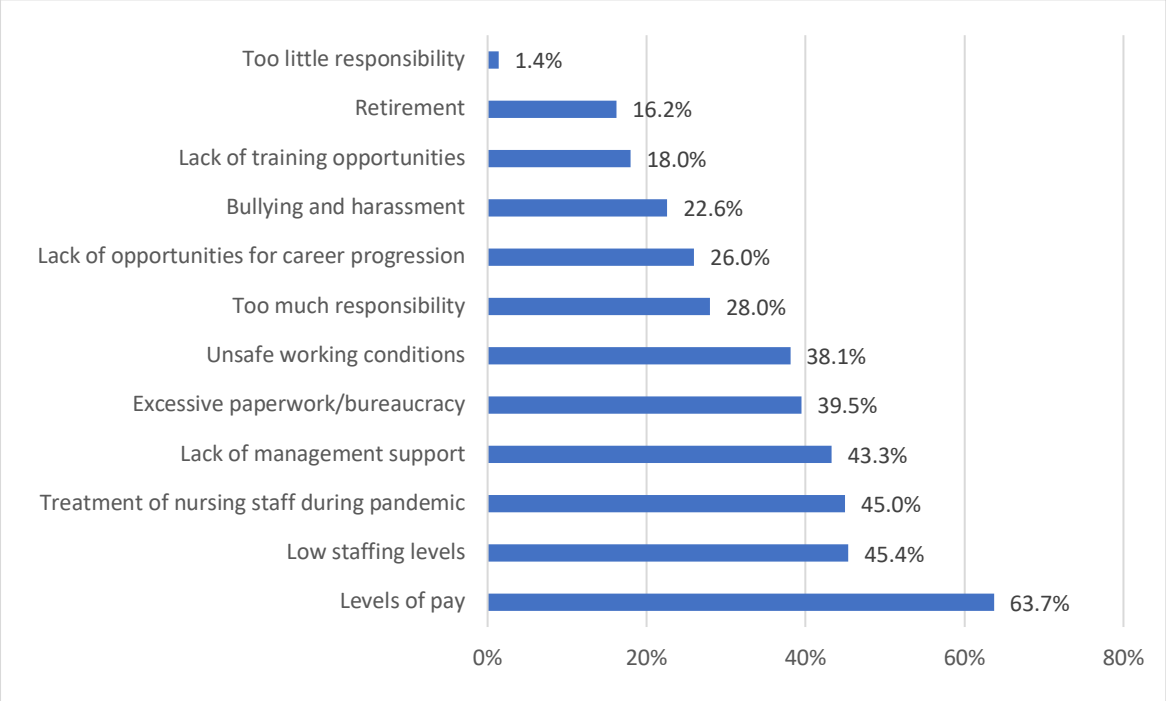
Source: RCN Pay and Working Conditions Survey 2020

8.3.1 Reasons for thinking about leaving

8.30 The 2020 RCN member survey found that the main reason given for thinking about leaving was pay (63.7%) followed by low staffing levels (45.4%) and the way nursing staff have been treated during the pandemic (45%) highlighting the main drivers of dissatisfaction among nursing staff. Once again – the issue of pay is underlined the most important factor affecting job satisfaction as well as intention to leave.

> *"The next pay increase will be the deciding factor on whether I leave or stay. Following COVID it is an insult not to reward nursing staff appropriately. Nursing is a graduate profession and should be paid accordingly end of. I love my role and have worked over and above during this crisis. If they freeze public sector pay now staff will leave in droves."*
>
> **Band 7 senior nurse**

Figure 13: Reasons for considering leaving the nursing profession



Source: RCN Pay and Working Conditions Survey 2020

All respondents who stated they would consider or strongly consider leaving during 2020 (n=10,246)

8.4 Nursing Students

8.31 UCAS data shows that the number of placed applicants for nursing courses in the UK this year has increased by 22% since last year (23% increase in placed applicants living in England; 20% in Scotland; 18% in Northern Ireland and 11% in Wales). There has also been a marked increase in mature nursing student numbers: placed nursing applicants aged 30-34 have increased by 27% compared with 2019 and there is a 37% increase in those aged 35 and over.

8.32 The UCAS head of analytical data has pointed to the media-driven image of heroic nurses working on the 'COVID front line' as one factor in the increase in nursing student applicants[17]. However, he also links the increase in applicants across all courses, including nursing, to a weaker job market.

8.33 The RCN report *Beyond the Bursary; Workforce Supply* states that the pandemic has shone a spotlight on the work of nursing staff and that 'we can no longer aim to train the bare minimum number of new nurses; instead, we should be aiming for an oversupply to make up for years of underinvestment. Now is the time to grow our domestic workforce supply to ensure we have as many nurses as are needed to deliver safe and effective care in every acute and community setting, in both health and social care, across the country.'[18]

8.34 Modelling undertaken by London Economic for this report looked at two alternative funding options: a universal tuition grant with means tested maintenance grant; and forgivable tuition loan for public service and a universal maintenance grant. Based on these models, the RCN has called on the Westminster government to abolish self-funded tuition fees for all nursing students in England and introduce universal living maintenance grants that reflect actual student need. Student debt should also be removed for all those who have taken out student loans to pay fees since 2017.

8.35 Significant investment is needed to sustainably support students through the nursing degree and into the workforce. Although the recent introduction of a £5,000 living grant for nursing students in England and increased apprenticeships funding is welcome, as is the continuation of the bursary for nursing and midwifery students in Scotland, much more is needed to support the future workforce.

8.5 Nursing apprentices in England

8.36 Extra money has been allocated to for nursing apprentices in England. Apprenticeships typically take four years, compared with three years for a full-time nursing degree.

8.37 While the increase in places is a welcome step to making a career in nursing more accessible, it falls short of the wider investment needed to educate enough registered nurses for the future. The RCN is clear that the full-time three-year nursing degree remains the best way to increase domestic nursing supply at the scale and pace needed to deliver safe and effective patient care.

9. Agenda for Change earnings and salary data analysis

> *"NHS pay has not improved in the 15 years I've worked for it. We are and have not been valued by government for years. Only when we risk our lives do we get a thanks. This is wrong."*
>
> Primary care nurse

9.1 The RCN report, *Gender and Nursing as a Profession: Valuing nurses and paying them their worth* highlighted the lack of opportunities for progression for nursing staff[19]. The structural and societal barriers to progression are multi-faceted and deeply entrenched within nursing as a highly gendered profession. These include job evaluation structures which fail to accurately and fully measure the technical, productive, cognitive and

[17] https://wonkhe.com/blogs/keep-calm-students-still-want-to-study/
[18] www.rcn.org.uk/professional-development/publications/rcn-beyond-the-bursary-workforce-supply-uk-pub-009319
[19] www.rcn.org.uk/professional-development/publications/pub-007954

emotional aspects of the role, on top of structural barriers facing women, people from ethnic minority backgrounds and others with protected characteristics in the world of work in general. All these barriers need to be tackled in order to make nursing an attractive and sustainable career.

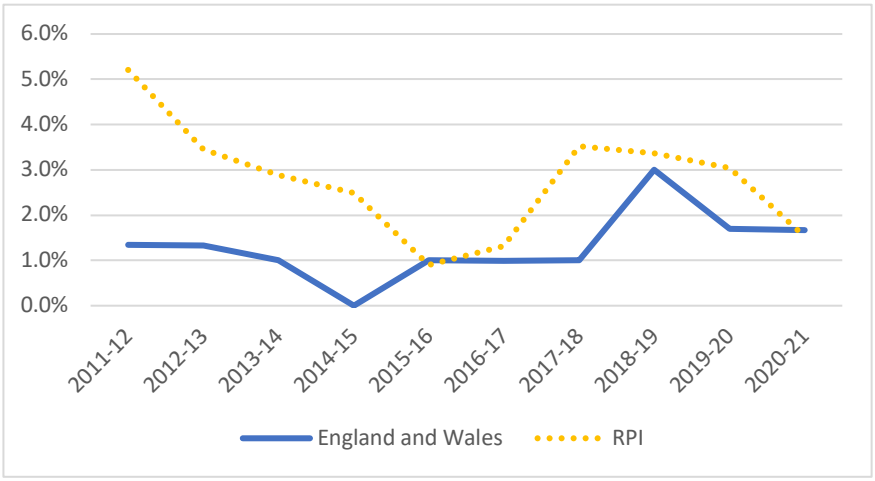
> *"Nursing pay should be competitive to other graduate professions. Nurse training was changed to graduate level but pay scales have not changed to reflect this. Nursing roles have changed greatly as have responsibilities which is not reflected in our pay."*
>
> **Band 5 staff nurse**

9.2 Not only are nursing staff held back in terms of opportunities for progression, resulting in the majority of registered nursing staff employed at band 5, but added to the impact of cumulative pay freezes, earning potential is flattened across a nursing career. Furthermore, around 40% of staff in each AfC pay band are employed at the top of their band and variations across the UK mean that this concentration is even higher in some areas. For example, 56% of nursing staff employed at Band 5 are at the band in Northern Ireland and 59% of nursing and midwifery staff employed at Band 5 are at the top in NHS Scotland.

following charts track the annual growth in the value of the top points of selected Agenda for Change bands against annual inflation across all four countries. In general, annual uplifts have failed to meet changes in the cost of living in every year and every country.

9.3 The RCN has always been clear that the top point of each pay band represents the rate for the job, with individuals satisfying all requirements for the role at that point. Not only does this cohort represent a large proportion of the workforce, they are the most experienced. It is therefore vital that they are adequately rewarded in this year's pay award.

Figure 14: Annual growth in value of top point of Band 3 against annual RPI inflation, 2010-2020



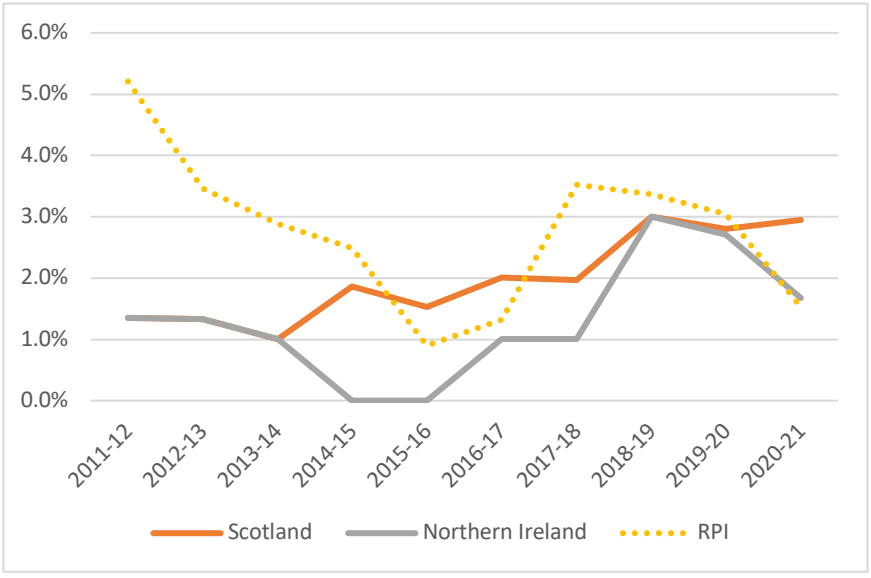
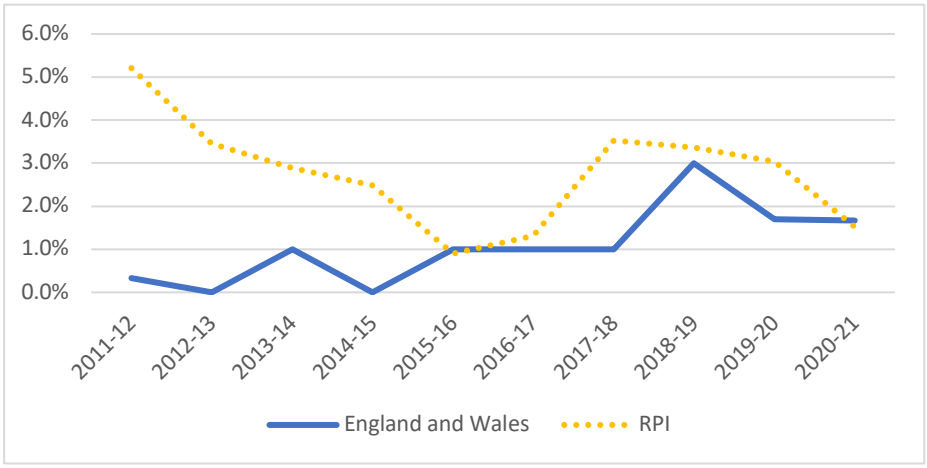


Figure 15: Annual growth in value of top point of Band 5 against annual RPI inflation, 2010-2020



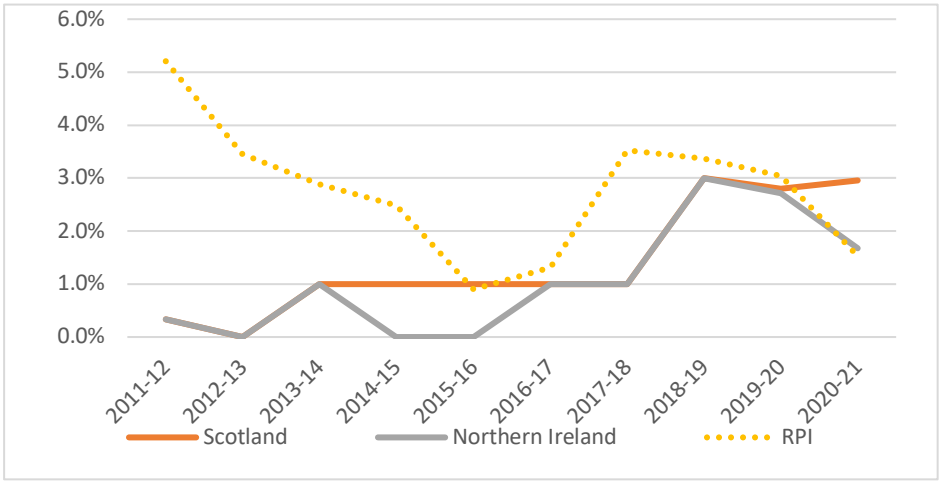
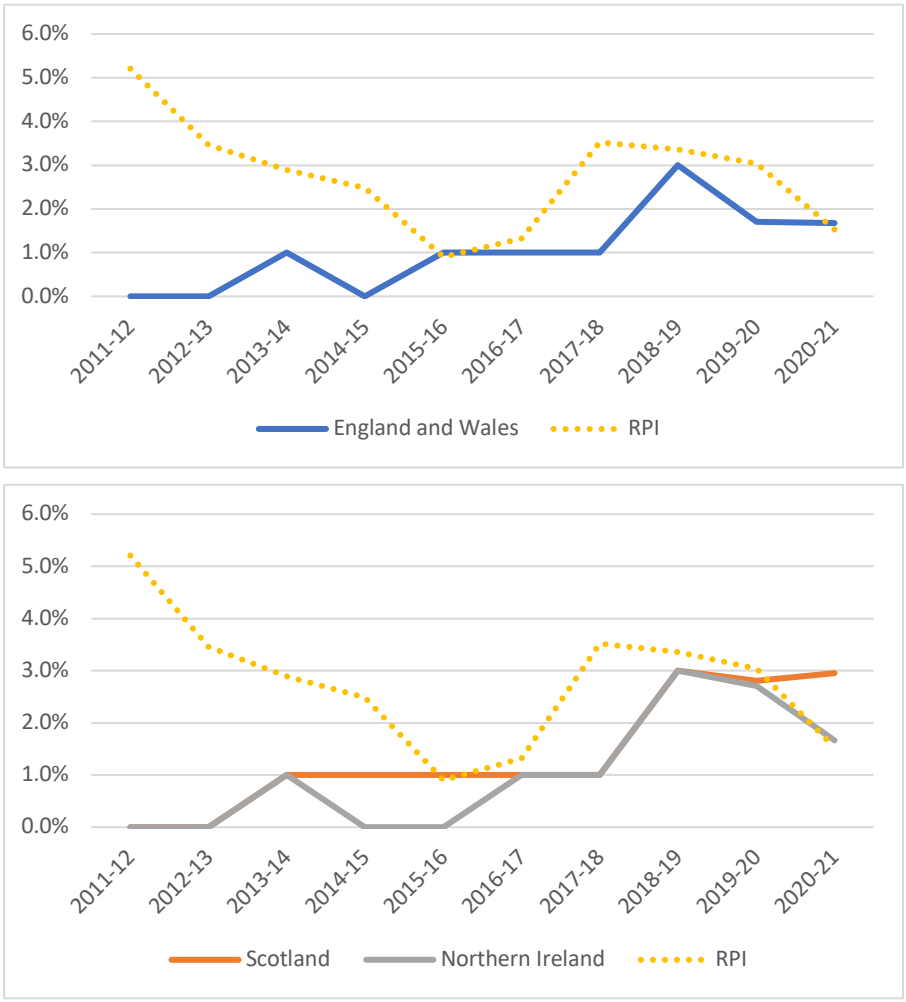


Figure 16: Annual growth in value of top point of Band 7 against annual RPI inflation, 2010-2020



9.4 Workforce data for NHS England since 2020 shows that earnings growth among all Agenda for Change staff has failed to keep up with the cost of living[20]. Annual earnings growth rates for all staff, including nurses and health visitors, midwives and nursing support workers have been below RPI inflation in every year between 2010 and 2018. In addition, in most years Agenda for Change earnings have failed to track annual growth in annual weekly earnings across the UK labour market.

9.5 The cumulative effect of this weak growth is that all Agenda for Change staff have suffered a 13.2% real terms drop in earnings since 2010. Among nursing staff, nurses and health visitors have seen a 12.6% real terms gap, while nursing support workers have lost 11.6%.

9.6 In England, Wales and Northern Ireland this situation is exacerbated by the fixed tiered contribution structure for the NHS Pension Scheme (the tiers are dynamized in Scotland). This means that any pay uplift, be it costs of living or pay step increase, sees a growing proportion of nursing staff actually experiencing a reduction in take home

[20] Similar analysis is not possible for Wales, Scotland or Northern Ireland as the same level of data is not available.

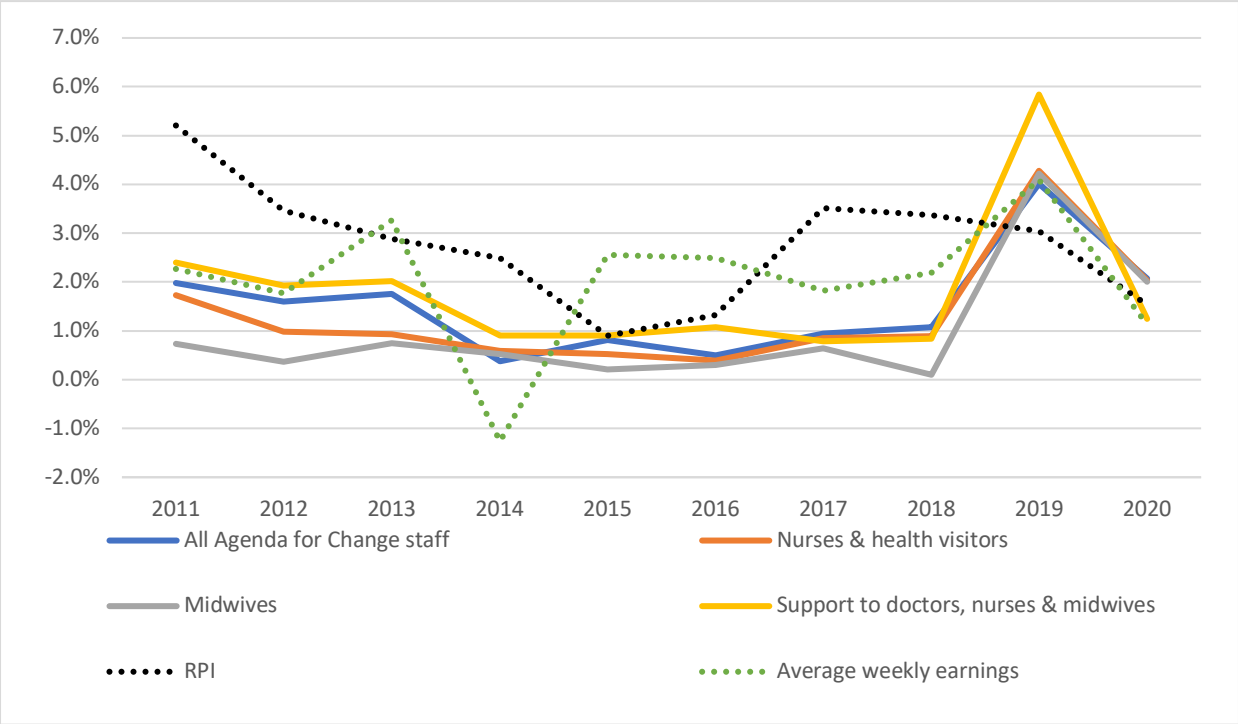
pay as they move into a higher pension contribution tier. For many of these pension scheme members there is no equivalent increase in the value of their pension benefit as the accrual rate is the same regardless of contribution tier. We had expected a new contribution framework to be introduced in 2021 but this will not now come into effect until April 2022 at the earliest.

Table 2: Real terms growth in earnings: NHS England

	Average real terms total earnings gap 2010-20
Nursing workforce groups	
All nurses and health visitors	-12.6%
All nursing support workers	-11.6%
Nursing staff employed at top of Agenda for Change bands	
3	-14.6%
4	-17.1%
5	-17.0%
6	-14.4%
7	-15.3%
8a	-15.4%

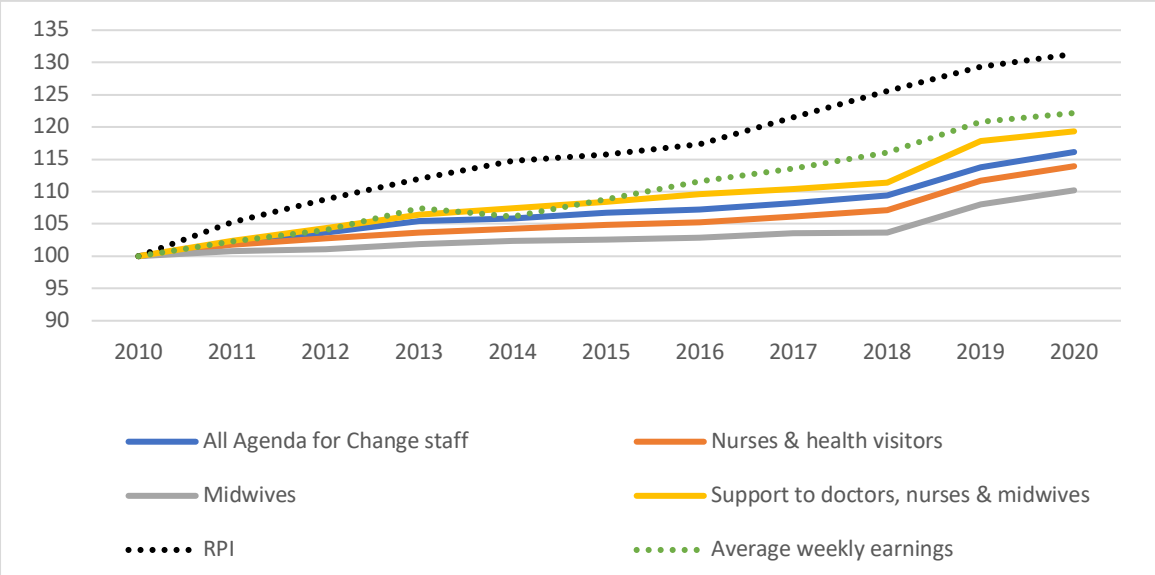
Figure 17: England: Nominal annual earnings growth; RPI inflation; average weekly earnings growth

2010-2020



Source: NHS Digital; ONS

Figure 18: Cumulative earnings growth since 2010 compared to inflation and average weekly earnings growth
Index 2000=100



9.7 The RCN notes that the new starting salary for teachers is set to rise to £30,000 in 2022/23 in England. The starting salary for newly qualified nurses is currently £24,907 in England, Wales and Northern Ireland and £25,100 in Scotland. A starting salary of

20% higher in a comparable profession to nursing is likely to be huge disincentive to individuals when choosing a degree course and will frustrate any efforts to attract people into the profession.

> *"[We need] pay that reflects the graduate status of the profession like physios, teachers and OTs and the regard that goes with it. One large pay rise to catch up with the years where we have slipped behind followed by inflation based rises."*
>
> ***Band 5 staff nurse***

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