Last spring, we saw

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

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 2020, we launched the *Fair Pay for Nursing* campaign, aiming to secure a fully-funded 12.

PPE

The shortages of PPE experienced in the first wave of the pandemic, 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 was not 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 g

ensure that those services

Unequal impact of the pandemic

The COVID-19 pandemic has both highlighted and exacerbated existing socio-economic and health inequalities. 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

It was the impact of these existing inequalities that further impacted societal resilience and saw different communities adversely impacted by COVID-19. 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 the root causes of inequality.

Since 2015, NHS England have published the NHS Workforce Race Equality Standard (WRES) on an annual basis. The WRES data examines differences in workplace experience and outcomes on the grounds of ethnicity and encourages organisations to close those gaps. The WRES covers staff working in the NHS and those organisations providing NHS services.

Often those employed at Agenda For Change (AFC) bands four to six, are professionals delivering 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. The WRES 2019 data return 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 AFC 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.[xiv]

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.

The development of a coherent cross-governmental strategy which is designed to tackle the impact of structural racism appears particularly necessary as part of an overall recovery measure.

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.[xv] 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.

£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

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 are at odds with an ambition from government to focus on increasing international recruitment. The health and care system must not be faced with these unjust fees for safely staffing their services. It is not appropriate to divert funding away from 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

international staff is therefore vital. 69% of th public think that
should publicly acknowledge the contributions of international st
social care during the pandemic.[xxiii] Granting In efinite Leave to R
positive step to show our internationally educated colleagues that the government recognises their commitment and value to the NHS and social care. It would also ensure that overseas staff who already pay their taxes and national insurance contributions are able to access public funds in time of hardship.

The Immigration Health Surcharge (IHS)

We welcomed the

Appendix 1: 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

- 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.

[i] Ball JE, Bruyneel L, Aiken LH, et al. Post-operative mortality, missed care and nurse staffing in nine countries: A cross-sectional study. *Int J Nurs Stud*. 2018;78:10-15. doi:10.1016/j.ijnurstu.2017.08.004

[ii] Royal College of Nursing, Building a Better Future for Nursing, [available at: https://www.rcn.org.uk/get-involved/building-a-better-