Royal College of Nursing

Gender and Nursing as a Profession

Valuing nurses and paying them their worth

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Executive summary

This report explores and critiques the gendered construction of value within the nursing profession and evaluates how value is attributed to nursing, the value placed on individuals and the status of the profession. The data collected to address these questions were drawn from quantitative data and in-depth interviews with senior stakeholders from the nursing profession.

Nursing, a profession in crisis?

In recent years, the combination of staff shortages and under-resourced services resulting from poor workforce planning have led to nurses feeling overworked and underpaid, and choosing to leave the profession. Yet an often overlooked feature of the crisis currently facing the profession is the fact that the workforce is overwhelmingly made up of women.

Nursing suffers from a historical construction as a vocation, where individuals – usually women – enter its gates as a calling and some inherited notions persist that have consequences for modern nursing. This is perhaps seen most clearly in the huge amounts of goodwill demonstrated by nursing staff, both in working beyond their paid hours and in difficult contexts, often without financial reward.

The construction of nursing as a gendered profession and the role of wages

The gendered construction of nursing leaves a legacy which continues to feed the current crisis, including suppressing wages and downgrading working conditions. Historic perceptions that care is a naturally feminine skill or characteristic sit in direct opposition to the high level of skills and professionalisation required in contemporary nursing. It also devalues the emotional labour required in nursing, taking this for granted as a natural ability rather than one that should be rewarded.

Examining concepts of professionalisation in relation to nursing and its status, the report reflects on why – in the face of a serious staffing crisis – nurses remain undervalued and underpaid when it might be expected that market forces would prevail in the present situation of high levels of vacancies, and force an increase in wages.

Going beyond orthodox market theories, we evaluate:

- wages as a social practice that informs and reflects deeply embedded views of a nurse's place in the hierarchy of jobs, revealing how wages are not only based on productivity or an assessment of job demands, but also shaped by gender or ethnicity
- how the NHS, as the largest employer of nurses in the labour market, exerts significant control over wage setting and acts as a trend setter for all health sectors
- how austerity has suppressed wages and weakened trade union bargaining power
- how nurses are positioned within the NHS Agenda for Change (AfC) pay structure and the implications this has in relation to equity with other occupational groups.

Gender and diversity in relation to pay and working conditions: quantitative evidence

Analysis of data sets from the Office for National Statistics *(ONS Quarterly Labour Force Survey 2018; ONS Annual Survey of Hours and Earnings 2018)* and the RCN *(RCN Employment Survey 2017)* reveals:

- a substantial gender pay gap exists among all health care professionals (nurses, doctors, managers and allied health professionals) – with women receiving an average of 30% less than men per week, or 16% less per hour as a result of two factors: men working on average more hours than women and sex discrimination

- the pay of registered nurses is 81% of the sector average (which includes health professionals; allied health professionals; health managers and directors; and therapeutic and technical staff)

- the pay of registered nurses is also characterised by little variation in earnings across the nursing workforce, despite the wide range of roles and responsibility and levels of seniority; this suggests there is low scope for progression and higher earnings across nursing careers

- among nurses, the gender pay gap amounts to 17% on a weekly basis, however, when other factors are considered (age, number of dependents or having management responsibilities) this gap disappears almost completely due to differences in working hours (women in nursing are more likely to work on a part-time basis than men)

- among those nurses who work paid overtime to boost their pay, men work on average more hours than women.

A decomposition of the nursing gender pay gap shows that if women and men worked the same hours, the pay gap would be reduced by £102.60 per week, accounting for the majority (95%) of it. In other words, it is the gendered construction of nursing that is suppressing wages rather than gender inequality in the workforce.

Exploring other differences among nurses:

- nurses from a Black, Asian and minority ethinic (BAME) background appear to earn more on a weekly basis than white nurses; typically this cohort of nurses is less likely to work part-time and more likely to use overtime to increase their pay than white nurses

- paradoxically, when structural factors such as working hours are considered, BAME nurses earn 10% less (weekly and hourly) than their white counterparts

- as many as one in three men, and the same proportion of those from a BAME background, are thinking about leaving their jobs because of financial worries.

The voice of senior stakeholders in the nursing profession

Interviews with senior stakeholders provided further confirmation that the unrealistic and outdated perceptions of nursing that persist within wider society and nurses' own self-concepts undermine professional identity. Stakeholders also identified the continuing failure to recognise the profession as a safety-critical role is linked to the fact that the majority of nurses are women.

Senior stakeholders identified a number of other complex challenges that are impacting the nursing profession:

- interviewees described how the registered nursing role is being diluted and overwhelmed by the increasingly diverse range of tasks being carried out by nurses – contributing to confusion about what nurses do and further devaluing the role

- growth in the number of unregistered health care workers/nurses, and the development of their scope of practice, was both viewed as a significant opportunity to address undersupply but one that further undermines the profession by hollowing-out the registered nursing role

- an increasing number of nurses are choosing flexibility over career development (either by remaining in lower AfC band roles or moving to bank contracts) in reaction to a lack of choice/control over working patterns or working hours, a paucity of care provision, and the lack of support for training and development.

Asked for their views on potential solutions, several interviewees cited the need for greater:

- engagement from leaders and managers in enabling more inclusive and adaptive working environments which suit the needs of an increasingly diverse workforce

- nursing leader input and influence in national policy development and in the workplace itself.

In terms of the RCN's position and potential, interviewees stated it has an important role to play in protecting and enhancing the profession's

knowledge and skills. This should be supported and prompted by the increased engagement of nurses, with better support from nursing leaders, to articulate their own value and use their own voice.

Final observations and recommendations

A range of factors have contributed to continuing low pay and poor working conditions within the nursing profession. While the effect of gender on pay is not direct, it is necessary to understand the critical role that gender plays in suppressing wages. Another factor is the dominating role of the NHS; as the primary employer in the health sector it acts as a significant point of reference for wages throughout the sector.

While the professionalisation of nursing has made great progress, the consolidation of the status of nursing as a profession can only be achieved by addressing two issues in parallel:

- questions of knowledge claims – what skills are at the heart of the nursing profession
- the autonomy and control of work – how work and working time are organised.

Gendered notions of nursing and nurses that fail to match the reality of a professional life defined by high level technical, emotional and cognitive skills continue to inhibit efforts to improve the standing and attractiveness of nursing as a career. In recent years, the RCN has engaged in campaigns and bargaining activities aimed at setting out a true picture of the realities and complexities of modern nursing. The RCN and other professional and representative bodies now need to build on these to describe, publicise and recognise the impact nursing staff make through their work in practice, research, advocacy and innovation. Campaigns, engagement and bargaining activities need to articulate the value of nursing on multiple levels – to patient safety, social mobility, public finances and economic growth. They also need to go one step further by emphasising the importance of nurses' voice and leadership in realising these benefits.

A key part of this work should include a new understanding of transformations in the economy, in society, and the world of work. Key areas for exploration should include changing views of:

- the psychological contract in terms of the relationship between workers and employers and the mutual expectations for each side (including opportunities for growth, pay and reward, recognition, progression, managerial and peer support, flexibility, and job security)
- what members want from their union, in relation to professional leadership, workplace representation and agents for social change
- how members wish to be their own advocates for change on professional and workforce issues.

Recommendations

1 **Research and engagement with RCN members should be undertaken to better understand the meaning of work for nursing as a profession against a changing world of work; and how the profession responds to future developments and changes.**

Not only is the RCN uniquely placed to lead research and engagement to understand these changes and trends, but it is imperative that it does so in order for it to continue representing its members and nursing.

2 **RCN to create a platform for the nursing profession to articulate the full scope of nursing as caring, compassionate, evidence based and safety critical.**

The RCN is also uniquely placed to provide a platform to enable the profession, and particularly its members, to express and assert the full value of nursing. This will enable nurses to present clear descriptions of what nursing actually is and what it does, the value it brings, and the need for nurses' voices at key points of all decision-making affecting the nursing profession.

3 **RCN to conduct further research (quantitative and qualitative) into the intersections of sex and gender with other variables such as ethnic background, disability, age and social class.**

Further research is needed to understand the nature of work and outcomes for nursing staff from an intersectional perspective, evaluating how factors such as ethnic background, disability, age or social class can shape the experience of nursing as a profession and outcomes, particularly career progression and pay levels.

4 **RCN to lead on the development of a clear and in-depth assessment of the mix of knowledge and skills in nursing – both on its own terms and in relation to other staff in the health sector – in current job descriptions and evaluation frameworks.**

5 **RCN to lead on the development of fairer and more realistic job evaluation frameworks for use in all settings and for the benefit of all of its members, followed by steps to ensure that nursing staff are employed on the correct banding to match their level of responsibility, skills and autonomy.**

A review of current job evaluation structures to assess if these are fit for purpose for a graduate profession; accurately and fully measure the productive value of all aspects of nursing (emotional, productive, technical and cognitive); and fully encapsulate new NMC standards is needed. While this activity relates primarily to AfC, any changes will have far-reaching consequences for nursing staff employed on other contracts and has clear implications for health care support workers; care must be taken to avoid unintended consequences that result in poorer conditions for support staff. The review should include a programme of work to ensure that nursing staff are appropriately banded and employed on a band that matches their level of responsibility, skills and autonomy. It is also important that nursing staff are fairly treated and supported in appraisals and other development programmes related to their employment and career progression.

6 **RCN to call for the development of a career framework which enables, rewards and supports horizontal and vertical progression.**

This research demonstrates that, in comparison to other health care professions, nursing provides fewer opportunities for progression. Associated with moving away from clinical roles (and away from care), progression is also associated with an element of risk that is perceived to be inadequately rewarded or supported. Progression also leads to less flexible roles, which can be unattractive to nursing staff with family or caring responsibilities. There is a clear need to better understand and support progression in nursing.

7 **RCN to promote the need for a change in how work is organised and call for the NHS and other employers to use their reputational power and resources to enable women's and men's careers at all life stages.**

All efforts to address chronic shortages in nursing and other health and social care occupations, and to develop a highly skilled, highly motivated workforce must be placed within the framework of a workforce where women predominate. This means addressing how work and working time is organised and recognising the different needs of staff at different stages of their life course. To achieve this:

- managers and union representatives need to ask how each new policy, change in service delivery or new way of working facilitates nursing staff to work to the best of their abilities (while considering the different needs of staff according to their personal circumstances/capabilities)
- employers need to engage with the workforce, listen to their needs and enable practical solutions (fair pay for nurses and support staff, training and development, occupational health provision, decent working conditions, subsidised childcare) as well as flexibility, career progression, inclusion and professional voice. This is particularly true for the NHS as the biggest employer in the UK.

8 **RCN to invite members and nursing leaders to debate and support the recommendations of this report and engage them in becoming advocates for change.**

Our final recommendation entails a broad invitation to RCN members and nursing leaders to debate the main points and other recommendations made in this report. Through the RCN, members and leaders can be brought together to discuss and plan strategies for joint working.

This work has been carried out at a time when it is more urgent than ever to ensure that nursing as a profession remains attractive and offers adequate rewards. Through this research, we hope to have contributed towards the path of critically evaluating where nursing in the UK stood as a profession, so that it can successfully more forward as a graduate and safety-critical profession.

Chapter 1: Introduction

In an era when reflections on the future of work are dominated by the extent to which artificial intelligence and robots will take over from humans, job roles such as nursing that require a high level of personal interactions and skills which machines cannot accomplish – such as empathy, resourcefulness and the ability to solve complex problems creatively – are set to become increasingly valued.

Indeed, the chief economist of the Bank of England has stated "the high-skill, high-pay jobs of the future may involve skills better measured by EQs (a measure of emotional intelligence) than IQs" (Haldane, 2015: 11). Never has there been a better time to reassess how we value skills that are the key components of caring roles such as nursing.

The issues facing the nursing profession have been well documented. Staffing levels are failing to keep up with an escalating demand that is being fuelled by an ever-rising need for health and social care, while recruitment and retention problems place additional pressures on the system. Meanwhile, past and present failures in workforce planning mean there is little confidence there will be enough nurses for future needs.

Against this backdrop, the development of new models of care that require new skills and approaches means the professional pace of change is increasing. In short, nursing is becoming more complex and more intense. In the wake of the recent series of investigations and reviews in response to incidents of poor practice, nurses are acutely aware of their professional accountability when working in environments where reduced staffing levels create the pressurised conditions that can be unsafe for both patients and nurses. The outcome of this increased complexity and pressure is a workforce which feels undervalued and powerless. When nursing is understaffed, nursing staff get burnt out and leave the profession, putting patient care at risk, and lack the time or resources to further their own clinical or theoretical knowledge.

This report examines nursing as a profession in the UK and takes stock of nurses' pay and status. Exploring how pay in the nursing workforce has been shaped and constrained by the impact of its

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history and status as a women-dominated and women-defined profession, the report looks at nursing through two specific lenses:

- professionalism and professional status
- gender, pay and autonomy.

While this report is focused on registered nurses (RNs), addressing gender and ethnic pay gaps while improving working conditions for this cohort of workers should also cascade into progression for the wider nursing workforce.

This report contends that the responsibility, knowledge, skills, accountability and education of nurses are undervalued – both in terms of status and financial reward – and that this undervaluing stems from the feminised nature of the profession. To address this, nurses themselves will need to play a central role in setting the standards. This raises questions about how jobs are evaluated and whether attention needs to focus on how nursing jobs are designed, evaluated and rewarded. This includes revising the Agenda for Change pay structure (see the Glossary for an overview) used across the NHS and by non-NHS employers, so that pay levels fully reflect the status of nursing as a graduate profession. To achieve this, the voices of nurses need to be heard: pay, rewards, and conditions should not be constructed in opposition to, or as negating, nursing as a vocation.

This contradiction in perception, we argue, results from a misalignment between images of the past and the current reality, and the gendered construction of nursing. As a result, serious discussions about what is really needed to make nursing sustainable in the future as a safety-critical profession are well overdue. This is all the more relevant as nursing is a profession that has been, and continues to be, incredibly diverse.

The report methodology utilises a combination of research approaches to achieve its objectives

Chapter 2 contains an overview of key issues facing nursing as a profession.

Chapter 3 examines previous health sector research findings and academic scholarship.

Chapter 4 provides a comprehensive quantitative analysis of nursing, both in isolation and relative to the wider health care sector. Examining wages and pay, working conditions and the standing of the nursing profession as a whole, the research evaluates how gender intersects with other diversity grounds such as ethnicity, age and disability.

Chapter 5 gives voice to key nursing stakeholders, examining how they see the profession; the threats, and opportunities for progress.

Chapter 6 brings the report to a close with final conclusions and recommendations.

Chapter 2: Nursing, a profession in crisis?

In this section we provide a brief overview of current issues, looking at staffing levels and the variety of roles and characteristics in the UK nursing profession. We then discuss some key issues in relation to pay, working conditions and quality of care, before outlining key changes in the nature of care.

Staffing levels

The number of nurses in the UK increased by 13% from 568,000 in 2011, up to 639,000 in 2018 (see Figure 1). The proportion of men in the nursing workforce has remained fairly constant over this period at around 10%. Despite an increase in the number of nurses over the last decade, the UK now ranks below the Organisation for Economic Cooperation and Development (OECD) average of nurses per thousand of the population, while the complexity and acuity of the health and care needs of patients and the public have risen (OECD, 2017). The main supply route for the registered nursing profession is new graduate nurses, yet numbers are failing to keep up with current and anticipated demand. The NHS faces vacancies of over 40,000 in England alone (equating to around one in nine posts), with 80% of vacancies in nursing in the NHS filled by temporary bank staff (NHS, 2019a). Social care also faces chronic shortages, with a nursing vacancy rate of 12.3% (Skills for Care, 2018).

The NHS faces vacancies of over 40,000 in England alone... with 80% of vacancies in nursing in the NHS filled by temporary bank staff.

The UK has experienced periodic recruitment crises in nursing throughout the 20th century, with various economic, demographic and political factors combining to affect demand and supply in the labour market. In 2015 the Migration Advisory Committee (MAC) placed the nursing workforce on its shortage occupation lists (SOLs) for the UK and Scotland due to the shortage of resident workers available to fill roles. Commenting on its decision, MAC noted a 'structural undersupply' of nurse training places to fill the current void and highlighted the decision to cut training places between 2009 and 2013 as a major contributory factor (MAC, 2016); in England, university places were cut

by more than 17%. It also pointed to failures in workforce planning, which it stated had taken little account of demand for nurses in the care and independent sectors, as well as pay restraint across all sectors as contributing to this structural undersupply. Leary (2017: 3761) states that the shortage of nurses has been "exacerbated by the growing awareness of the body of evidence that graduate RNs improve outcomes and skill dilution at point of delivery increases risk" and that supply has failed to keep up with demand and the complexity of caring. In addition to the poor pipeline of students, Leary (2017: 3761) also comments on an "inability to retain nurses in the workforce or encourage returners".

More recently, the removal of the nursing bursary in England has been identified as a key risk for recruitment. Applications from first-time students for nursing degrees dropped from 52,740 in 2016 to 39,665 in 2019, a fall of 13,075. In recognition of the impact of the bursary removal, there has been a part reversal of the policy. From September 2020, all nursing students in England will get a £5,000-a-year maintenance grant. In addition, those who plan to work in areas with severe shortages of nurses, or in one of the areas of care where the lack of nurses is acute – such as mental health or learning disability care – will receive another £3,000.

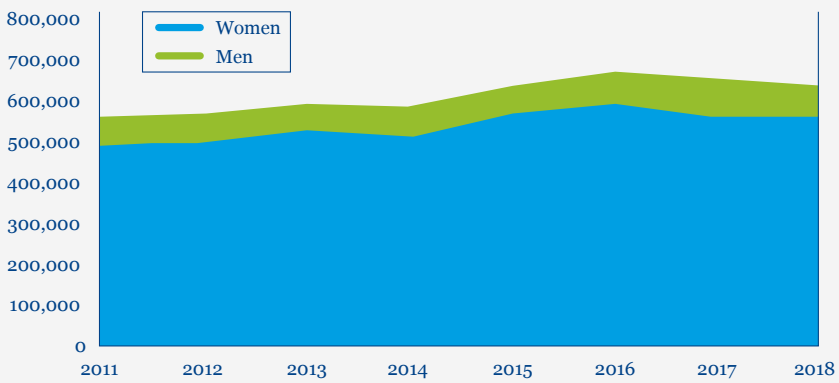
Demographic factors also play an important role in the recruitment and retention of nursing staff. With one-third of UK nurses due to retire by 2026, the current workforce is ageing. Yet a decline in birth rates has eroded the traditional pool of 18-year-olds which might now be applying for nursing degrees. Meanwhile, following the UK's vote to leave the EU, there has been a reduction in the number of nurses migrating from the EU to work in the UK due to uncertainty about their working terms and concerns about how working in the UK once it leaves the EU may no longer support a future career in their home country (Hurlow, 2016; NMC, 2019).

Varieties of nursing

Nurses work in a wide range of roles across the health and social care sector: in the NHS, GP practices, social care, private providers, higher and further education, and the voluntary sector. In addition, private schools employ nurses as do pharmaceutical companies, research organisations, the armed forces, police law courts and prisons. Many nursing personnel work via a nursing agency as well as for NHS banks. Nurses play a central role in the delivery and coordination of physical and psychosocial care, working both independently and as members of larger health care teams. They conduct health promotion, disease prevention and maintain health and wellbeing, and are united as a profession through common standards, a code of ethics, professional rights and responsibilities.

In a profession where women largely predominate, they should arguably occupy greater numbers of senior roles, negating the effect of vertical gender segregation seen in many other sectors. However, several studies have shown that women are under-represented in leadership positions in the NHS and across the medical profession more widely (Hauser, 2014;

Figure 1: Number of nurses in the UK 2011-18 by sex



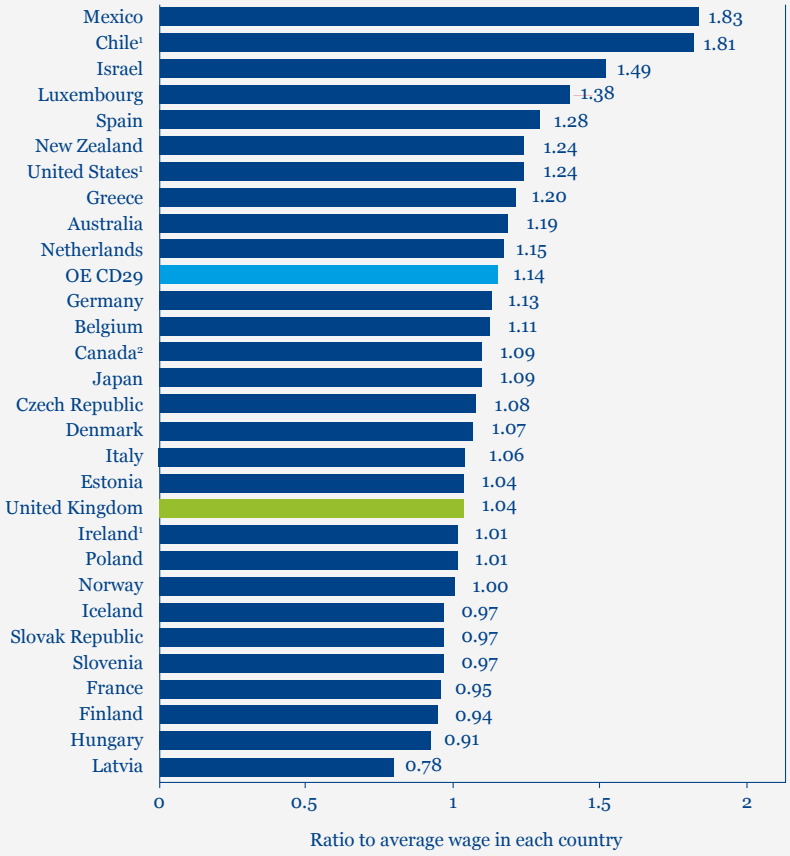
Source: Office for National Statistics, 2019

Hopkins et al., 2006; Hoss et al., 2011; Lantz, 2008). Despite women making up around three quarters of all NHS staff, they account for around a third of all senior roles (NHS Digital, 2018). Furthermore, women in senior roles within the NHS tend to be clustered in human resources or roles such as directors of nursing (King's Fund, 2011). Individual contributory factors certainly play a role here; childcare needs, lack of confidence, employers' attitudes, maternity leave and career breaks, and the high propensity for part-time working.

Acker's explanation of vertical gender segregation maintains that even when institutions are dominated by women, men benefit from an organisational logic which privileges the characteristics associated with masculinity, such as assertiveness, leadership and rational thought (Acker, 1990). As a result, men who enter the nursing profession benefit from the 'glass elevator' phenomenon (Williams, 2013), with disproportionate access to high-level positions and higher pay (Busch, 2018; Punshon et al., 2019). This may be exacerbated by highly specialised work contexts, including mental health nursing, being particularly attractive to men with the resulting role advancement serving to alter gendered constructions of nursing as men find opportunities at higher pay bands while remaining in clinical roles (Woolnough et al., 2019).

Diversity characteristics in relation to nursing workforce pay gaps are also worthy of consideration and exploration. For example, in 2017-18, registered nurses from a non-white background represented a significant proportion of the UK workforce (see Table 1). Ethnic background is relevant to the experience of working as a nurse when it comes to pay, disciplinary rates or bullying. Recent NHS workforce equality data for England (NHS England, 2019) shows that BAME nurses, midwives and health visitors are under-represented in senior Agenda for Change (AfC)

Figure 2: OECD, remuneration of hospital nurses, ratio to average wage, 2015 (or nearest year)



1. Data refer to registered ("professional") nurses in Chile, the United States and Ireland (resulting in an over-estimation)
2. Data refer to registered ("professional") nurses and unregistered nursing graduates

Table 1: Registered nurses on the NMC register by ethnic background, 2017-18

Ethnicity	% of nurses on NMC register
White	73.5%
Asian	8.1%
Black	7.9%
Mixed	1.9%
Other ethnic group	0.9%
Not specified	7.7%

pay bands across the NHS. According to the report, the number of BAME nurses, midwives and health visitors at senior AfC pay bands is increasing, "but this is not happening at a pace that will ensure equality in representation across the workforce pipeline" (NHS England, 2019: 6).

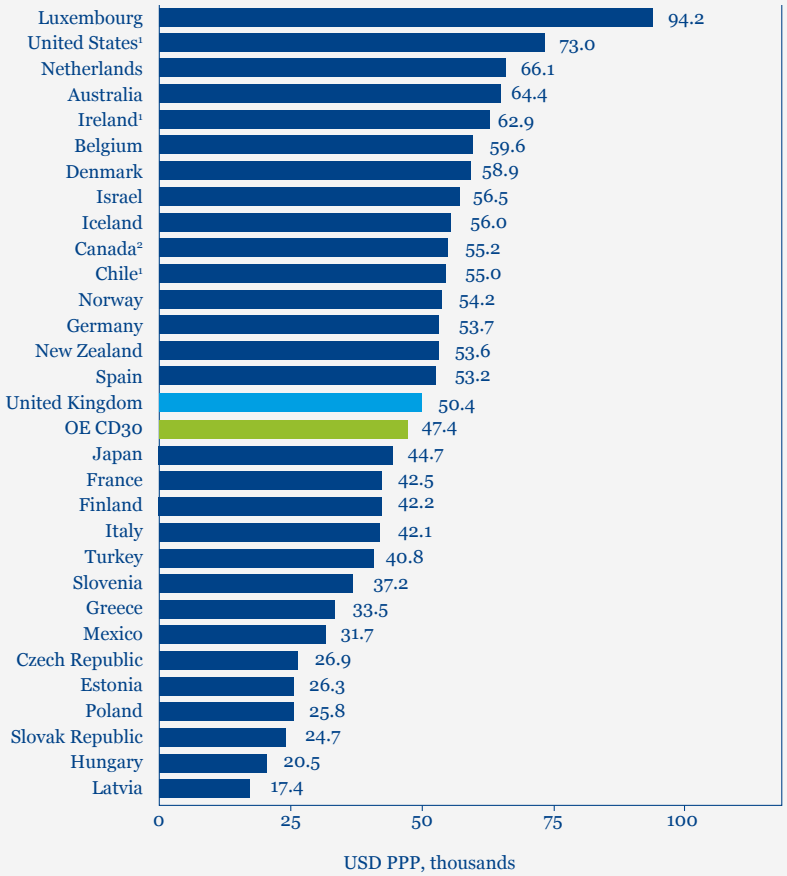
Furthermore, disciplinary rates for minority groups are higher than for white staff while discrimination at work, bullying and harassment are also proportionally higher for BAME staff. As there is little available data for NHS staff in other parts of the UK, it is difficult to draw a full UK-wide picture of staff experiences.

Pay, working conditions and quality of care

The following figures illustrate nurse salary levels across OECD (Organisation for Economic Cooperation and Development) countries in 2015. Figure 2 shows the relative financial status of nurses compared to other occupations, and reveals that nurses in the UK earned just 4% more than average wages across the whole economy in 2015, compared to an OECD average of 14%.

Figure 3 illustrates remuneration levels in a common currency – US dollars – that has been adjusted for purchasing power parity (PPP) to give an indication of the relative

Figure 3: OECD, remuneration of hospital nurses, USD to PPP 2015 (or nearest year)



economic wellbeing of nurses compared to their counterparts in other countries. When converted to a common currency and adjusted for PPP, remuneration of nurses is revealed to be higher than that in the UK across 15 of the 30 OECD countries, including the USA, Canada and Australia.

These international comparisons highlight how the UK nursing profession ranks poorly in relation to both average earnings and purchasing power. Further data shows how nursing is losing out compared with other graduate occupations. Table 2 presents Department of Education data on earnings outcomes for those completing higher education, showing median earnings one, three, five and 10 years after graduation. Median earnings for those on nursing courses were above the median for graduates as a whole one year after graduation (£25,800 compared to £18,900). However, 10 years after graduation, median nursing earnings were lower than the median for the whole group (£30,100 compared to £30,600) demonstrating the lost earnings potential compared to other graduate professions.

International comparisons highlight how the UK nursing profession ranks poorly in relation to both average earnings and purchasing power.

Exploring a range of issues impacting the nursing workforce, the *RCN Employment Survey 2017* revealed a workforce that felt overworked and underpaid, and unable to give the quality of care their role demanded. The findings also show how nurses' pay does not equate with the level of responsibility and autonomy they hold, or their skills, knowledge and experience. Median earnings among RNs have fallen by 12.9% in real terms between 2010 and 2018 (RCN, 2018b). Driven largely by a policy of public sector pay restraint, this mirrors wage stagnation seen across much of the UK economy since the financial crisis.

Table 2: Median earnings by subject, one, three, five and 10 years after graduation

	Year 1	Year 3	Year 5	Year 10
	£	£	£	£
Education and teaching	20,400	22,100	24,000	25,000
Psychology	17,100	20,700	23,200	26,600
Nursing	25,800	26,900	28,300	30,100
Sport and exercise sciences	15,800	21,100	24,100	30,600
History and archaeology	17,900	22,800	25,900	30,700
Veterinary sciences	28,000	31,400	32,500	31,200
Pharmacology, toxicology and pharmacy	24,200	29,700	33,700	31,600
Languages, linguistics and classics	19,700	24,300	27,500	31,800
Business and management	20,500	24,300	27,200	32,400
Computing	22,400	25,900	28,600	34,100
Politics	20,200	25,300	29,000	34,700
Chemistry	21,000	25,200	29,100	35,000
Engineering	26,500	30,800	34,300	41,200
Economics	26,000	32,000	40,200	49,800
Medicine and dentistry	36,600	43,000	47,100	53,300
All	18,900	22,800	25,700	30,600

First degree graduates from English higher education institutions and further education colleges. Cohorts: 2005/06 (10 years after graduation); 2010/11 (5 years); 2012/13 (3 years); 2014/15 (1 year).Tax year: 2016/17

Source: Department for Education, SFR 15/2019

Nursing work is also subject to increasing levels of intensification and is one of the professions most prone to psychosocial risks such as burnout and stress (Ackroyd and Bolton, 1999; Adams et al., 2000; Cooke, 2006; Zeytinoglu et al., 2007). These factors lead to increased levels of sickness and absence related to stress, and the Health and Social Care Select Committee report into the nursing workforce (2018) shows that nurses are leaving the profession as a result. Pressure comes from high workloads, added to which changing patient demographics means that older patients with multiple co-morbidities need more care and attention than before. Finally, nurses reported a lack of recognition for all their efforts, not being paid for doing overtime or staying late, and employing organisations increasingly relying on their goodwill to perform these duties.

The changing face of care

To become a registered nurse (RN) in the UK, a programme recognised by the NMC must be completed that involves a degree, giving both an academic award and professional registration. An apprenticeship programme, usually lasting four years with an NHS employer was also introduced in England in 2018. Although degree-level nursing courses have been available since the 1970s, the change to all-graduate entry came into came into force in 2013. The move to graduate status has not been without its critics with many (both lay and professional) arguing that nurses cannot be taught to 'care' and that nurses are 'born rather than made'. Media representations reflect the generalised perception that the 'technical side' of nursing has taken precedence over the 'caring side', with nurses 'too posh to wash' (Chapman and Martin, 2013).

Nurses reported a lack of recognition for all their efforts, not being paid for doing overtime or staying late, and employing organisations increasingly relying on their goodwill to perform these duties.

This is an ongoing debate within the profession, with nurses and commentators alike having long discussed "nursing's persistent inability to grasp the nettle of reconciling our technical skills with our caring skills" (Kitson, 1996: 1650). It's a debate that frequently raises its head at times of crisis, where investigations into failures of care often portray nurses as lacking the assumed care and responsibilities of their profession (for example, the 2013 Francis Report). Leary (2017) urges a wholesale reframing of the purpose of nursing to emphasise the complexity of safety critical care and to give more weight to nurses' ability, rather than their values. She concludes that there is an anti-intellectualism in nursing that is not found in other safety critical professional groups and contends that this is grounded in nursing's own insecurity.

Conclusion

In this section we have provided an outline of some of the current and well-known issues impacting UK nursing, going on to further detail the growing crisis facing the workforce and the changing face of care. In the next chapter, we draw on this overview of the nursing profession to question why, given the low pay, low progression and challenging working conditions, market rationale commending higher wages does not apply.

Chapter 3: The construction of nursing as a gendered profession and the roles of wages

The following literature review explores the development of nursing as a profession and sets out some of the complex and interrelated factors which have impacted on nursing's quest for professional status. The evolution of nursing from apprenticeship training to a professional discipline has been a hard-fought battle; one that has seen a move away from nursing as a vocation and an extension of the physical and emotional work of wives and mothers, towards a professional status.

The majority of today's health care workforce are women; increasingly, women are entering professions such as medicine that historically have been dominated by men, as well as maintaining their presence in professions where women have predominated, such as nursing. As the literature review will show, this has coincided with nursing becoming more formalised, professionalised and clearly distinguished by what are considered to be the key criteria or traits of a profession: formal educational requirements, autonomy of practice, a code of ethics, and an expansion of knowledge, common cultures and values. Yet in other ways nursing still struggles to assert its professional power and autonomy and its professionalisation has yet to translate into higher pay.

In this chapter we consider how the development of professional status has been shaped by historic gender relations and the gendered division of labour. Women's and men's roles in the health sector have, in the past, been identified as having distinct traits and abilities. As a result, medicine has been broadly defined as work for men, and nursing as work for women; a social construction of gender roles that has left an enduring legacy.

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Claims to expert, scientific knowledge – in opposition to practical knowledge – continue to be held up as the point of reference and defining feature of a profession. Practical knowledge itself connotes femininity and imbues lower status, in

large part because of its association with care. As long as definitions of nursing are based on its practical work over and above its expert, scientific knowledge – whether determined in the public image, nurses' own self-concept or professional identity – this will continue to devalue nursing.

This chapter looks at the key traits or markers of professions and considers how nursing measures up in an attempt to understand how its successes or struggles have combined to influence the development of nursing as a profession, particularly in relation to its pay, status and sustainability – the so-called low wage puzzle in nursing.

Nursing and the gendered division of labour

The industrial revolution marked a decisive change in the location and status of women's labour, with productive work largely moving outside the home into waged employment. This created a clearer demarcation between productive work in the public sphere and reproductive work in the private sphere. However, the distinction between reproductive and productive and between private and public is in fact largely illusory; for example, certain tasks conducted outside the home (such as cooking) easily switched between being reproductive and productive (Fraser, 2013; Walby, 2009 and 2013). What is important is the salience given to gender in establishing this distinction, and the different values attributed to it (Héritier, 1996).

Reproductive work is, de facto, associated with women and 'feminine', and as a result is devalued in contrast to the productive 'masculine' work associated with men. The concept of 'women's work' is based on essentialist notions of gender which prescribe that women and men have different characteristics which are inherently biological. This belief has profoundly shaped the way work is valued in our society and, because of its association with 'natural' feminine attributes such as love, care and empathy, nursing is viewed as an occupation particularly suitable for women (McDowell, 2009).

Within nursing, the tension between work that can be understood as both reproductive and productive is apparent. Early definitions of nursing considered that since the skills required of nurses resembled many 19th century domestic tasks, they were deemed "low skill in comparison with emerging industrial skills" (Hart, 2004: 224) and consequently devalued in relation to more masculine manual jobs. Understanding nursing work as a form of domestic work is also apparent in Florence Nightingale's vision of modern nurses, as it emphasised the moral virtue of nursing (Morley and Jackson, 2017), and as a result informed the popular notion of the nurse as a charitable, "good woman" who is kind, caring, compassionate, honest and trustworthy (Gordon and Nelson, 2006: 63). Nursing was deemed to be a suitable career for respectable women, as it required "duty, devotion and obedience" (Allan et al., 2016: 229), but not quite considered real 'work'. Writers such as Manne (2017) continue to define caring roles as a 'moral good' and as 'morally' valuable. However, these caring roles also need to be understood as being material and constituting functions that need to be performed to support the economy. The legacy of this tension – between the image of nursing as a virtuous vocation for women and the reality of the highly skilled and demanding profession that it is today – is felt in current debates about status, autonomy, and authority.

Many commentators have called for a revaluation of nursing work that fully recognises the extent and importance of 'emotional labour' (the requirement of workers to manage and/or regulate their own feelings in order to display a publicly acceptable image). For example, through monitoring body language and facial expression (Hochschild, 2003). Smith and Gray (2000:12) define emotional labour as the work which "intervenes to shape our actions when there is a gap between what we actually feel and what we think we should feel" and is a core element of many jobs described as 'women's work'. James (1989) described emotional labour as hard and productive work which should be valued in the same way as physical or technical labour.

The development of nursing as a profession

Assumptions that caring is a natural feminine trait have long influenced the development of nursing as a profession, and the level and type of training and education required. This section discusses three key markers or traits of professions which have relevance to nursing – and its professionalisation – as well as the inherent tensions these cause.

1 **Occupational boundaries and closure**
Professions establish themselves and their members' position in the labour market by setting occupational boundaries and licensing by a national body or a professional institution (Witz, 1990); in the case of nursing, registration was introduced in 1919 and is maintained by the NMC. However, registration provides labour market protection against competition, but also protects knowledge and skills. Despite the 'professional rhetoric' which emphasises its autonomy, nursing's proximity to medicine raises questions about the extent of control over its own practices (Traynor, 2014). Since the time of Nightingale, the gender distinction that assigns women as nurses and nursing work as different from medicine ultimately seems to have entrenched nurses as a subservient occupational group (Morley and Jackson, 2017).

2 **Knowledge claims**
Professions also establish themselves through controlling knowledge claims, with a body of specialised knowledge and control over what counts as knowledge. Nursing has developed a comprehensive body of knowledge that links to a wide range of fields such as sociology, psychology and medicine and has been criticised as not being nursing knowledge. According to Kelan (2008), expertise is not only a rational technical ability, but also a social competence that is a vital feature of nursing and caring roles. Often rewarded for men but deemed 'natural' for women, social competence is key to the core of the knowledge claims being made in the process of establishing nursing as a profession.

3 **Autonomy and control over work processes and practices**
Professions create a sense of identity through establishing and legitimating control over patterns of work, work processes or volume of work. This is to ensure that value is retained by its members, and that the work is rewarded. The notion of professional identity has to be understood as deeply intertwined with having control and autonomy (McKeown and White, 2015). For most nursing professionals, control over these patterns is affected by service needs and often results in highly-structured work patterns. This in turn undermines the control that nurses are able to establish over their work.

Understanding the professionalisation of nursing is all the more important, given that it is the route through which an occupational group such as nurses establish their standing and their rewards. Professionalism is constructed 'from within', as well as being imposed 'from above' by employers and managers. According to Evetts (2003), when definitions of professionalism are made and used by the occupational group 'from within' then the returns to that group can be substantial. The group can have success in constructing its own occupational identity, promoting its image and securing and maintaining its regulatory responsibility. This is done to promote not only its own interests but also to promote and protect the public interest.

What needs to be questioned in the context of nursing is the extent to which professionalisation 'from within' has been sufficient or successful. In the case of professionalism imposed 'from above', Evetts (2003) explains that professional values are instead "inserted or imposed and a false or selective ideology is used to promote and facilitate occupational change." The occupational group itself may grasp this ideology as a way of improving the occupation's status and rewards collectively and individually. However, the

ultimate outcome is that occupational control of the work is not held by the workers but rather by organisational managers.

This brings into question the role that other institutional players, such as the government, the NHS or trade unions play in the professionalisation of nursing. Evetts (2012: 13) goes on to assert that "occupational control of the work is the new test for occupational power, authority and status. Control and order of the work and work processes and procedures by the workers, employees, practitioners, occupational group and profession might constitute the criteria for assessing the extent and exercise of professionalism in work." This provides a useful test for the nursing profession, posing valid questions about the extent of its own occupational control and impact on power, authority and status.

Professionalisation in a changing context

It is important to look at the professionalisation of nursing and its professional status in the context of broader social, economic and political developments, particularly the current staff shortages in medicine and nursing. While this has prompted the creation of new roles and accountabilities, ongoing staff shortages, alongside cost containment in the health and social care sector, have also led to demoralisation among the workforce (Select Committee on Health and Social Care, 2018). Other forces spring from a greater emphasis on consumerism and patient-centred care as citizens call for greater involvement in decision making, in addition to social transformations led by changing attitudes to gender, class and ethnicity. This is leading to challenges in the traditional contract between professionals and service users (Salvage, 2002).

Since the era of new public management in the 1980s (Hood, 1991), the public sector has been exposed to the introduction of a market-oriented model, as well as increased financial control and target setting. In the public sector, professions and the organisations they work in are subject to performance targets to justify the receipt of public expenditure. This enables them to be measured and compared; as a result, accountability is operationalised as audit. In this regard, professionalisation is both a way to seek public protection, but also a way to control costs and assert control.

Professionalisation also controls costs, denying access to higher paying jobs by maintaining occupational closure (the means by which professions seek to protect their boundaries and entry routes). In nursing, this goes hand in hand with the expansion of support and assistant roles in health care. Nursing has been said to have sought to create a dual closure strategy by creating a monopoly over care provision and the skills needed to undertake care (Witz, 1990). Registration in the UK ensures the exclusion of non-members but also allows self-governance. This is ongoing work, which is being called into question by the creation of new nursing roles and increasing reliance on assistant practitioners and support workers. While the medical profession is perceived as having been somewhat successful in achieving professional closure, asserting knowledge claim, shaping policy and subordinating other professions, Rafferty (1996) suggested that nurses have followed the same strategy of professionalisation, but less successfully.

There has been a growing trend in nursing for tasks to be delegated to health care assistants and nursing support staff, and nurses now perform tasks that in the past would have been the preserve of doctors. Recently, nursing has seen the introduction of the new nursing associate role as well as degree-level apprenticeships. Writing in 2005, Nancarrow and Borthwick identified the burgeoning growth in assistant roles and commented on the growth of patient-centred care which emphasises the needs of the service user, rather than the needs of professional groups as creating a need for "flexibility in both working practices and service organisation which presents significant challenges to professional power." (2005: 898).

The trend may be seen as a challenge for the professional status of occupational groups, particularly in relation to occupational demarcation and professional boundaries. Traynor et al., (2015) suggested that there are two main positions that health care support workers take: either a subordinate role with the traditional boundaries of the profession; or alternatively, a usurpatory stance towards these boundaries and an attempt to take over the core of 'care' as their own central value rather than that of nurses.

This fluidity between occupational boundaries further complicates the picture in terms of the professionalisation in nursing. As Davies (1995)

argued, any attempts to emphasise the technical aspects of nursing over care will devalue the contribution of non-registered nursing assistants providing essential care. Despite the cost benefit of skill substitution at the top and bottom of the nursing pyramid (McKeown and White, 2015), this raises questions as to whether it is desirable for the nursing profession, or whether it will serve to displace inequalities and associated devaluation.

Professionalisation and the low wage puzzle

In light of the increased professionalisation of nursing combined with chronic shortages of nurses and poor working conditions, it is puzzling that market forces have not prevailed in the shape of higher wages. One approach to unlocking this conundrum is to examine the range of functions performed by wages beyond a simple reflection of market value (Koskinen Sandberg and Saari, 2019; Rubery, 1997 and 2019).

The standard approach in mainstream economics to human capital is to view wages purely as a price. However, other perspectives see labour market inequality in terms of 'unearned' or 'unjust' allocations of resources to dominant groups. There are four different lenses through which it is possible to understand the setting of wages: standards of living, social practice, as a management tool, or as macro-political. In this section, we consider how these different forms of understanding wages relate to pay in the nursing profession.

1. Standards of living

Rubery (1997; 2019) explains that while pay is an important contributor to employers' costs, it is just as important to see pay as workers' main source of purchasing power and means of achieving and maintaining their standard of living. As society moves away from a model of the 'male breadwinner' in a household, it has become even more important to address the traditional undervaluation of women's work. This has been a clear objective of trade unions and others in the development of job evaluation frameworks as a means of achieving equal pay for work of equal value. Rubery explains that instead of focusing on needs, the promotion of 'unbiased' job evaluation schemes will achieve fair prices for the jobs performed by women and men, independent of supply factors.

In the NHS, all non-medical staff are paid according to the Agenda for Change (AfC) pay and grading system, underpinned by a job evaluation framework. This was introduced in response to growing pressure to overhaul the previous pay system – the Whitley system – which was generally seen as overly complex and inflexible, and unable to incorporate the development of new roles. Crucially, it was also open to challenge on the basis of equal pay for work of equal value. AfC was intended to deliver fairer pay for non-medical staff based on the principle of 'equal pay for work of equal value', to provide better links between pay and career progression and to harmonise terms and conditions of service such as annual leave, sick pay, and unsocial hours pay.

2. Social practice

Wages can also be understood to be determined as a social practice. Mutari et al., (2001: 26) describe this concept as emphasising the social and historic processes of wage-setting which "shape as well as reflect gender, class, and race." Lower wages reflect the invisibility of women's social skills, and their greater propensity to undertake caring and nurturing roles (Rubery, 2019). Koskinen Sandberg and colleagues (2018: 708) also describe how gender valuations of jobs determine wages, resulting in "institutionalised under-valuation." In nursing, we can see how social practice can trump market rationality, due to the undervaluation of caring and emotional skills, particularly when it is performed by women. When nurses talk about the rewards from their job, they often emphasise the non-monetary over the monetary, citing the wish to care and valuing relationships with colleagues and patients, the praise and recognition received and the experience of self-growth and personal achievement (Ahlstedt et al., 2019; Lu et al., 2012; Newman et al., 2002). Women's vocation for caring and nurturing can therefore be used to justify lower pay as a trade-off for gratifying work.

3. Wage setting as a management tool

Social practice is also related to wage setting as a management tool. Job satisfaction, whether intrinsic such as in the case of vocation or extrinsic as through the provision of flexible working arrangements even if minimal, may offset any increases in wages among women. Furthermore, in these cases, work is organised

so that there are few differentiations between the levels of skills and responsibilities in women's work. Keeping women's wages low in these conditions is particularly acute where there is a situation of monopsony (in economics, defined as a situation where there is only one buyer), as in the case of the NHS which is the main employer for health sector workers (Link and Landon, 1975). This creates a trapped labour supply and increases the potential for work intensification due to reduced hours at the organisational level and little scope to negotiate better working conditions or rates of pay (Rubery, 2019).

4. Macro-political contexts

Finally, wages can be seen as determined by their macro-political context and influenced by institutions such as trade unions or political parties. Rubery et al., (2005: 187) for example, called for recognition of the "role for social actors in structuring pay within the labour market, including collective actors, such as trade unions and employers' associations, as well as individual employers and individual workers." Wages become an outcome of capital labour relations (Rubery, 1997; Rubery et al., 2005), and result from bargaining agreements. This is shaped by power relations, including that of gender. Koskinen Sandberg and Saari (2019: 634) explain that this entails "understanding wages as part of gender power orders [...] subject to ongoing, gendered struggles between interest groups over power and legitimacy." In the NHS, pay determination operates through the independent NHS Pay Review Body (PRB), which makes national pay recommendations based on evidence submitted by trade unions, employers and government as well as its own research and analysis. However, the role of the PRB has been constrained in recent years due to government public sector pay freezes. The extent to which the PRB can deal with gendered struggles between different interest groups is unclear.

Since the 2008 financial crisis, the government has sought to reduce the pay bill across the public sector through initiatives such as changes to pensions and retirement age, attacks on national pay systems and repeated attempts to introduce regional pay, reduce unsocial hours pay, skills re-profiling (through the substitution of support roles for more qualified staff), attacks on trade union facility time (which allows local representatives to conduct trade union duties), as well as the increased outsourcing of local services.

Unions representing workers across the public sector, including the NHS, have sought to defend against these attacks through campaigning, national and local negotiating, partnership infrastructure and, where appropriate, legal challenges. The picture is therefore one of health sector unions, individually and collectively, fending off attacks on pay and working conditions, and defending the status quo with limited scope for promoting progressive changes.

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Outside the NHS, the picture is more diffuse, as it is populated by separate employers pursuing different agendas. For example, as independent contractors, GP practices determine their own pay and conditions and contracts for practice nurses. Many organisations contracted to provide NHS services, such as social enterprises and private providers, generally follow AfC pay rates. For non-NHS employees, collective bargaining largely relies on unions' ability to negotiate recognition agreements with individual employers – either workplace by workplace, or across chains of providers. In the absence of an effective employers' association or body to represent health and social care providers outside the NHS, trades unions have recommended the establishment of a new national staff council to negotiate for all nurses and care assistants in health and social care not directly employed by an NHS organisation. This would provide a mechanism for workforce planning and skills development, as well as pay discussions. A key objective for the trades unions is to ensure there is a level playing field on pay and conditions across the sector to provide minimum standards on pay, conditions and development.

Conclusion

This chapter argues that within nursing, undervaluing (both standing and pay) stems from ongoing struggles in terms of professionalisation, from the roles that wages can play, as well the control and autonomy nursing exerts. We summarise these pressures and influences in the table below.

We have argued that the devaluation of nursing stems from how the profession has developed historically. The legacy of the past is something that the profession is struggling to leave behind, despite efforts to establish nursing as a profession on a par with other groups. The lack of change derives, in part, from the large proportion of women in the nursing profession: nine in 10 nurses are women. This creates a strong association between care work, the 'feminine' and the reproductive sphere at the expense of understanding nursing as productive, and thus valued, work.

Gender is only one aspect of the working inequalities that are endemic in nursing. The barriers in the world of work faced by women, by people from ethnic minority backgrounds or different social classes, and others with protected characteristics are well documented – whether at the individual, interpersonal, organisational, institutional or structural level – and understood as persistent and omnipresent manifestations of practices and processes that produce and reproduce inequalities. As a result, Azocar and Ferree (2015: 1086) point to the need to think how "the social value of groups and expertise work together, and why changing either will transform the way in which power gets materialised in professional battles." Professions are not neutral, but imbued with race, class and gender differences.

Nursing has also been examined in relation to professionalisation, yet the outcomes of this ongoing struggle seem mixed. To some extent nursing has successfully established itself as a profession, but this is not linked to better pay and working conditions. Wages remaining low is the result of a bigger societal context, and previous research suggests that the problem cannot be tackled without understanding and addressing the different roles that wages play.

Table 3: Pressures and influences on nurses' pay in the UK

The nature of the work	Pay and status	Control and autonomy	Voice and leadership	External pressures
				
The location of nursing within a gendered division of labour which undervalues caring roles.	Compressed pay scales both reduce earnings and hinder retention and progression over the course of nurses' careers. Pay structures also prevent realistic recognition and evaluation of the full value of nursing.	The role of the NHS as the main employer and the control it exerts on pay and working conditions serve to undermine the professional status of nursing.	Lack of leadership in nursing, both within the professional and representative structures, in harnessing the profession's voice to emphasise the importance of both technical and caring skills and both extrinsic and intrinsic rewards.	Financial pressures caused by austerity and the uncertainties of Brexit.

Chapter 4: Gender and diversity in pay and working conditions – quantitative evidence

The previous chapter outlined the historical development of nursing as a gendered profession. This painted a broad picture of how the development of nursing has influenced the status and pay of nursing. We now present an analysis of pay and reward in the profession in order to add quantitative evidence to this picture. This is done through an examination of evidence from Office for National Statistics (ONS) national datasets and further analyses of surveys conducted by the RCN.

In this analysis, we make use of sex-disaggregated data which we analyse from a gender perspective. We therefore distinguish between the characteristics of women and men to inform on gendered disparities of power within the health sector, and nursing in particular.

We begin with an analysis of pay in the health sector as a whole, to contextualise nursing within this wider sector. Next, we examine how gender and diversity, together with other structural factors, are related to pay within the nursing profession. We continue by providing a decomposition of pay in the health sector and then among nurses, examining the explained (for example, working hours or sector) and the unexplained (for example, being a woman or a man) components of the gender pay gap. We conclude by considering how gender, diversity and levels of pay interact with nurse wellbeing and the perceived desirability of nursing as a career.

Pay in the UK health sector

This section examines the issues of pay, gender and diversity across the health sector in the UK. This includes workers across the NHS and other public sector, independent and private sector organisations. A typology of workers in the health sector was created using the standard occupation classification (SOC) based on data provided through the ONS Labour Force Survey for the first quarter of 2018 (QLFS 2018 Q1). Five categories of workers in health-related sectors were included based on the professional coding:

- nursing professionals
- health managers and directors
- health professionals (including doctors and dentists)
- allied health professionals
- scientific, therapeutic and technical staff.

The SOC codes and associated sample sizes included in each category are provided in Annex 1.

Gross pay weekly and hourly by occupation

Table 4 shows that according to figures from the QLFS, the gross weekly average pay for nursing professionals in 2018 was £526.58, which is just over 80% of the sector average of £650.67 for all health care professionals. Average pay for nursing professionals is 56% of that for health care managers and 60% of health professionals.

There is a relatively low variation in pay among nursing professionals (as evidenced by the standard deviation). This suggests that, in comparison with health care managers and health professionals, there is little scope for high earnings in the nursing profession and is likely to signal low opportunities for progression and access to leadership positions.

Examining earnings on both a weekly and hourly basis, although hourly earnings provide a useful marker of a base rate for labour, it is also important to compare with weekly earnings to better capture people's actual take home pay. This is particularly relevant from a gender perspective, since women are much more likely to work on a part-time basis.

Table 4 shows that health professionals (which includes doctors and dentists) earn the most on an hourly basis, with average hourly earnings of £24.84. However, health care managers earn the most on a weekly basis (£24.53 an hour). This is related to health care managers working longer hours.

On an hourly basis, nursing professionals receive 38% less than health professionals (doctors and dentists) and 18% less than all health care professionals, with an average gross hourly pay of £15.42. On a weekly basis, nursing professionals receive 40% less than health professionals and 19% less than all health care professionals.

The variation in pay among nursing professionals is lower than any other category of worker, confirming that those in the profession experience very narrow ranges of pay, which provides further evidence that lack of progression is a key issue for nurses.

Additions to basic pay and second job

Further analysis of ONS data makes possible to examine the components of additional pay, including overtime, shift pay, unsocial hours payments and geographical allowances (such as London weighting). Across all health-related sectors (with the exception of health care managers and directors) about one in four workers report additions to basic pay. In addition, about 5% of workers in the health care sector had a second job in the reference week of the survey. Few nursing professionals had a second job compared to health professionals or allied health professionals. This might reflect the higher potential that these two categories of health workers have to develop their activities in private practice than for nursing professionals (Table 5).

Table 4: Gross weekly and hourly pay in main job for workers in health-related sectors 2018 Q1

	Weekly		Hourly	
	Mean	SD	Mean	SD
Nursing professionals	£526.58	£182.24	£15.42	£4.32
Health care managers	£941.80	£522.90	£24.53	£12.59
Health professionals	£883.76	£511.39	£24.84	£13.08
Allied health professionals	£550.95	£202.16	£17.70	£5.56
Scientific, therapeutic and technical	£447.06	£225.99	£12.86	£5.40
Total	£650.67	£384.52	£18.71	£9.68

Source: QLFS 2018 Q1
Notes: weighted by income weight 2017 (PIWT17)

There are structural differences in pay between various types of health sector workers. Table 6 provides a snapshot of the three most commonly received types of additional pay across all health sector workers – unsocial hours pay, shift pay and overtime. Compared with health care managers and professionals, nurses are much more likely to receive unsocial hours pay (11.7%), shift pay (7.9%) and overtime (10.8%).

Working overtime is widespread in the health sector, with 44.3% reporting they work overtime (Table 7). However, the extent to which this is paid or not across different categories of professionals is interesting:

- health care managers report working 11.4 hours of usual unpaid overtime hours per week
- scientific, therapeutic and technical staff work 10.1 hours unpaid overtime per week
- nurses work the least number of unpaid overtime hours, combined with the greatest number of hours of paid overtime.

This finding about nurses' overtime working appears to contradict the view that nurses work high levels of unpaid overtime. For example, the *RCN Employment Survey 2017* showed that 71% of nursing staff reported working additional hours at least once a week, much of which was unpaid. This paradox might be the result of the ONS data only capturing reported overtime by survey participants and is likely to underestimate actual overtime. It is also likely that nurses often stay beyond their usual working hours but may not class this as overtime in official data. Nevertheless, the average length of paid overtime worked per week of 3.3 hours per week indicates the limited scope for nurses to boost their earnings through working paid overtime.

Table 5: Additions to basic pay for workers in health-related sectors by category 2018 Q1

	Receives additional pay	Has a second job
Nursing professionals	26.4%	2.9%
Health care managers	16.5%	1.0%
Health professionals	23.2%	7.9%
Allied health professionals	23.5%	8.4%
Scientific, therapeutic and technical	26.6%	4.5%
Total	24.6%	5.3%

Source: QLFS 2018 Q1
Notes: weighted by person weight 2017 (PWT17)

Table 6: Types of additional pay for workers in health-related sectors by category 2018 Q1

	Unsocial hours	Shift pay	Overtime
Nursing professionals	1.7%	7.9%	10.8%
Health care managers	5.8%	2.9%	2.9%
Health professionals	7.6%	3.2%	4.2%
Allied health professionals	0%	0%	0%
Scientific, therapeutic and technical	10.9%	3.1%	12.4%
Total	8.9%	5.0%	7.4%

Source: QLFS 2018 Q1
Notes: weighted by person weight 2017 (PWT17)

Welfare benefits and tax credits

In addition to earnings from employment, individuals may also receive state support with some benefits directly linked to pay levels. For example, child benefit is universal, although it is now taxable for households where a member earns in excess of £50,000 per annum. Others, such as tax credits, housing benefit or pension benefit are only payable below certain income thresholds. Health care managers and health professionals are the least likely groups to claim state benefits, which is assumedly related to higher pay levels. Across all groups, women are much more likely to claim benefits than men (32.4% compared to 8.9% claim state benefits, Table 8).

Among nursing professionals, the vast majority of those receiving any state support (93.6%) claim child benefit which is not linked to pay levels. Further, 15.5% claim tax credits which are designed to support individuals that have dependent children and/or are in work but have a low income. This shows that a small, but significant proportion of nurses are affected by a lower household income. Looking at differences according to ethnic background, white nursing professionals are only slightly less likely to claim benefits than those from an ethnic minority background, with around 32% of white nurses and 36% nurses from an ethnic minority background stating they claim any income-related benefits.

Table 7: Paid and unpaid overtime in health-related sectors by category 2018 Q1

	% that work overtime (paid or unpaid)	Average hours PAID overtime usually worked per week	Average hours UNPAID overtime usually worked per week
Nursing professionals	46.5%	3.3	3.1
Health care managers	46.0%	1.0	11.4
Health professionals	46.9%	1.4	4.7
Allied health professionals	38.4%	1.5	3.6
Scientific, therapeutic and technical	32.4%	2.2	10.1
Total	44.3%	2.3	4.5

Source: QLFS 2018 Q1
Notes: weighted by income weight 2017 (PIWT17)

Table 8: Receipt of state benefits in health-related sectors by category and by sex 2018 Q1

	Women	Men	All
Nursing professionals	35.2%	8.3%	32.1%
Health care managers	25.6%	7.1%	20.0%
Health professionals	24.0%	7.3%	17.5%
Allied health professionals	35.2%	8.4%	32.3%
Scientific, therapeutic and technical	40.4%	18.2%	31.3%
Total	32.4%	8.9%	26.9%

Source: QLFS 2018 Q1
Notes: weighted by person weight 2017 (PWT17)

Access to home ownership

Across all health care professions, the vast majority (79%) own their own home (either outright or with a mortgage) and 20.5% are renting (Table 9). However, it appears that differences in pay across the categories of workers have implications for access to home ownership. Indeed, home ownership is significantly lower among nurses and scientific, therapeutic and technical staff (76.6% and 74.1%) than it is among health care managers (87.5%), allied health professionals (85.4%) and to a smaller degree among health professionals (80.4%).

Access to home ownership is marked by other axes of difference, notably around ethnicity and geographical location. In total, 81.7% of white health care workers own their own home (either outright or with a mortgage/loan) compared to just 66.9% of health care workers from an ethnic minority background. The proportion of nurses from a white background is similar (81.1%) but it appears that the number for nurses from an ethnic minority background who own their own home is much lower (57.7%). This points to the importance of considering ethnic background when considering the implications that pay can have on nurses' opportunities. Similarly, the divide between certain areas needs to be taken into account. London's housing market is the least affordable in the UK and accordingly 51.8% of nurses who live in the capital own their home, compared to 76.6% across the UK.

Factors explaining variations in pay

Evaluating the main characteristics that can explain variations in pay allows us to explore the association with pay levels and certain variables such as education, hours worked and age as well as sex.

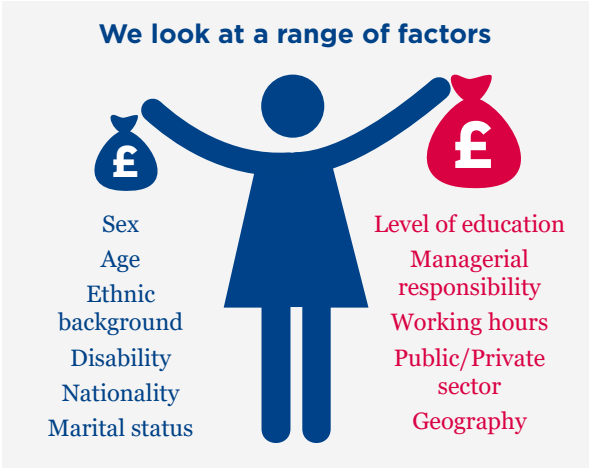


Table 9: Housing status in health-related sectors by category 2018 Q1

	Own home	Rent	Rent free
Nursing professionals	76.6%	22.7%	0.7%
Health care managers	87.5%	12.6%	-
Health professionals	80.4%	19.2%	0.4%
Allied health professionals	85.4%	13.8%	0.8%
Scientific, therapeutic and technical	74.1%	25.1%	0.8%
Total	79.0%	20.5%	0.6%

Source: QLFS 2018 Q1
Notes: weighted by Person Weight 2017 (PWT17)

Across the health sector there is evidence of a direct relationship between pay and sex. On a weekly basis, women working in professional occupations in the health sector receive 30% less than men, while on an hourly basis they receive 16% less gross pay. However, when applying controls for a wide range of characteristics and circumstances in a regression analysis, this gender gap is reduced to 10% for gross weekly pay and 12% for gross hourly pay (see Annex 2). In our model, none of the indicators for diversity (age, ethnic background, disability) are statistically significant suggesting that when it comes to pay, the health sector is relatively inclusive. What does appear to matter are functional characteristics related to education and working arrangements. Having a higher degree, for example, increases weekly gross pay by 21% or having managerial/supervisory responsibilities by 14%.

Pay among nursing professionals

Nursing professionals are included in the 10 occupations in the UK with the highest density of women (full-time) employees, alongside nursery nurses, personal assistants and secretaries, teaching assistants, senior care workers and managers in health and care services. It is also

the single largest occupation among women, accounting for around 6% of women in UK workforce. Within the top 10 occupations with the highest density of women, average earnings range from £330 to £629; for the top 10 occupations with the highest density of men, weekly average earnings are much higher, ranging from £407 to £830.

In this section we further analyse differences in gross pay in relation to characteristics and circumstances specifically within the nursing profession. The analysis relies on two data sources: the ONS QLFS 2018 and ASHE 2018. The factors explaining variation in pay in nursing are first examined using QLFS data. However, due to the smaller sample size (n = 274 nurses), further analysis is conducted using ASHE (n = 5,038) with information about the different components of pay and a decomposition of the gender pay gap provided.

Factors explaining variation in pay in the nursing profession

Using ONS data from the quarterly *Labour Force Survey* (QLFS 2018 Q1), we focus on the pay gap from the perspective of gender, but also consider how other circumstances and characteristics affect the gender pay gap. We then examine the effects of low pay for nurses further.

Not only is the nursing profession highly feminised (approximately 90% are women) but it also has a significant gender weekly pay gap. In 2018, men earned an average of £617 gross weekly pay (SD 162) compared to £512 for women (SD 183), amounting to a 17% gender pay gap ($p < 0.01$). However, much of this difference is driven by working hours. We can see this by examining hourly gross pay. On an hourly basis, both women and men receive on average about £15.50 indicating there is no gender pay gap in hourly pay.

Men in the nursing profession nearly all work full time (89%), compared to just over two-thirds of women (68%). The gender pay gap in the nursing profession thus appears to be structural rather than related to direct discrimination (see Annex 3). It is important to distinguish between what in the gender pay gap is structural, by which we mean individual characteristics and circumstances such as having dependent children or working hours, from what direct (discriminatory) effects remain once these have been considered. As the analysis shows, no gendered effect on either gross weekly or hourly pay are present when other factors are considered. There is therefore no evidence of a direct effect. This suggests that it is important to consider how gender relates to these structural factors. In fact, the model indicates that other drivers of pay (both hourly and weekly) are factors such as rising educational level, having managerial responsibilities or working in the private sector.

Previous research on gender and the nursing profession (Punshon et al., 2019) has shown that progression and access to leadership positions, and thereby higher levels of pay and responsibility, are gendered. Looking specifically at the NHS in England, data (NHS, 2018) shows that while men make up 10% of band 5 registered nurse roles, they represent 15% of band 8 roles. In our analysis, we therefore extended the model to also consider how being a woman intersects with managerial responsibilities (see Annex 3). The results show a negative effect ($p < 0.05$) for hourly earnings of 18%, but the effect is less pronounced, and not statistically significant, for weekly pay. This provides some evidence of a glass elevator for men, which is, however, closely related to working hours. Among nurses with responsibilities, men worked an average of 36 hours while women worked 32 hours per week ($p < 0.01$). This explains why the glass elevator phenomenon applies for hourly pay and not weekly pay.

Previous research from NHS trusts in England (NHS, 2018) indicates that as well as a gender pay gap of 3%, there is an ethnicity pay gap. Our results show that nurses from an ethnic minority background earn 10% less gross pay than white nursing professionals, on a weekly or hourly basis ($p = 0.06$ and $p = 0.05$) when other factors are considered.

Looking at the ethnic pay gap in relation to gross hourly pay, nurses from an ethnic minority group earn a similar amount to white nurses on an hourly basis but earn more on a weekly basis (£566 vs £515, $p = 0.06$). This is clearly related to the fact that they work more hours (36 vs 32 hours on average, $p < 0.01$).

The different components of pay among nurses

Further analysis allows us to examine the different components of nurses' earnings, including basic pay, overtime and shift pay, as well as making comparisons between women and men in the nursing profession. Pay estimates

from the ONS provisional *Annual Survey of Hours and Earnings* (ONS, 2019) are relatively similar to that provided by the QLFS 2018 with £550.92 to £526.58 gross weekly pay respectively for each data source. Annually, this corresponds to an estimate of approximately £26,000 gross annual pay for the *Annual Survey of Hours and Earnings* and £27,000 for the *Quarterly Labour Force Survey* in 2018. While the QLFS provides the means to conduct an analysis across the health sector, as the sample of nurses is limited the *Annual Survey of Hours and Earnings* provides more indepth information including disaggregation by sex (Table 10).

Table 10: Pay and earnings by different components in nursing

	Women			Men			Total			Sig.
	N			n			n			
Annual gross pay	4,434	Median	£26,140.76†	577	Median	£30,569.34†	5,011	Median	£ 26,707.31†	
		Mean	£25,440.41		Mean	£30,113.77		Mean	£25,978.53	**
		SD	£12,632.81		SD	£15,606.26		SD	£13,093.34	
Average gross weekly earnings	4,456	Median	£541.93†	580	Median	£633.84†	5,036	Median	£550.92	
		Mean	£541.18		Mean	£648.91		Mean	£553.59	**
		SD	£235.17		SD	£277.00		SD	£242.78	
Basic weekly pay	4,455	Median	£484.55†	580	Median	£552.82†	5,035	Median	£494.57	
		Mean	£491.97		Mean	£585.39		Mean	£502.73	**
		SD	£215.91		SD	£257.96		SD	£223.14	
Average weekly overtime pay	4,455	Median	£0.00	580	Median	£0.00	5,035	Median	£0.00	
		Mean	£11.53		Mean	£22.19		Mean	£12.76	**
		SD	£45.16		SD	£71.14		SD	£48.97	
Shift and premium payments	4,455	Median	£0.00	580	Medin	£0.00	5,035	Median	£0.00	
		Mean	£29.50		Mean	£29.51		Mean	£29.50	
		SD	£55.76		SD	£49.94		SD	£55.12	
Incentive pay relating to the pay period	4,455	Median	£0.00	580	Median	£0.00	5,035	Median	£0.00	
		Mean	£0.46		Mean	£1.72		Mean	£0.61	
		SD	£6.80		SD	£24.48		SD	£10.49	
Pay received in the pay period for other reasons	4,455	Median	£0.00	580	Median	£0.00	5,035	Median	£0.00	
		Mean	£7.68		Mean	£10.10		Mean	£7.96	
		SD	£35.13		SD	£42.24		SD	£36.03	

** p < 0.01, * p < 0.05

† To avoid statistical disclosure, this value refers to the mean value of the 10 middle observations where n is even, and 11 middle observations where n is odd. Where an exact value for the median is provided, this applies to at least 10 observations in the middle of the distribution.

Note: pay is reported weekly for the reporting period, with the exception of annual gross pay. Unweighted.

Source: ASHE 2018

Average gross weekly earnings are composed of five categories: basic pay, overtime, shift and premiums, incentive pay, and other pay (Figure 4). Differences are evident in basic and overtime pay (both $p < 0.01$). Among nurses, men receive an average of £585.39 per week basic pay, compared with £491.97 for women. Men also received more overtime pay (£22.19) compared with women (£11.53).

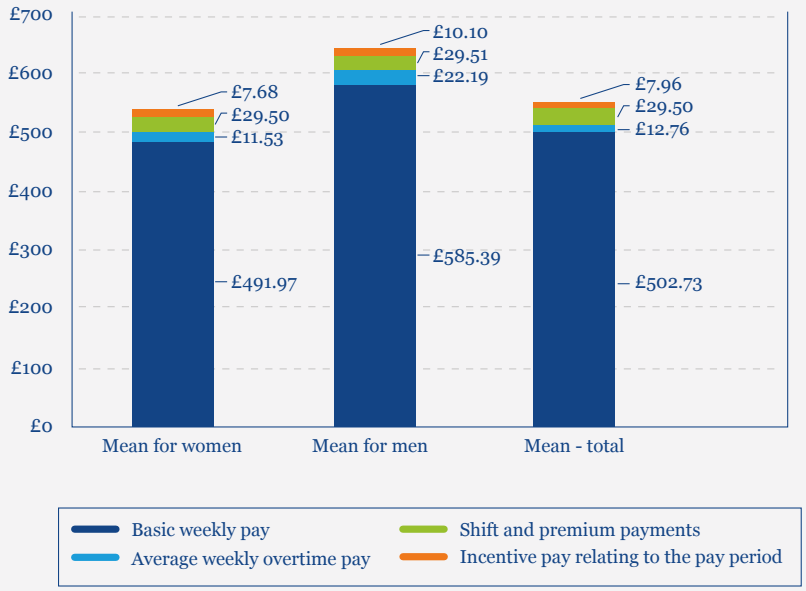
Pay decomposition among nurses

To further understand the factors associated with gender and pay in the nursing profession, we built a simple linear regression model that examines the roles that different factors play. These factors included:

- basic paid hours and average weekly paid overtime hours worked - this controls for potentially different working patterns, particularly relevant from a gender perspective as women are more likely to work fewer hours
- permanent or temporary contract - this looks at employment types, as rates of pay may be different depending on the contractual arrangements used
- shift or premium payments - examining the extent to which respondents receive any additional payments; in nursing, shift payments are usual and should therefore be controlled for
- age – provides information on the stage of the life course for individuals and acts as a proxy for number of years of working experience
- number of years worked for an organisation – a further measure of years of experience
- type of organisation - captures whether nurses work in the public, private or not for profit sector
- work government office region - measures the region is which respondents are working.

Descriptive statistics for the variables used in the model are provided at Table 11 and Table 12. The majority of nurses are employed on a permanent contract (92.2%) and work in the public sector (78.8%), with no statistically significant difference between women and men relating to contract or sector. Experience, as measured by proxies such as age or number of years worked for the current organisation, also did not reveal any differences. In total, nurses were on average nearly 44 years old and had been working for their current organisation for about 8.5 years.

Figure 4: Average gross weekly earnings among nurses by category of pay and sex



Source: ASHE 2018
n = 4,455 for women, n = 580 for men, n = 5,035 in total

Table 11: Nursing professionals: type of contract and sector of employment by sex

	Women		Men		Total	
	n	%	n	%	n	%
Permanent	4,089	92.3%	526	91.0%	4,615	92.2%
Temporary	339	7.7%	52	9.0%	391	7.8%
Public	3,508	78.7%	460	79.3%	3,968	78.8%
Private	724	16.2%	98	16.9%	822	16.3%
Not for profit	226	5.1%	22	3.8%	248	4.9%
Total	4,458		580		5,038	

Source: ASHE 2018
Note: unweighted

Table 12: Nursing professionals: key employment data by sex

	Women			Men			Total			Sig.
	n			N			n			
Shift and premium payments (£)	4,458	Median Mean SD	0.0 29.5 55.8	580	Median Mean SD	0.0 29.5 49.9	5,038	Median Mean SD	0.0 29.5 55.1	
Basic paid hours (£)	4,458	Median Mean SD	36.47† 30.4 10.2	580	Median Mean SD	37.5 34.4 9.0	5,038	Median Mean SD	37.4 30.9 10.1	** **
Average weekly paid overtime hours worked during the reference period (£)	4,458	Median Mean SD	0.0 0.7 2.7	580	Median Mean SD	0.0 1.2 3.7	5,038	Median Mean SD	0.0 0.7 2.8	** **
Age at the survey reference date	4,458	Median Mean SD	44.2† 43.7 11.7	580	Median Mean SD	44.0 43.4 10.9	5,038	Median Mean SD	44.0 43.7 11.6	
Years worked for the organisation	4,431	Median Mean SD	5.0 8.5 8.3	575	Median Mean SD	5.0 8.1 7.9	5,006	Median Mean SD	5.0 8.5 8.2	

** $p < 0.01$
† To avoid statistical disclosure, this value refers to the mean value of the 10 middle observations where n is even, and 11 middle observations where n is odd. Where an exact value for the median is provided, this applies to at least 10 observations in the middle of the distribution.
Source: ASHE 2018
Note: unweighted

Finally, women and men received approximately the same amount of shift and premium payments (£29.50) on a weekly basis.

The main difference in employment characteristics was in the number of working hours, as measured by both number of basic and overtime hours. Men in the nursing profession worked more ($p < 0.01$) basic paid hours per week on average (34.4 hours) than women (30.4 hours). There was also a difference in the number of overtime hours, which was statistically significant ($p < 0.01$) even though it is in fact small. Women in nursing worked on average 0.7 hours of paid overtime, compared with 1.2 hours for men. The median for both is 0, which shows that the majority of nurses in the survey did not work any paid overtime.

Evidence suggests that in nursing, the gender pay gap is structural rather than a direct discriminatory effect.

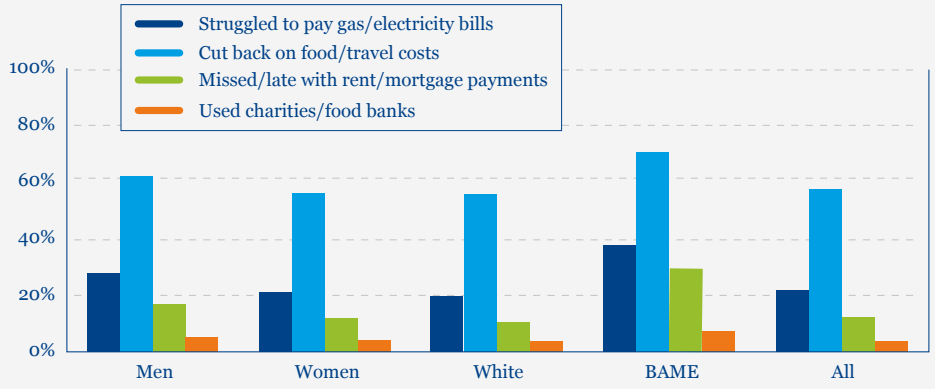
A regression model was developed to examine factors related to annual and weekly gross wages in nursing (wages were log-transformed to account for the minority of individuals with much higher wages; as a result, the coefficients need to be interpreted through the use of exponentials, see Annex 4). This analysis suggests that when other structural factors are accounted for, being a woman does not have a statistically significant effect on weekly nor gross wages. Other factors, such as being on a temporary contract, have significant effects on pay. This provides further evidence that in nursing, the gender pay gap is structural rather than a *direct* discriminatory effect and corroborates the findings obtained using data from the QLFS 2018 presented above.

Effects of low pay in nursing

Among all groups of health sector workers, nurses are among the least paid. According to the RCN's survey of members conducted in 2017, one in five (20.8%) have struggled to pay bills, just over half (55.9%) have cut back on food or travel costs, 11.2% have missed or been late with rent or mortgage payments and a small number (2.4%) have used charities or food banks in the previous 12 months (Figure 5). BAME respondents were more likely to have done all of these than their white colleagues.

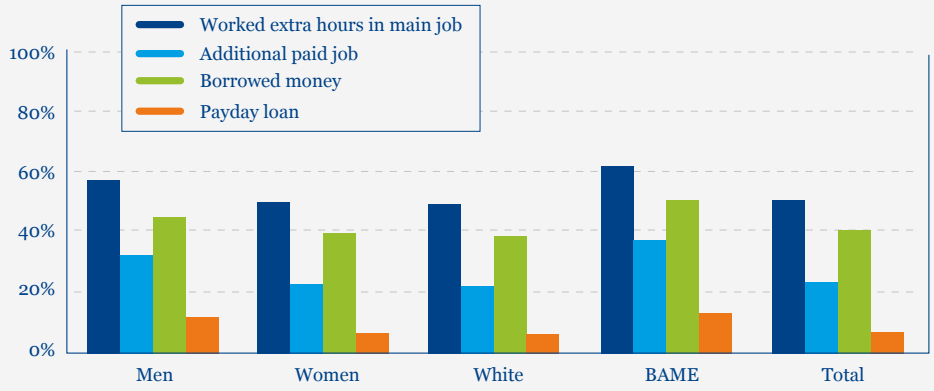
Many nurses adopt strategies to increase earnings (Figure 6). Half (49.9%) of all respondents stated they had worked extra hours in their main job, 23.1% had taken another job in addition to their main job, 39.7% had borrowed money from a bank, family or friends, and 6.1% had taken out a payday loan to get by financially. Nurses from a BAME background were much more likely to take any of these approaches to get by than white respondents. It is probable that this is related to the fact that BAME nurses are more likely to be the primary breadwinner in their households than white nurses (36% of BAME nurses are the sole earner compared to 27% of white nurses).

Figure 5: Experiences of hardship, by sex and ethnicity



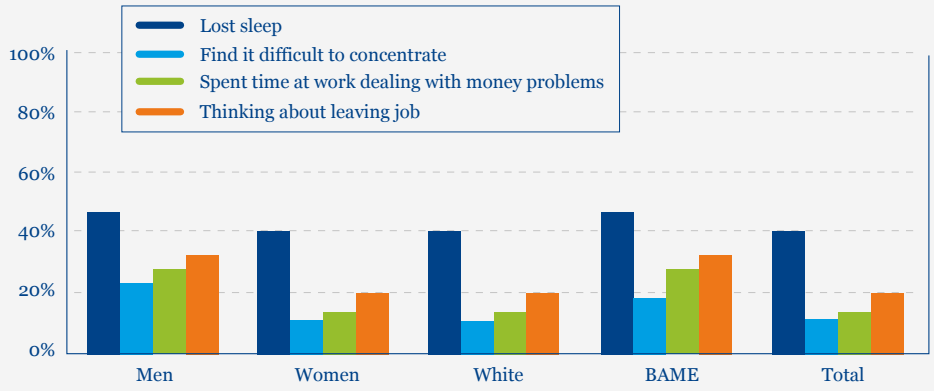
Source: RCN Employment Survey 2017

Figure 6: Actions taken to get by financially, by sex and ethnicity



Source: RCN Employment Survey 2017

Figure 7: Impact of financial worries, by sex and ethnicity



Source: RCN Employment Survey 2017

Low pay can create financial worries for nursing respondents (Figure 7), with two in five (40.9%) stating they had lost sleep, 13.6% stated they were finding it difficult to concentrate or make decisions, 15.9% had taken time while at work to deal with financial problems and a quarter (23.9%) were thinking of leaving their job because of money worries. Men were more likely to have experienced the impact of money problems in all the ways described than women, once again because of the gendered societal expectations likely placed on them and internalised as such.

Decomposition of the gender pay gap among health care professionals and nursing professionals

Decomposing the gender pay gap in the health care sector

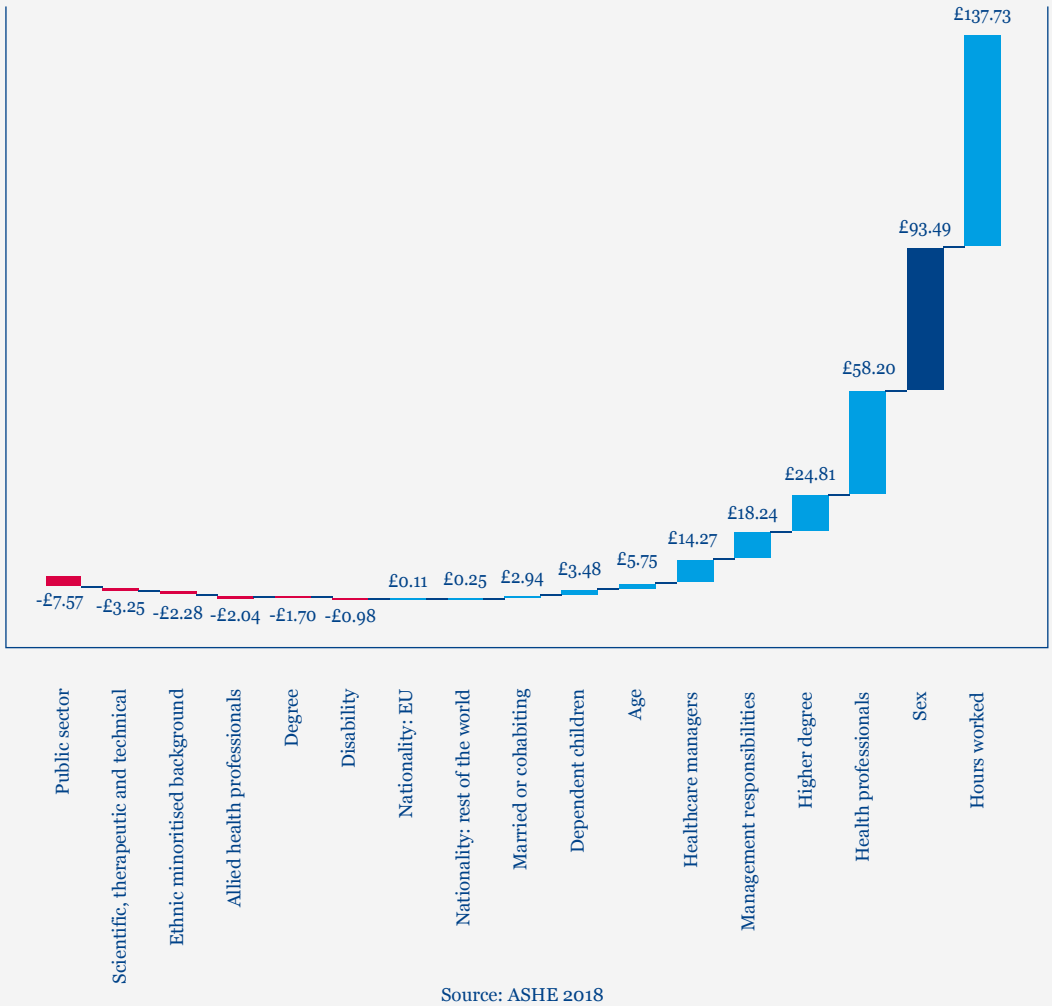
In this section, we decompose the gender pay gap within the health sector, to provide information on the position of nurses in relation to other groups of health professionals. Decomposition is a method often used in research on gender and pay, that attempts to isolate factors that are

related to sex differences alone (being a woman or a man) and other factors that may be gendered (such as number of working hours; sector). This approach recognises that gender can have a direct effect and an indirect effect through other variables (Olsen and Walby, 2004). Gender is thus something that manifests itself within two components: individuals' characteristics that can represent attributes or preferences (the potential indirect effects of working hours or type of occupation), and discrimination which can be understood as the portion of the gender pay gap that remains unexplained by other factors (the direct effect of being a woman or a man).

Several techniques have been used to decompose the gender pay gap into its explained (indirect effects) and unexplained (direct effect) components, including the well-known Oaxaca-Blinder decomposition or the simulation method used by Olsen and Walby (2004). This latter method is particularly useful to understand how the gender pay gap can be decomposed across variables that are themselves gendered. The method relies on hypothetically changing the values used in a statistical model to reach convergence between women and men (bringing women up or down to the level of men). This difference is then multiplied by the percentage change obtained from the regression model on log wages. The relative percentage of the gender pay gap accounted for by each variable can then easily be calculated (Annexes 5 and 6).

The gender pay gap in the health care profession when unadjusted is 38% for weekly gross pay and 27% for hourly gross pay. The main factors of gendered difference for weekly gross pay are sex, hours worked and working as a health professional (Figure 8). Equalising working

Figure 8: Decomposition of the gender pay gap (weekly gross pay) among health care professionals



Source: ASHE 2018

The main factors of gendered difference for weekly gross pay are sex, hours worked and working as a health professional.

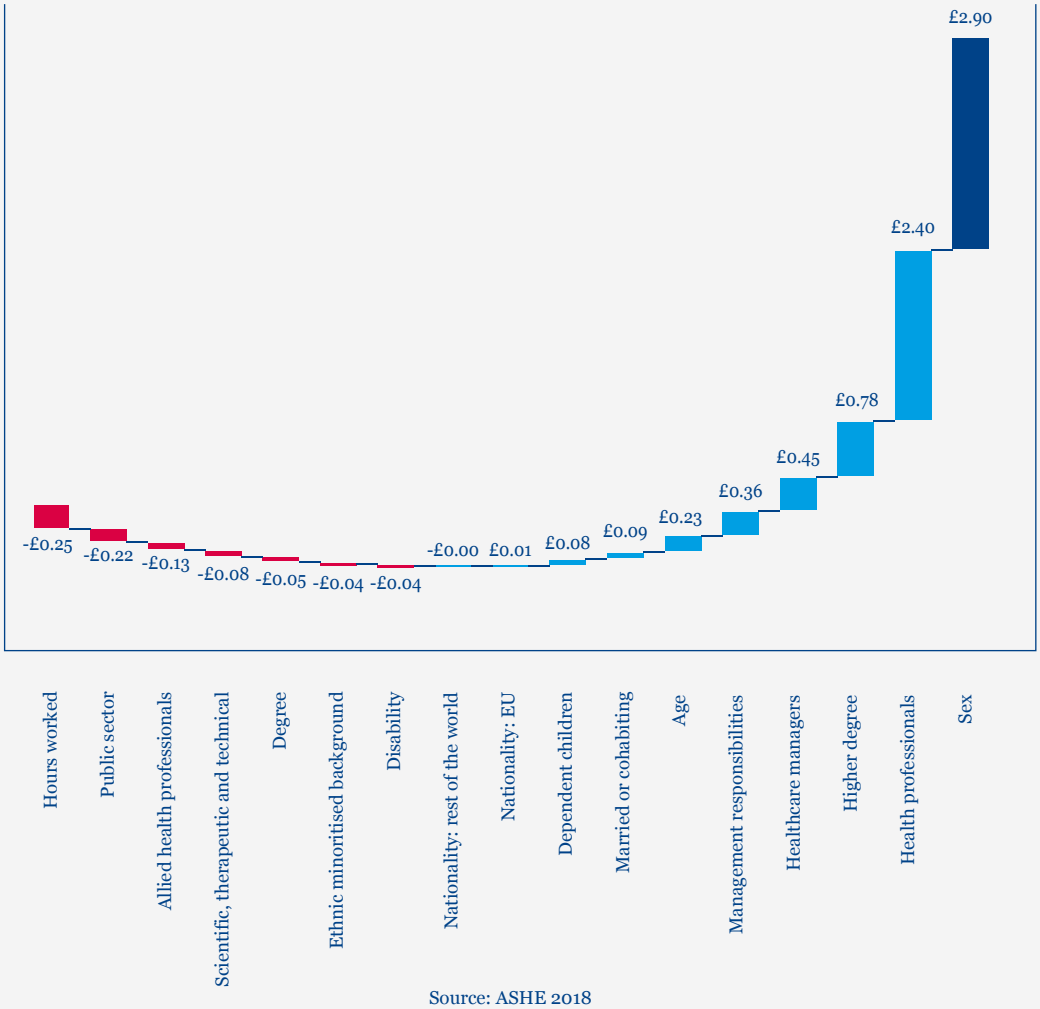
hours between women and men in the health sector would tackle 39% of the gender pay gap, equivalent to £137.73 per week gross. Getting rid of segregation and ensuring that women and men are equally represented as health professionals would address 19% of the gender pay gap, or £68.20. Finally, these results show that discrimination amounts to 27% of the gender pay gap, equivalent to £93.49 weekly gross pay.

On an hourly basis (Figure 9), where working hours are not as salient, the results show that the gender pay gap is driven by two main factors in the health care sector. Equalising women and men as health professionals would address 37% of the gap, or an extra £2.40. The discrimination element (direct effect of being a woman or a man) is substantial, amounting to 45% of the gap or £2.90.

Decomposing the gender pay gap for nursing professionals

The gender pay gap in nursing was further assessed using the simulation decomposition method outlined previously, using secure access data from the *Annual Survey of Hours and Earnings* (2018, provisional) provided by the UK data service (ONS, 2019). In this part of the analysis, we examine pay both on an annual and weekly basis among nurses.

Figure 9: Decomposition of the gender pay gap (hourly gross pay) among health care professionals



Source: ASHE 2018

Decomposition

The gender gap in annual and weekly gross wages were decomposed into their main elements following the simulation method proposed by Olsen and Walby (2004) outlined above. The results of the regression analysis showed that, in nursing, the gender gaps in annual and weekly gross wages are structural (in other words, related to other factors such as working time) and not related to sex. Performing the decompositions shows that the gender gaps are predominantly the results of differences in basic paid hours between women and men (Annexes 7 and 8). If women were to work the same number of basic paid hours as men, the decomposition model states that this would result in an additional £5,164.46 in annual gross wages (Figure 10) and an additional £102.60 in weekly annual wages (Figure 11).

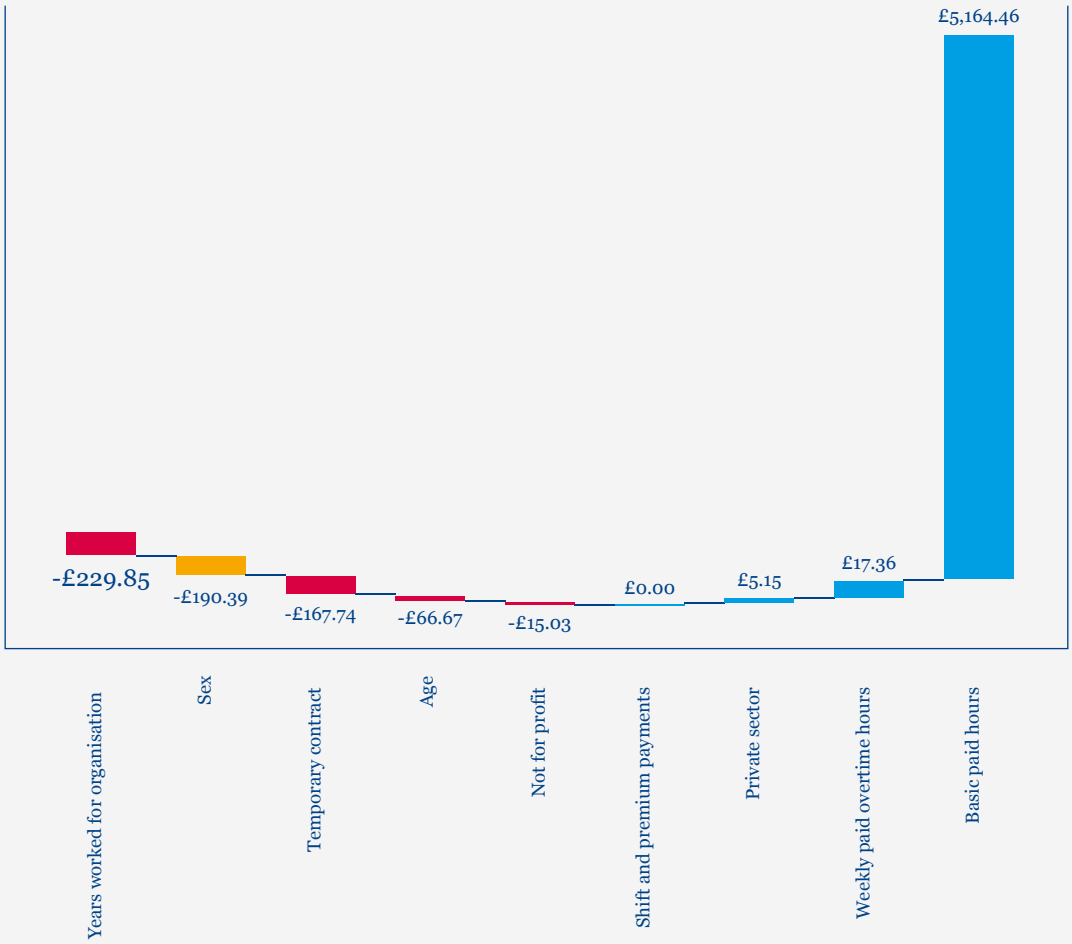
Value and voice: nurses' perceptions

Pay represents only one facet of the value that can be given to the nursing profession. Value can also manifest itself through the working conditions experienced by nurses. In this section, we review statistical evidence on the demanding nature of the nursing profession before turning to the relationship of pay levels with wellbeing at work and on the standing of nursing as a profession.

The demanding nature of the nursing profession

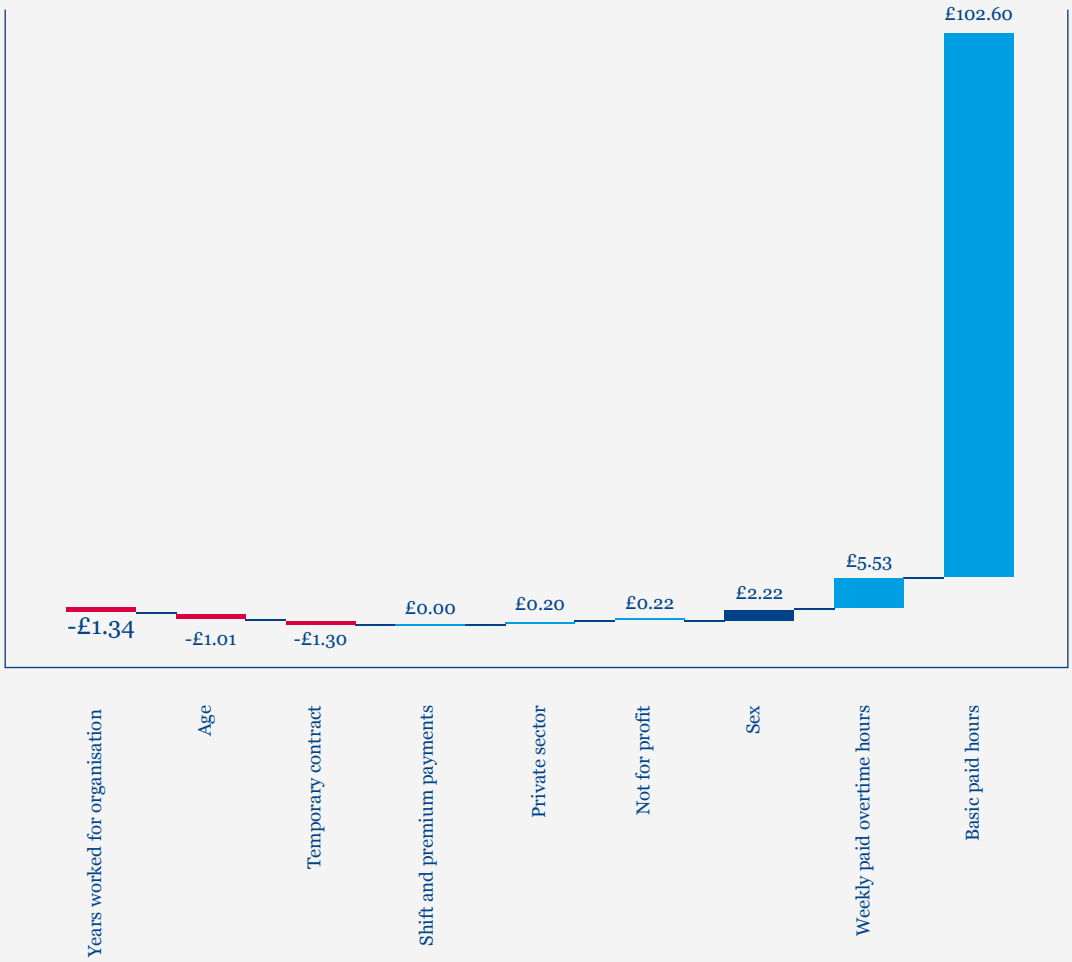
Nurses frequently work excess hours: in total, nearly three in four (72.2%) work excess hours at least once a week (Figure 12). This includes 15.3% of all nursing staff work excess hours every shift and a further 35.4% do so several times a week. Working excess hours does not seem to be related to whether an individual is a woman or a man, or

Figure 10: Decomposition of the gender pay gap (annual gross wages) among nurses



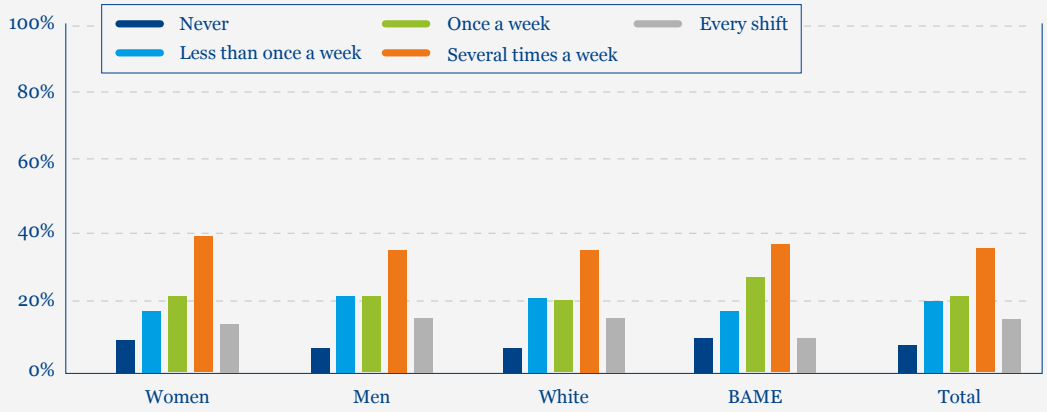
Source: ASHE 2018

Figure 11: Decomposition of the gender pay gap (weekly gross wages) among nurses



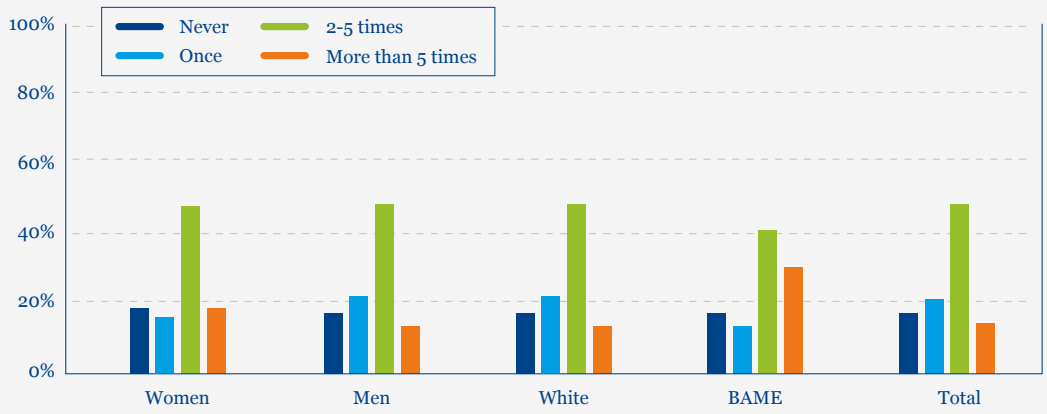
Source: ASHE 2018

Figure 12: Frequency of working excess hours, by sex and ethnicity



Source: RCN Employment Survey 2017

Figure 13: Frequency of going to work despite not feeling well enough to do so, by sex and ethnicity



Source: RCN Employment Survey 2017

to whether individuals are from a white or BAME background.

The majority of respondents (83.2%) stated they had gone to work at least once in the previous 12 months despite not feeling well enough to do so (Figure 13). Nearly half (48.3%) did so more than five times. The most notable difference is that 29.5% of BAME nurses went to work more than five times despite feeling unwell, compared to 12.4% of nurses from a white background.

Perceptions of bullying are high among nurses: 44.5% of all respondents stated they had experienced bullying in the workplace over the previous 12 months (Figure 14). Of these, 44% had reported it, which means that overall 13.9% of respondents had experienced bullying and reported it. Differences across women and men, as well as among white and BAME respondents, were only marginal.

Perceptions of nursing as a career

In this section, we examine perceptions of nursing as a career. This can be assessed through a measurement scale consisting of six items ($\alpha = 0.81$) included in the RCN Employment Survey 2017:

- I would recommend nursing as a career
- I think that nursing is a rewarding career
- Most days I am enthusiastic about my job
- Nursing will continue to offer me a secure job for years to come
- I would not want to work outside of nursing
- I regret choosing nursing as a career (reversed).

The means of each item were aggregated into a single measurement and showed that as a career, nursing is rated more positively by women (49% of positive responses) than by men (42%), a statistically significant difference (chi-square, $p < 0.01$). As illustrated in Figure 15, the standing of nursing as a career is lowest for those in band 5 (for example, staff nurses) and closely followed by those in band 6 (for example, senior nurses), possibly because of lower pay. Professionals in band 5 and band 6 are least satisfied (44% and 48% of positive responses respectively) compared to those in band 8 and band 9 (56%) (chi-square, $p < 0.01$). This might be the result of a combination of lower control and lack of progression opportunity.

Interestingly, the effects of pay bands on perceptions of the standing of nursing as a career is only statistically significant among women compared to men as well as to white respondents compared to those from a BAME background (chi-square, $p < 0.01$ for both). Women in band 8 and band 9 have much more positive responses than those in band 5 (59% vs 45%), a difference that does not apply among men. The same applies to white respondents with 57% of positive responses in the highest bands compared to 44% in band 5.

To better understand the effects of pay bands and different grounds of diversity on the standing on

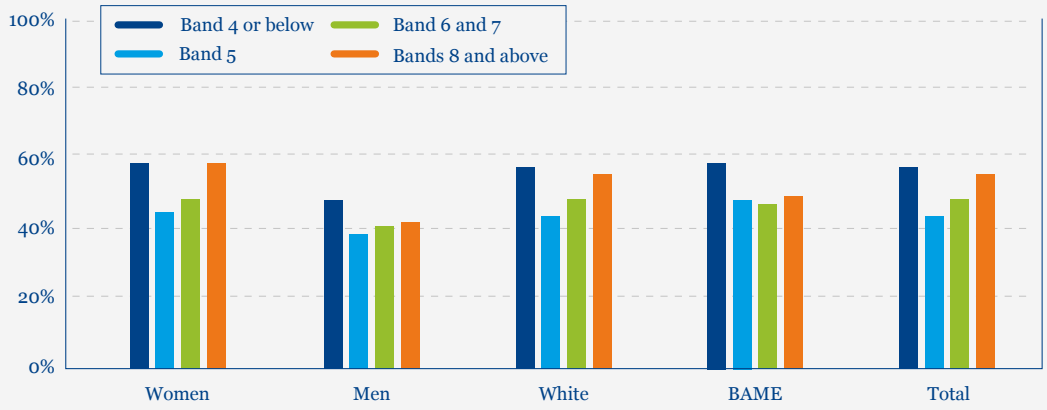
nursing as a career, we now analyse each item separately. Responses were recoded into binary codes (0: strongly disagree to neither; 1: agree or strongly agree) and used in logistic models. Diversity grounds in the *RCN Employment Survey* 2017 included sex (88% women vs 12% men), ethnicity (91% white vs 9% other background), generation (42% under 45 vs 58% at or above 45) and disability (91% with no disability vs 9% reporting a disability).

Women also have higher levels of satisfaction with nursing as a career, but reporting a disability is associated with lower levels of satisfaction (Annex 9). Being from a BAME background provides mixed findings. On the one hand, it is associated with higher propensity to recommend nursing as a career and see it as a secure career, but on the other it is associated with perceptions of lower rewards. This might be related to seeing nurses as a 'safe haven' where discrimination is lower than in other sectors of the labour market, despite the low rewards associated with the profession. Being aged 45 or over has a positive effect on not regretting nursing as a career. This is at odds with older nurses feeling that nursing offers fewer rewards or security, questioning the future of the profession and/or their role in it.

Figure 14: Frequency and reporting of bullying in previous 12 months by sex and ethnicity

Source: RCN Employment Survey 2017

Figure 15: Positive perceptions of nursing as a career, by sex and ethnic background and level of seniority (%)



Source: RCN Employment Survey 2017

Conclusion

This chapter provides a more nuanced understanding of the gender pay gap in the nursing profession by looking at workforce and diversity factors in greater depth. Results from our analysis show that nurses are amongst the lowest paid professionals in the health sector. However, it does not go further into comparisons between nurses' pay levels and those of other professions, graduate or otherwise. Invidious comparisons between other professions which may be deemed to have similar levels of skills, responsibility or demands are not useful.

Rather, the study aims to examine an occupation which has traditionally been seen as women's work and how this viewpoint impacts on levels of pay. But low pay is not the only issue: the low variation in pay signals that nurses lack opportunities to progress in their careers. This has implications for the retention of nurses, who may opt to leave nursing altogether or else leave the NHS (or other health care employer) or find other ways of increasing their earning potential in nursing, for example, through agency nursing.

On the face of it, a gender pay gap exists as women in the nursing profession earn 17% less than men on a weekly basis. However, when other factors such as qualifications, working hours or managerial responsibilities are included, the gender pay gap disappears. This suggests that the gender pay gap is structural, in other words related to factors such as working time. Our analysis expanded on these findings by also considering diversity in relation to pay in the nursing profession. An important result is that, while controlling for other structural factors, nurses from a BAME background earn about 10% less weekly (and hourly) pay than their white counterparts. This result is only statistically significant, perhaps owing to the fact that the analysis relies on a small sample size (n = 274), warranting further analyses. What is certain, is that in examining pay equality in the nursing profession, ethnicity matters.

Although there is no gender pay gap when structural factors are taken into consideration, this does not mean that pay is not an issue in the nursing profession. Differences arise because men benefit slightly from a glass elevator. On an hourly basis, men with managerial responsibilities earn significantly more than women at the same level, although this is somewhat softened on a weekly basis because men work more hours than women despite having similar levels of responsibility.

The perceptions of nursing as a career provides interesting results in relation to ethnicity.

In nursing, therefore, it is not the gender pay gap that is the overriding problem. Rather, it is how the ingrained devaluation of nursing translates into low pay for everybody, with the exception of a few visible men that take this glass elevator. Low pay, we argue, is linked to the devaluation of nursing because it is a highly feminised profession and constructed in relation to the 'feminine' and to 'care' (McDowell, 2009). The profession reproduces societal expectations of femininity and masculinity, with consequences for those who can access higher positions. Men are more likely to reach leadership positions because it is seen to be congruent with expectations of hegemonic masculinity (Eagly and Karau, 2002).

We concluded our analysis with an examination of gender, diversity and pay in relation to perceptions of nursing as a career. Our results confirm that nursing is rated more positively among those with greater seniority, but not among men. Moreover, men on the whole rate nursing as a career less positively than women. This might speak to nursing being perceived as a 'feminine' profession, and therefore less congruent with stereotypical expectations of masculinity.

Women are also less likely to achieve positions in (senior) management, and their progression might therefore be associated with greater satisfaction.

Women are also less likely to achieve positions in (senior) management, and their progression might therefore be associated with greater satisfaction. In contrast, men's progression in the workplace might be expected or taken for granted, possibly explaining the observed difference. The perceptions of nursing as a career provides interesting results in relation to ethnicity.

Paradoxically, being from a BAME background was associated with being more likely to recommend nursing as a career and seeing nursing as offering opportunities, but not finding it rewarding. That BAME nursing professionals are more positive might reflect that even if inequalities in nursing exist (The Guardian, 2014), as a career it may be more inclusive than other sectors of the labour market. In addition, nursing as a profession has a long history of relying on BAME individuals (Cummings and Serrant, 2018) making it an obvious career option.

Orthodox economic theory would predict that a labour force facing a supply crisis – such as the 40,000 nursing vacancies in the NHS in England alone – would lead to substantial wage increases. Likely explanations relate to the roles that wages play in society besides an outcome of capital labour relations (Rubery, 1997; 2019). Explanatory factors may include:

- the operation of the NHS as a monopsony employer and policy-setter
- the operation of pay determination in the NHS for all occupations, including nurses as the largest occupational group (except doctors and dentists), which in turn drives pay decisions in other health care sectors
- the relative lack of industrial unrest in health care (and particularly among nurses).

Another likely factor is the social norms attributed to both care work and women's work, which position these as less valued forms of work. To explore these issues further, in the next chapter we listened to the voices of senior stakeholders in the nursing profession.

Chapter 5: The voice of senior stakeholders in the nursing profession

Introduction and participant demographics

This chapter reports on the findings from qualitative interviews designed to capture the views of key senior stakeholders. The majority of interview participants highlighted the importance of external pressures facing the profession, such as the financial burden of austerity, Brexit and the negative role that these factors play. The following sections address the main themes that arose in addition to those external factors — the nature of nursing, pay and status, control and autonomy, and voice and leadership.

This qualitative study involved 15 telephone interviews with key senior informants, ranging in duration from 45 to 70 minutes, conducted between late October 2018 and early June 2019. The interviews were undertaken with a diverse range of stakeholders; eight women and seven men, with representation from across the UK.

The interviewees all worked in or with the nursing profession; several had 35+ years' experience in the sector and most of the others had 20+ years. All but three participants had trained as nurses, with the others having backgrounds in administration, business management and/or change management. Six of the trained nurses had migrated into academic, educational and/or research roles, either on a full-time or part-time basis (often combined with continued work in a nursing role). Others worked primarily for the NHS. Backgrounds in the nursing field were broad, with participants describing experience in mental health, oncology, and critical care nursing in community and hospital settings. Some had been involved with nursing overseas and were able to bring an international perspective.

In addition, three interviewees were currently, or had been, involved with the profession as a trade union representative or employment relations specialist. The majority were now in senior strategic and leadership roles, that is, at executive or director level, with several having extensive commissioning experience.

The nature of work

Valuing nurses: angels, heroes or villains?

The ways nursing is valued as a profession, it was argued, are impacted by entrenched societal perceptions of the role. Interview participants agreed that, despite overwhelming evidence of the link between registered nurses and patient outcomes and advances in nursing roles, perceptions have not kept pace. They pointed

to a lack of realistic portrayals of nursing as a complex, diverse and challenging profession.

Interview participants attributed this to failure of society and the media to understand or recognise that these 'hands on' aspects of nursing are, in themselves, not simply natural or inborn, but a very skilled and learnt aspect of the role and *"not just physically, but a very emotionally demanding job."* (Nurse with an employment relations background).

One participant felt that society would be unlikely to ever perceive the basic aspects of nursing as highly skilled when *"there are many tens of thousands of individuals who are basically members of the general public who are doing all of those things for their loved ones at home without any training."* (Director level nurse with commissioning experience).

However, many others argued that the *"old-fashioned"* view of a nurse who simply washes and changes people must be challenged, with one participant saying *"I'm not sure we've done enough with the public to actually promote the range of skills and knowledge that nurses now have and what they can and can't do."* (Nurse in senior academic/HE role). The advanced practice role was pointed to in particular as *"a hugely powerful role breaking down the barriers between nursing and medicine."* (Director and strategic leadership).

Some also argued that nursing roles becoming more diverse, for example, registered nurses and health care assistants, those who can prescribe and those who cannot, has made things *"muddied and messy"* for the public which contributes to difficulties in making sense of what nurses do (Nurse background, in senior academic/HE role). Another argued that:

> "I think the perception of what a nurse is nowadays probably needs to change... I think perceptions are very different from 10 years ago... there's still a little bit of this angel perception and actually... It is a career and when you pick up a glossy magazine and they talk about career women – they never once mention a nurse... I think people just see it as you just become a nurse and there's very little progression."
>
> **Nurse in academic/HE role**

Though several felt that the profession has public support and is held in high regard, the idea of nurses as *"angels"* or *"heroes"* was often felt to be unhelpful. Furthermore, when attention has been focused on certain high-profile negligence cases which have questioned the reputation of nursing, the portrayal of the profession has often quickly flipped from hero to villain. The blame placed on nurses was attributed, by one participant, to the gendered nature of the role and *"a very different approach to how women are treated and how men are treated in the media."* (Nurse background, in senior academic/HE role).

One participant felt that society would be unlikely to ever perceive the basic aspects of nursing as highly skilled.

Such attitudes, tho.ugh, were also seen as prevalent in all corners of society, with one participant stating that it is essential to challenge those perceptions from an early age through education: *"... with young people, particularly in primary school, there's still an issue about gender neutral stuff, so they still perceive nurses to be women, men to be something else and within secondary schools we still have among teachers and particularly career advisors. 'You're clever'. You'll be a doctor. You're not so clever. You be a nurse.' So just all those stereotypical barriers that we need to overcome to break those perceptions."* (Nurse in strategic leadership role with employment relations background).

When talking about perceptions of nursing, participants identified the need for challenge from within the profession and to be confident about its skills: *"So, when you listen to nurses you ask them, 'What do you do?' They always default to, 'We care, we support ... compassion, cradle to grave.' All of those kinds of expressions, and what I'm trying to get nurses to do is to say, 'Actually, we are specialists. We have expert knowledge, we're researchers, and we bring and deliver all that in a caring and compassionate way. That's what unique about our profession."* (Nurse in strategic leadership role with employment relations background).

It was also argued that nursing must become more politically engaged and must better

articulate its value to health care in financial terms to make the case for more resources. There was wide recognition that being considered 'women's work' causes its devaluation, with one interviewee stating that: *"The biggest issue is the devaluation of professional care. So I think it is tied up with gender that a job predominantly done by women isn't seen as ... a safety-critical role."* (Nurse in senior academic/HE role).

Participants went on to state that the profession needs to find a way to show the potential variety of roles and possibilities for autonomy, as it is often portrayed and misunderstood as being *"fairly static"*. One participant asked: *"why aren't we showing off, why isn't there a media campaign that shows off the huge diversity of the nursing role?"* (Nurse, employment relations background). Careers with some similarities, such as the fire, police or ambulance services, were seen to attract greater respect and attention, as were health care specialisms such as paramedics, which some perceived as more masculine: *"...driving fast with blue flashing lights ... part of the emergency services"* or *"A&E – faster paced, action-packed, saving the world."* (Nurse in academic/HE role).

The prevailing narrative of nurses as caring, compassionate and empathetic, qualities that are perceived as innate feminine traits, can:

> "...obscure the highly accomplished, highly skilled evidence-based technical work that nurses are involved with day in, day out" and this is further complicated by "... this dichotomous view you can't be educated and caring."
>
> **Nurse background, in senior academic/ HE role**

The 'nature' of care

The 'nature' of nursing care was central to several interview discussions, and most of the participants who had trained as nurses some time ago described how this has changed. They had, for example, spent a greater proportion of their time face-to-face with patients, whereas they judge that working in the current environment is often more *"removed from the bedside"* or *"shifting in an upwards direction ... away from the patients slightly"* (Nurse in academic/HE role), for example, with computerised and pre-set care-planning.

Combined with increasing acuity, and more complex patient needs, this means a greater proportion of hands-on care is delegated to unregistered staff, while registered nurses take on more advanced tasks. Though aspects of this were generally seen as a positive development, allowing nurses to have influence and use their knowledge and expertise, it was also perceived as a loss, not least for practical reasons as face-to-face engagement enables a better assessment of a patient's condition: *"... it's a bit old-fashioned, but by talking to the patient, you get much more from them apart from them showing you their sore arm – you pick up a lot more information that needs managing."* (Nurse in academic/HE role).

Moving forward, looking back?

Some participants, though, argued that the existing division of labour across registered nurses, health care assistants, and so on, represents a retrograde step, fracturing the workforce where care is delivered *"almost like a car production line"* rather than a seamless way, and that *"we spent 30 years getting out of that and now we're sort of tumbling back into that."* (Nurse with employment relations background).

Interview participants highlighted that associate practitioners or health care assistants are increasingly leading on work which nurses have traditionally carried out, and the *"skill mix of the nursing team ... has been diluted in terms of skills and education and knowledge underpinning what was being done."* (Nurse background, in senior academic/HE role) and despite *"plenty of research evidence to indicate that the more associates and health care assistants we have, the worse outcomes will be and the worse our mortality and morbidity will be."* (Nurse background in senior quality improvement role). This exemplifies a tension around the occupational boundaries and closure, which are key markers of a profession (as described in Chapter 3).

There was also a widely reported feeling that the profession is in a *"strange place"*, trying to keep hold of 'traditional', hands-on and rewarding work (often described as what attracted people to nursing in the first place), and that *"the vast majority of ... nurses are nurses first and foremost because they are very*

caring individuals and that the professional satisfaction, the immediate gratification they get from doing that basic caring duty …" (Nurse, background in senior leadership role).

While some acknowledge that nurses like to *"do the doing"* this can sometimes curtail advancement in the role. This underpinned repeated references to perceived incompatibility between caring and academic pursuit and that overall *"you're not a real nurse"* unless you are *"at the bedside in clinical practice with … sleeves rolled up,"* (Nurse, background, in senior academic/HE role). Therefore, the ideas prevail (both within and outside of the profession) that not only do you not need to be academic to carry out caring work, but that the two are mutually exclusive. This undermines the key knowledge claims which establish the professionalisation of nursing.

It was argued that nursing itself, therefore, needs to broaden its thinking and decide what it wants to be to move forward: *"… we argue that nursing care should be delivered by registered nurses and if you look at the evidence … registered nurses provide better care than health care support workers who, on the whole, have a minimal level of training."* (Nurse, director level with commissioning experience).

It was argued that nursing itself, therefore, needs to broaden its thinking and decide what it wants to be to move forward.

While health care support workers deliver a significant amount of care, a general lack of planning to invest in developing their skills levels was questioned by some participants, for example, with one asking: *"What would be the position if we had registered nurses replaced by highly-skilled, highly-competent individuals who are not registered but did receive a significant level of training and investment in order for them to undertake a role we want them to undertake?"* (Nurse, director level with commissioning experience).

This, it was argued, is one way in which the profession *"… is in this limbo land, trying to cling onto the past, trying to look to the future, arguing that there is not enough of us and the reality is there's never going to be enough."* (Nurse, director level with commissioning experience). This was said to be a dilemma at the heart of the profession and represents a key tension in setting professional boundaries: that it needs to show its complexity in order to be valued more, though, as summarised by one participant: *"How do you shift a whole profession in one direction when there's probably a big element of it which doesn't want to go there?"* (Nurse, director level with commissioning experience).

The role of non-graduate caring

Interviewees pointed to the complex picture of the nursing workforce, characterised by graduate entry since 2013 which has resulted in a growing proportion of the registered workforce holding a degree, working alongside health care assistants and associate practitioners as well as the development of new roles such as nursing associates and nursing apprentices in England. Although the development of nursing as a graduate profession was described in positive terms, some participants also raised as an issue those nurses and support workers who may not be able (or do not wish) to reach graduate-level. One participant described these as the 'backbone' of the NHS, and there were suggestions that a model which incorporated non-graduate nurses would provide greater career structure and bring more nurses into the profession: *"We've increasingly started to fill bands 3s and 4s [in the NHS] with developing non-qualified nurses and I think we have to actually say if we want to have some regulation around this maybe."* (Nurse, background in senior leadership role).

The question of whether it is the lack of historical training in support roles or their non-registered status is the main issue. One interviewee, for example, saw the increased use of associate practitioners as designed to lower employment costs as part of *"…the financial culture of an organisation that starts to affect and degrade the culture of how you deliver that service"* (Nurse with employment relations background). Another agreed that the associate role was designed to *"take all the tasks and downgrade them"*, maintaining that while health care assistants *"have a very important role to play into the delivery of care"* the reason for introducing a further role *"should not be because we haven't got enough nurses. It's about making sure that what we do, it's done appropriately with the right delegation, education and*

training." (Nurse in strategic leadership role with employment relations background).

One participant argued for more investment and support in education for health care support workers *"Because they are the ones who are delivering the bulk of what we think of as the nursing care delivered within our clinical environments ... if we invested more in them, they would be more highly skilled and then the registrars ... that are in the workforce would be able to be freed up to focus on those things where their knowledge and skills would be better utilised."* (Nurse in senior academic/HE role). By enabling registered nurses and support workers to work in this way, this points a way to nursing being able to position itself more clearly as a profession.

The RCN had found it necessary to campaign to encourage nursing staff to self-care.

Control and autonomy

Participants' responses referenced existing research that attributes high attrition rates in nursing to work pressure, intensity and unsafe staffing levels. In particular, they expressed concern about the wellbeing of nurses, who are *"constantly putting everyone else first but themselves."* So much so, it was argued, that the RCN had found it necessary to campaign to encourage nursing staff to self-care (by resting, rehydrating and 'refuelling') and assert their right to a break (Nurse, background in senior academic/HE role).

In addition to immediate health and safety concerns, the potential for longer-term, psychosocial harm was identified, for example: *"When nurses face short staffing there's more burnout, ... then they go off with stress and anxiety issues or they start becoming ill because they're burnt out and then that makes it all worse because then there's even less staff, so it really is caught in that vicious circle."* (Nurse, employment relations background). It was argued that such levels of emotional labour require resilience, and this *"now seems to be something you have to put on like a coat of armour to go on and deal with the day"*, where instead it *"should be a skill whereby you experience a challenging event, you would then go back and reflect upon that event, think about how you could deal with it differently, and then ... use that skill to go back out and feel slightly stronger."* (Nurse, employment relations background).

Career flexibility, development and progression

Existing levels of career flexibility and the ability to move in and out of nursing were perceived by participants as a feature which can both attract and retain staff. This was primarily identified as a strength of the profession in terms of being able to attract women: *"We do push that you can jump in, jump off, jump in, jump off ... and that's the way because we've been a predominantly female profession, of course we've had to see people taking career breaks for children or parental leave or carer leave or whatever, and yes we do need a flexible approach to that."* (Nurse in senior academic/HE role).

However, the ability to return is not always straightforward for some: *"We're very used to saying, 'Well, if they've been away for five years they just have to come back and do a return to practice programme.' Well that's fine in relation to skills, but it's a very different NHS you've probably come back to, it's a very different organisation and expectation of how you operate within that skillset and that makes it complex."* (Nurse in senior academic/HE role).

In relation to progression, a range of barriers and enablers to progression were identified and some said that that there has arguably *"never been a better time for career development and progression"* (Nurse, background in senior leadership role) as the roles which nurses can take on have expanded considerably. One participant cited the role of nurses in clinical decision making as increasingly important, with a move away from the *"stereotypical stratification of doctors who tell nurses ... it's just nonsense now, we're so far along the multidisciplinary team ... that just doesn't happen to anything like the same extent."* (Director level, strategic role).

Another interviewee agreed, saying that nursing needs to match new entrant's expectations: *"... the generation we have now, are more concerned with having value in their lives, making a difference. Well, where else are they gonna get that more than anything else, but through a career in nursing, and you can still earn a good income, support a family, you can*

still do that through the nursing profession and go on to have a really good career?" (Nurse in strategic leadership role with employment relations background). It was therefore felt important to understand: *"What do our future nurses, or potential nurses, really want from a nursing degree; where do they think that's going to take them?"* (Nurse, director level).

The most common barriers to training and development to enable progression were identified as time and money, which included nurse directors being unable to release staff to participate in higher education because they do not have the time to leave their role; and cuts to funding for continuing professional development (CPD), including professional development within higher education, which nurses are required to fund themselves but are unable to afford from their own salaries. Therefore, additional investment in staff and training costs is needed. A further suggestion to help the profession *"shine and move on"* (Nurse in strategic leadership role with employment relations background) was to invest in enabling more nurses to undertake research, and that progress within academia can make a real difference to nursing being recognised for the impact it can have.

The most common barriers to training and development to enable progression were identified as time and money.

Retaining existing staff and their skills was considered as important as recruitment into the profession, and several argued that this has been neglected "*cause everyone's been arguing that for the last five to seven years, we need to train more, and at the same time ignoring the fact that our bucket has got a big hole in it and we're not doing anything to address that."* (Nurse, director level with commissioning experience). Another participant agreed with this, and argued that in order to address this *"... we've got to make sure that we don't take our eye off the ball with our current workforce and how we maintain them and how we develop them and how we set out career pathways for them and how we look at their working environment."* (Nurse in senior academic/HE role).

The underrepresentation of women at higher levels in nursing was attributed to a range of factors. These included reducing to part-time hours or relinquishing permanent contracts, rather than leave the profession often because of unsocial hours and shift work (particularly after having children). It was, however, also argued that shifts can fit well with childcare (for example, if shared with a shift working partner).

Interviewees pointed to nurses making a calculated choice to work solely or primarily on bank or agency contracts or to work reduced hours to provide them with enhanced flexibility despite the risk of diminished opportunities of access to training or professional development. In a health service beset by high vacancy rates, this not only demonstrates the power that many nurses have to make a choice between permanent over temporary contracts or full-time over reduced hours, but also how employment relationships are also curtailing work-life balance and job satisfaction.

Women choosing to work flexibly or reduce their hours to fit in with childcare or other caring responsibilities, and the resultant limitations this can place on their careers, was often attributed to a lack of support, as *"we just haven't got the infrastructure to do the childcare and the school runs and all that"* (Nurse in academic/HE role). The lack of strategies and support for those with childcare or other caring responsibilities, through job share, flexitime, free and/or onsite childcare and nurseries was seen as a key factor in restricting women's progress in the workforce, and it was argued that the profession needs to be *"creative around 9-day fortnights, or part time, or whatever in a way that is celebrating people being at various stages of their life."* (Director level, strategic role).

A narrative that some nurses make a choice to actively avoid progression was also identifiable here. Alongside the assertion that many would choose to remain in a lower-paid position to retain a more hands-on role, some participants described a choice to remain in their current role on band 5 or 6 to maintain flexibility in their role. This, it was argued, is *"increasingly common"*, as having control over working hours is more important to them than moving to the next band (Nurse, background in senior leadership role).

Progression to senior leadership roles was also discussed by interviewees, with one participant identifying that the levels of accountability and responsibility faced by nurses at director and board level are too high in comparison, for example, with a finance director. This is exacerbated by high-profile investigations and the pressure that nurse directors face to maintain quality. Subsequently, there is difficulty in recruiting nurses at directorship level.

Another interviewee felt that salary at that level was not the key issue, and that *"turnover at that level is terrible. People basically don't want to do the job anymore because they're under such phenomenal pressure and scrutiny ... and actually the salary doesn't really make up for that ... So the leadership at that level ... is very stressed and under terrible amounts of scrutiny."* (Nurse, background in senior quality improvement role).

Workforce diversity

The need for a diverse workforce that represents society is well understood and supported, and especially the need to empower women and support them into more senior roles, which would help increase diversity in the profession overall as it will *"transform the view of women's work and ... the view of nursing, and then that will bring in people of all ages, genders, ethnicities, sexualities, and that gives us a more diverse workforce that represents the community."* (Nurse, employment relations background).

The need for a diverse workforce that represents society is well understood and supported.

At the present time, however, a number of participants identified that BAME staff are underrepresented at senior levels and overrepresented both in lower pay bands (offering limited career prospects and training opportunities) and in disciplinary referrals. One participant recognised that for these people: *"... when you're in the workforce and you feel that there's a lot of you around and you're all trapped within the same band and there's no internal training, there's no internal development of you ... it can make people feel that what is general neglect becomes specific to them."* (Nurse with employment relations background). Nurses from a BAME background, it was argued, need to show extra vigilance because:

> "... their ... mistakes won't be forgiven ... All sorts of things that would normally be seen for others as a learning experience and something that could be remedied with coaching ... they are given the impression that these are fatal flaws rather than coachable characteristics ...if you make a mistake then that is somehow emblematic of all the mistakes and the fatal flaws in an entire race. There is a distinct racial illiteracy in nursing..."
>
> **Change manager, strategic role**

Disability within the workforce was also raised as something not being dealt with adequately, in particular mental health issues which can arise and/or be exacerbated by work pressure often remain hidden because of stigma and shame, because *"There seems to be a sense you should be all right. A lot of that is related to, possibly, 'identity as nursing'. It is almost this super-strong woman that is supposed to care for everybody and not do too much to care for herself."* (Change manager, strategic role). This was described as often leading to individuals exiting or being managed out of nursing, which is a loss to the profession, not least because of their experiences being a potential asset in providing better care.

Others argued that a holistic view of nursing is needed to recognise the value of all nursing staff, one participant stated:

> "We need to ask some fundamentally different questions about people's experience in the workplace on the understanding that they don't occupy one protected characteristic alone, but they occupy many over time, through time and at the same time ... One of the things you are going to have to ask is, do I have the right metrics? Am I measuring the right thing? This is giving me the impression increasingly that what people are looking for is the quick and easy as opposed to the difficult and possibly intellectually taxing. I think that is to the detriment of nursing."
>
> **Change manager, strategic role**

Sustainable working patterns?

Overall, interviewees argued that not enough is being done to understand why nurses are leaving the profession or where they are going. While some argued for a more strategic nationwide approach to understand this, there was also wide recognition that particular factors are to blame.

Current working patterns, for example, requirements to work long shifts, were repeatedly identified as being inflexible, and unsustainable as a long-term strategy. Some described senior management as recognising a need to change and modernise at a strategic level, but that new ways of working are not always recognised 'on the ground', and that nursing needs *"very different ways of working and flexible careers, flexible working, more annualised working, less people counting time in regards to when people come and go, actually just having a workforce which is much more flexible and recognising the individual's family's needs, aspirations of the individual as well as needing to man busy clinical areas."* (Nurse, director level with commissioning experience). Such inflexibility, through hindering autonomy and control over work practices, is a distinct barrier to professionalisation.

It was acknowledged that there is more awareness of the need for greater flexibility to reflect nurses' different needs across their life course in order to improve retention in the profession. One participant stated: *"Every poster … says that we value our people … the ways that you demonstrate that value are about being flexible when they need you to be flexible, understanding that a 40-year career will have in it periods when you can do certain things and periods when you can't. That you will change your life."* (Director level, strategic role).

Moreover, faced with an ageing workforce, health and social care organisations need to reflect how they can retain older staff, including changing working patterns and redeployment, increased use of digital technology; and drawing on older nurses' experience to operate helplines or mentor trainees and junior staff. One participant stated that as: *"We've got people who've committed a huge amount of their life … if it comes to a point where they're no longer able, for whatever reason, to fulfil the full range of duties … [we should] … expect teams to explore with them what they could do, because we have a huge variety of roles."* (Director level, strategic role).

Conversations about the pace of change and the profession's complexity must feed into new approaches to development, including preceptorship phases and mentoring (where newer members of the profession might be better supported), in addition to a reassessment of the existing 'return to practice' provision (for experienced nurses), and so on to build/rebuild skills and confidence.

High-level policy decisions, made both within and outside nursing, that affect the profession are perceived as actively contributing to the undervaluing of the profession. Several interviewees drew unfavourable comparisons with the medical profession in this respect, with one describing the introduction of the 6Cs of nursing campaign in the wake of reports relating to failure of care, stating: *"… it's never wrong to push compassion and to push the kind of things, but from a policy perspective why are we doing this? What would happen if we said that to the medics, you know we want our medics to really understand compassionate care, they'd never allow it on the table! … yet it seems to happen with nursing."* (Nurse in senior academic/HE role).

Representation of policy decisions in the media and wider public/governmental discourse was also felt to feed the way that the profession is undervalued, and some participants attributed this, in part, to the failure of senior policy-makers to sufficiently understand the more complex aspects of the nursing role. Indeed, some respondents argued that nurse leaders reach a point where adopting the norms of their organisation can override their clinical experience and affect the way in which they represent nurses. The RCN was felt to have a specific role in improving this, by more openly 'calling out' criticisms and misrepresentation of the profession rather than simply trying to bring about change through influence and explanation, with one participant saying: *"Do you know what? Let's just call it out. … Do [RCN] do it? No [they] don't. That's the difference. Would the BMA be sitting back? No, they would not. So that's the challenge, I think."* (Nurse in strategic leadership role with employment relations background).

Participants described initiatives to change perceptions of nursing and increase its visibility, including wider sectoral projects such as Nursing Now, general media appearances on current affairs programmes or raising the profile of

events such as the *Nursing Times* Awards. In relation to negative representations of nurses, one participant asked:

> "Where do we talk about nurses who have done good things? And I know the media don't want to see these things but I do believe that our population can speak up for us, so things like awards ceremonies and things like that are so, so important but we've got to do more to get the fantastic work we do, not just in our trade press, but in our normal press too. And things like International Nurses, Day on 12 May, we need to do much more to celebrate that, we need to use the media and multimedia, social media, to really drive a much stronger message about what a great profession this is."
>
> **Nurse, director level**

It was widely felt that that TV dramas such as Call the Midwife and Casualty present an image of nursing as *"at the bedside being caring and compassionate"* (Nurse, director level with commissioning experience). Though not necessarily negative representations, these reinforce the stereotypical roles which can be so influential. Some felt that there are missed opportunities for improving perceptions of the profession to show its need for intelligence and skill.

One participant suggested that *"...instead of getting a doctor on ... the Good Morning sofa, that, that is a nurse who's there on that Good Morning sofa, giving expert advice around [the challenges of diabetes, for example] ... So we need to develop the confidence, as a profession, to be able to do those things."* (Nurse in strategic leadership role with employment relations background). It was felt that the RCN might work harder on its relationship with the media and suggestions included some nurses who are unafraid of speaking out are offered media training to become representatives of the profession. One participant argued that:

> "... we have to stop apologising for being nurses ... I think if we're bringing young people in to be nurses, and heaven only knows we need them, then we need to instil them with a sense of pride, and we need to instil them with, 'Actually, this is your disciplinary, specific knowledge and be proud of it'."
>
> **Nurse, background in senior quality improvement role**

Some interviewees felt that senior leadership does not always speak with 'one voice', giving the impression that nursing is divided as a profession. The RCN was, again, seen as having an important potential role to play in overcoming this, with suggestions that the RCN could provide high-level developmental opportunities to increase policy-making expertise. One participant contended that: *"The professional voice of nursing should have been the professional arm of the RCN primarily I guess ... But ... it's not a voice of nursing. So all we end up with is a few vocal groups, professional associations, who are quite good, and then individuals I guess."* (Nurse in senior academic/HE role).

Looking forward

The need to appeal to the particular needs of a new generation of nurses was identified as a significant factor in attracting people to the profession. This was seen as hugely positive for nursing in some respects, as *"they are a generation for whom meaning and value can be very important, so a patient caring role thereby should be very attractive"* (Director and strategic leadership). Many participants, though, identified the different workplace cultures and expectations of younger people potentially entering the profession who have clear expectations with regard to professional boundaries and knowledge development. A typical description of *"millennial"* expectations was to be *"involved in strategic decision making"* and *"front line, staff-led change"* (Nurse, background in senior quality improvement role).

Another participant agreed that *"the opportunities that they're looking for are not the same opportunities as existed in nursing twenty years ago. They're just not. [The students are] interested in a high degree of specialty, they're interested in specific aspects of the nursing career very early on...mapping out [careers] in public health or sexual health ... paediatrics ... they're looking for*

equality around the table." (Director level, strategic role).

The way multigenerational teams work together, ensuring all approaches are valued equally was identified as an important workplace concern for younger nurses. Described as being as dedicated and hard working as more established staff, differences were are identified in what these workers are *"prepared to tolerate"* (Nurse, director level). In other words, they have higher expectations of their employers — to be supported and have opportunities for growth and development — and are *"asking questions about return on investment because they get one shot at this."* (Change manager, strategic role).

It was also argued that this cohort of workers would expect more flexibility and fluidity in their careers with regard to both work-life balance and being prepared to move around or take career breaks/sabbaticals. This is different to previous generations, who were considered more predictable in viewing nursing as a job for life. The newer generation of nurses were perceived as less likely to accept some of the long-standing work patterns which impact on work-life balance, such as extended shifts.

This outlook was seen as not fitting in with the current environment in the profession, with one participant articulating, for example: *"... so we're still thinking rather old-fashionedly that we'll train this many nurses and they'll stay there forever, whereas I know that isn't gonna happen. So there's something here about understanding what do our future nurses, or potential nurses, really want from a nursing degree; where do they think that's going to take them ... is it part of a bigger plan or is it that they do tend to stay in nursing forever ... with the attrition rate as it is, both in training programmes and in newly qualified nurses across the UK currently, that would suggest to me that there's something that's making people not stay."* (Nurse, director level)

Pay and status

Pay was generally described as low across health and social care and, in the opinion of some, not in line with a graduate profession, particularly as a result of the public sector pay freeze. One participant (Nurse, director level with commissioning experience) stated that: *"the nursing profession feels that goodwill and the austerity agenda that we had from 2008 onwards has run its course"* and wants to see nursing remunerated appropriately to regain what has been lost over the last 10 years.

Pay levels were, however, perceived to be fairer in relation to gender than other sectors because of the expectation that women and men of similar experience would be on the same pay. Some also argued, though, that low pay might be a concern for men who are considered the family 'breadwinner'. This response demonstrates how wages are not simply a price for labour but, also, from some individual's perspective, the expectation of a particular standard of living and allocation of resources to a dominant group.

Our interviews elicited an overriding theme of intrinsic rewards dominating extrinsic rewards. Pay and benefits were identified as an important factor in nurses feeling valued, but in general, they are not something nurses wish to talk about. The theme of 'virtue' (in other words, the intrinsic value of being a nurse overrides the desire for extrinsic reward) was recurrent throughout the interviews. Some challenged this view, though, with one participant arguing that:

> "There's unwillingness to stand up ... as a nurse ... in terms of working conditions, one of which is pay .... It's always subsumed or put against this argument of 'but the patient comes first' ... but I think in some instances we have been our own worst enemy in that ... we have always coped, we have always gone over our working hours ... and so we are very much taken for granted as a profession."
>
> **Nurse background, in senior academic/ HE role**

Another interviewee argued:

> "Why should it be this almost unspoken view that because you are a nurse you have got to be poor or that the caring should be enough? We would never say that to police officers."
>
> **Change manager, strategic role**

A further respondent stated:

> "If we really, really wanted to come back into looking at what we can do in the workplace to ... make them feel valued, well, there's only one way you can value people in the society that we live in and that's what you pay them."
>
> **Nurse with employment relations background**

For others it was more about the balance of intrinsic and extrinsic rewards and these respondents describe the importance of nurses feeling valued through recognition of their work, with one participant saying that: *"When I talk to a nurse on a ward, she'll say to me... 'If I go home thinking I've done absolutely everything I can for a patient then actually I feel like I've done a good job and that makes me feel valued'."* (Nurse, director level).

The narrative of 'choice' was also prevalent, with some arguing that senior roles having less 'hands-on' contact acts as a disincentive to seeking progression, despite the higher pay. As one respondent put it: *"Most [nurses] would look for value in the fact that we make people better or we've given more comfort to end of life or we've dealt with some difficult situations ... That's not quite so easy as you become more senior..."* (Nurse, director level).

The narrative of 'choice' was also prevalent, with some arguing that senior roles having less 'hands-on' contact acts as a disincentive to seeking progression, despite the higher pay.

Several interviewees argued that this prevailing narrative, where intrinsic rewards compensate for (and can therefore justify) low pay, must be changed if the profession wishes to see dramatically increased salaries. This is arguably an example of the profession both looking back and forwards, where nursing must reposition itself to change perceptions that it is focused on a particular 'type' of care, that is:

> "... caring for patients, washing, feeding, taking patients to the toilet, doing those fundamentals of care are a laudable area of practice. So, while nurses ... are continuing to argue the corner that they should be doing all those fundamental elements of care, then the salary level is going to stay where it is ... and I don't think the general public is going to be persuaded by the arguments of, you need someone to have a degree and be a registered nurse to be able to wash somebody..."
>
> **Nurse, director level with commissioning experience**

This narrative and its associated societal perceptions need to be challenged if there is to be a change to social practice, the gendered valuations of jobs determining wages, and the notion that intrinsic rewards can justify inadequate wages.

Senior and executive pay levels, such as those for nursing directors, were also raised as an issue for those in the profession along with the likelihood that they are less well paid than those at the same level from a different professional background. It was identified, though, that pay at higher levels within nursing is difficult to address: firstly, because pay negotiations have, understandably, focused on pay levels for nursing in general; and secondly, because not only are nurses seen to have come into the profession *"because we absolutely love what we do"* (rather than the pay) but also since executive-level nurses earn so much more than many others in their profession *"it becomes difficult then to have these conversations"* (Nurse, director level).

Pay structures and bandings

Looking at NHS pay structures and their role in and outside the NHS, while some appreciated the way these give equity and allow understanding of earning potential, they were also felt to be somewhat rigid. The banding, it was argued, means nurses do not feel they are making progress, either in relation to financial rewards or recognition:

"I still meet lots of nurses, newly qualified nurses and nurses who've been in the profession for a long time who don't always feel that they're being rewarded for the hard work and commitment and how they develop themselves, because we've got a pay structure that doesn't allow them to see that."

Nurse, director level

It was also argued that, in particular, the nursing pay structure lets down two distinct groups: band 5 nurses and those who have taken on levels of skill and competence that were previously the responsibility of the medical profession, and that the higher advanced practice levels should be better rewarded. Pharmacists were cited as an example of achieving higher salary levels through showing that higher levels of professionalisation are essential for their role, demonstrating how professionalisation might be structured 'from within'.

Voice and leadership

Some interviewees suggested that, as a large part of the workforce nurses are already highly influential, particularly within their own immediate organisation at board level through directors of nursing. However, not all agreed that this provides sufficient representation for nurses. In particular, where policy is being developed that affects the profession, the questions that need to be asked at the highest levels are: *"Where's the nursing input to that? Where's the nurse around the table?"* (Nurse in strategic leadership role with employment relations background).

Some argued that the mechanisms have not been in place to allow the nursing voice, for example, where *"there's been heavy criticism of nursing leadership for being quiet and maybe for not speaking out or for when nursing has spoken out it's been hushed by a louder voice."* (Nurse background, in senior academic/HE role).

Nursing leadership itself was described as hierarchical, and *"less of a networked leadership but very much command and control."* This was contrasted directly to the assertion of power and independent leadership in other professions, particularly, doctors *"who are often given much more autonomy and much more freedom and are much more networked to lead in their own way"* (Change manager, strategic role). Another participant described *"leaders ... who think in a seventies or eighties way not in a 'now' way"* (Nurse, background in senior quality improvement role).

These approaches were seen to feed into inflexible cultures which support neither change nor skills for inclusive management, with inability to change described as "almost a learned helplessness", and a failure to understand that *"inclusive leadership is a verb. It means doing things, role modelling ... possibly about giving power back and sharing power ... having those big conversations about how culture is framed"* (Change manager, strategic role).

Several participants agreed there is a need for a greater 'voice' from within the profession if wages and conditions are to improve.

Leadership, and the potential to initiate positive change, though, can take many forms within the profession, from sisters who lead wards, through to those leading organisations. If any change is going to be successful, it was argued, there are senior leaders who might be *"very powerful in creating a strong narrative ... people at the middle layer ... who are very powerful in having strong clarity about what the team ... are there to do"* and then peers, who act as *"social leaders at a relatively junior level"* who build trust and proximity which is *"very powerful in shaping culture"* and *"the things that need to happen alongside the big policy change"* (Change manager, strategic role).

Several participants agreed there is a need for a greater 'voice' from within the profession if wages and conditions are to improve. One participant stated that nurses are *"... not a very militant lot and I think we should be, or we should be encouraging ourselves, to become more militant"* though from the current perspective of the profession would not *"know how to quite go about that..."* (Nurse in academic/HE role).

Another agreed that there is a need to speak more loudly:

> "Do we speak up in the profession and say, 'And where's the money to do this'? No. We don't. We try and influence. We try and do it by the back door. We're nice and quiet. Let's find our voice, let's speak with one voice and say, 'Enough. If you want us to deliver' this is what we need to articulate: 'This is what we need to do it properly, and this is what you need to invest in, and you will get the return in investment.'"
>
> **Nurse in strategic leadership role with employment relations background**

Some interviewees suggested that the decision not to strike has led to the nursing profession being less adept at protesting because options to take the argument further were *"capped"*. In the future, it was argued, nurses may *"have to speak a bit louder and with slightly more actions"* (Nurse in academic/HE role), including striking or a 'work to rule', with some pointing to the superior working conditions nurses enjoy in other countries where they had been *"prepared to flex their industrial muscle"* (Nurse background, in senior academic/HE role).

The role of the RCN was seen as paramount in advancing the debate on rewards, status and influence, yet a recurring theme throughout the interviews, was that the RCN is not perceived as a particularly strong voice in comparison to other unions such as UNISON, which was seen as more prepared to take strike action over pay. The recent pay deal agreed for the NHS was raised in this context, with one participant stating that: *"I think people lose faith then, don't they, if it's continually not what it's sold to be? … I talked to a lot of relatively newly qualified staff, they see it not as a good thing."* (Nurse, director level with commissioning experience).

RCN representation was often felt to lack visibility and accessibility at local level, and it was argued that many nurses could not identify their hospital representative with support being increasingly online. This was identified as a cause for members failing to consult the RCN or ask for their support when an incident arises, and of particular concern to nurses working shifts who might experience even greater difficulty accessing representation or attending meetings.

The RCN, it was argued could take a significant step by sponsoring:

> "… research into what meaningful engagement means, how … best [to] communicate with [members] and … support them to be engaged. … So are there other ways of doing it; are there other ways we can communicate; can … reps and … stewards be going out into the workplace to talk about campaigns …? … 'cause quite often it can just feel like you're shouting into a wind tunnel."
>
> **Nurse, employment relations background**

It was argued that the 'millennial' generation also have different perspective in this respect, and that 'co-producing' elements of their working environment would include involvement in workforce strategy development. It was argued that this group are looking to explore career opportunities and desire flexibility in a way which the previous generation did not. This impacts the way in which they would want to be represented, that is, through inclusive, *"modern industrial relations" rather than "trying to preserve the past in aspic"* (Director level, strategic role). One participant stated that: *"I think we have probably some relatively young nurses who are quite political and there's the campaign against the removal of the bursary, they were out on the streets campaigning. They were campaigning against the pay deal even though the RCN recommended it … I think this sort of political activism that we're seeing in young nurses is to be welcomed. It's been passive for a long time."* (Nurse background, in senior academic/HE role).

Participants identified a wide range of ways in which the RCN might amplify the 'voice' of nursing. In particular, it was felt that the RCN could play a greater role in defending the profession when under criticism or threat. An example provided was the introduction of the 6Cs of nursing campaign *"… where nursing basically fell on its sword and said, 'It was all our fault.' Took the blame for what happened, 'We'll make ourselves more compassionate and caring', without thinking about why things went wrong. They just accepted the blame without question, and I think that was a really bad move."* (Nurse in senior academic/HE role). A further example was the introduction of the nursing associate role,

which it was argued is: *"essentially about filling registered nurse vacancies … And that's not great. So I would like to have seen the RCN take a much stronger stand on that, rather than just putting out a statement saying they don't agree with it."* (Nurse in senior academic/HE role).

The way in which the RCN is configured, that is, as a *"combined trade union and professional body"* was challenged by some, who felt that this was a less effective way to further the cause of nursing as a profession, with one participant saying: *"When you look at other professions, the doctors have their BMA which is their trade union type thing, but they have the royal colleges … feeding their professional agenda around education and the professional direction of them as doctors … They're a combination of professional issues which a professional body should be pursuing."*

It was argued that this can lead to conflict with the activities required for achieving pay awards as *"the solution for one is necessarily the solution for the other …"* (Nurse, director level with commissioning experience). Another participant felt there has been a loss of a delicate balance between being *"trade union focused, and … profession identity in setting the standards of doing that. … how are they going to refocus on that … Because you need both. You need professional and trade union to be successful."* (Nurse in strategic leadership role with employment relations background). Another suggestion included RCN engaging other organisations to work towards a common agenda for the profession, joining with other allied health professions, because there would potentially be *"a bigger voice that people would listen to if, actually, we were a bit more joined-up in our voices and our thinking?"* (Nurse background, in senior academic/HE role).

Several participants described how the RCN might exercise more proactive intervention, for example: *"When we know that there's a piece of work going to be starting, or some policy piece of work or something, and saying, 'Where's the nursing input to that? Where's the nurse around the table?' So we need to be flagging that up more, of that very, very senior level."* (Nurse in strategic leadership role with employment relations background).

Another argued that the RCN should be trying to exercise more influence over how care could and should be delivered, stating:

> "I feel that both nursing and indeed the medical colleges have tended to be very passive when it comes to future models of care, and to not really step out and use their expertise and insight to say this is how it should be. They've tended to react to whatever policy makers have thrown at them and … been more or less enthusiastic about it, whereas I always felt there was a void that they could have filled on that one."
>
> **Director and strategic leadership**

One also thought that *"the RCN … tended to focus on the bad things that have been going on for nursing, so the shortages, the demands, the burnout etc. And the stuff … in terms of new roles, advanced opportunities, the patient focus, the really fabulous quality of work that a nurse can have when the role is at its best, doesn't tend to get much of a voice in the media, and I think the College could be a lot more vocal and visible about those opportunities."* (Director and strategic leadership).

The RCN might, therefore, play a significant role to *"showcase nursing for what it is and really empower and highlight what a great job nursing is and why we should value that work"* (Nurse, employment relations background). Enhanced perceptions of the profession, it was argued, would both increase recruits and attract higher salaries. As one senior stakeholder confirmed:

> "I came into the profession to care for people but also to grow, develop and ensure that no day would ever be the same as the day before and I can absolutely tell you that is exactly what it has been. And I know many nurses who are no longer nurses but are absolutely brilliant in the job that they now do because they were nurses once. So we don't talk like that and we don't get the opportunity to talk like that, we don't celebrate what we do well, and I think Royal College could really help with that."
>
> **Nurse, director level**

Conclusion

The interviews with key stakeholders provided a rich data set that enabled deeper exploration of current issues that affect the nursing profession. The interviews confirmed and emphasised a great deal about the current state of the profession, against a backdrop of wider macro-political and economic factors. They identified much that is positive, including developments in the nursing role that provide greater opportunities for more diverse and complex work, autonomy and influence.

However, nurses face high levels of work intensity with unsafe staffing levels contributing to high levels of psychosocial harm and high attrition rates. Unrealistic and outdated perceptions of the role persist in the public image and nurses' own self-concept, which undermines their professional identity. 'Old-fashioned' perceptions remain, of nursing as a job carried out by women for whom caring is 'natural', which lead to it being de-skilled and devalued. The growing complexity and technical nature of the work, the difficulty of the emotional labour required, and the skill required to carry out the hands-on aspects of the role are not widely recognised and do not feed into societal perceptions of what a nurse does. The picture is further complicated by conflicting 'knowledge claims' within the profession, potentially causing tensions between the profession defined by expert, scientific knowledge and the more practical, caring aspects of the role.

Senior highly experienced stakeholders identified key issues, which, it can be argued, undermine the construction and status of nursing as a profession. They identified an increased blurring of occupational boundaries and a dilution of the registered nurse role, which is caused by the growing range of tasks being undertaken by both registered nurses and support workers. They also identified that debates persist around the caring and academic aspects of nursing; while many see both aspects as essential and complementary, others question the prominence of academic pursuit.

Other issues identified by stakeholders related to the working environment and working preferences, including a tendency for nurses to emphasise their desire to care over and above being suitably rewarded; their choosing flexibility over career development (that is, through remaining in lower band roles or moving to bank or agency contracts). These must be recognised as gendered in their nature, and as being underpinned by structural barriers.

Change is required from within, which means that leaders at all levels must work together to better understand and tackle the issues identified in this report so that nurses are no longer *"taken for granted"*. This involves ensuring the profession is valued by:

- addressing the way in which nursing is perceived
- providing appropriate input to policy which addresses the barriers to progression that women encounter to diversify leadership, and
- meeting the needs of a 'millennial' generation who expect greater career fulfilment and input to their working environment.

The RCN has the power and potential to protect and boost the profession's knowledge and skills, building on the engagement of its members to articulate their own value and voice.

Chapter 6: Final summary and recommendations

At the heart of this report is the concept of value: the value of work that is done and the care given, the value of individuals as nurses, and the value given to the nursing profession overall. Not valuing nursing, we contend, manifests itself through a devaluation of its status, pay and autonomy which is associated with the construction of the nursing profession as work for women.

Current perceptions of nursing reflect a misalignment between past images and present reality; professionalisation sits in tension with the notion of nursing as a vocation. Efforts to professionalise and revalue the nursing profession have been shaped and constrained by a history that positions nursing as a woman's profession, and we argue that real change cannot be realised without a critical approach to pay, status and autonomy, which emphasises the gendered nature of this construction.

Pay and conditions

Women occupy 90% of nursing roles in the UK, while nurses' pay is 80% of the average in the health care sector. We also find a gender pay gap within the nursing profession which is caused by structural factors, such as working time. This low level of pay reflects the fact that the profession is dominated by women, because of the broader gendered division of labour.

At first glance, a gender pay gap of 17% exists on a weekly basis, but when pay is calculated hourly this gap disappears. This is the result of a gendered difference in working patterns, where women are more likely to be working part time than men. In fact, if women were to work the same number of hours per week as men, the

At first glance, a gender pay gap of 17% exists on a weekly basis, but when pay is calculated hourly this gap disappears.

gender pay gap would close by £5,164.46 per year (gross). Although the majority of nurses do not work more than their contract hours, they are still more likely than any health care workers to receive extra income through shift work and

working overtime, with much of this extra work involving unsocial hours.

Most nursing professionals work shift patterns during their career and while the nature of shift work provides the flexibility that many nurses value, it also sets them apart from the rest of the health care sector and wider professional labour market. Overtime tends not to be paid for those in professional contracts, both within and outside the health care sector, because, rather than setting shift patterns with fixed working hours, there is an implicit requirement to work the necessary hours to get the job done. Allied health professionals, for example, tend not to receive regular overtime pay which demonstrates the markedly different way in which nurses are positioned in the wider health care sector. This suggests that other groups in the health sector have been more successful than nurses in establishing autonomy and control over their working hours.

Low pay is not without consequences. Two in five nurses who responded to the 2017 RCN survey said they had lost sleep because of money worries which may, in turn, impact on quality of care they deliver. Almost a quarter of respondents were considering leaving their job because of financial constraints but this figure rose to a third of nurses among men and those from a BAME background. These findings demonstrate the nuanced ways in which pay, wellbeing and retention are intertwined and how future measures to address pay and conditions must recognise intersectional inequalities within the profession and across society as a whole.

Senior stakeholder interviewees emphasised that nursing at all levels involves high levels of work intensity.

Further evidence from the interviews with senior stakeholders suggests that women in nursing are prioritising flexibility over career progression. This finding may contribute to the so called glass elevator phenomenon that appears to be emerging from the data, as men occupy 12% of roles with management responsibilities but represent only 10% of the overall nursing population. Men with supervisory or management responsibilities also receive more pay per hour and work more hours per week than women in equivalent roles. In general, the main route for nurses wishing to further their careers is to enter management and supervisory roles but the low variation in pay across the profession signals that nurses lack opportunities for career progression. The data suggest that managerial positions in nursing offer greater satisfaction and autonomy but at the expense of longer hours and increasing demands. Taking up managerial positions also usually means moving away from clinical roles, which is perceived as being more distant from the core values of nursing. Therefore, such responsibilities may not appeal to nurses who prefer flexibility or remaining in clinical work.

The data also indicates a low variation in pay which signals that nurses lack opportunities to advance their careers and increase their pay. This has significant implications for the retention of nurses. Our quantitative results suggest that while senior positions in nursing are considered to be more demanding than mid-career roles, senior stakeholder interviewees emphasised that nursing at all levels involves high levels of work intensity. Nurses are required to perform increasingly complex and technical tasks whilst simultaneously engaging in ongoing emotional labour. Providing this level of service, whilst maintaining safe levels of care, requires substantial knowledge and expertise which is not reflected in the perceptions of the profession or its rewards. Several stakeholder interviewees explain that this expertise is increasingly recognised and valued by others within the health care sector.

Although this is leading to a dismantling of the doctor/nurse hierarchy of the past, it has not translated into increased rewards. Interviewees also valued both aspects of the role but said that there is widespread misunderstanding of the technical side of nursing. They felt that many nurses were, first and foremost, attracted to the caring aspect of the role but recognised that care and technical skill are often considered to be mutually exclusive. The image of nurses as 'angels' is entangled in nurses' own construction of value and a desire for appropriate levels of pay and acceptable working conditions are perceived to be at odds with the 'virtue' required when caring for others.

While the health and social care sectors, and nursing specifically, face a crisis of retention this has not led to any significant pay increases. In this respect, the nursing profession appears immune from normal market forces where significant staffing shortages would be expected to lead to wages catching up in order to improve recruitment and retention.

This may be partially explained by the NHS having a near monopsony over employment in the nursing profession, as it is the dominant employer in the economy. Moreover, as the largest employer of health care workers in the UK, NHS wage levels act as a benchmark for all other health care sectors. When coupled with a gradual erosion of trade union powers by governments and a relative lack of industrial unrest, wages across the health care sector appear resistant to orthodox market forces. However, comparing nursing to other professions that are considered to have similar levels of skill, responsibilities or status detracts from the structural causes of low pay which we have evidenced in this report.

Instead we argue that, in addition to the monopsonistic conditions in the UK, nursing eludes traditional economic doctrine because it is an occupation which has traditionally been seen as women's work, a perception that simultaneously impacts pay, status and professional autonomy.

Status and perceptions

It is perhaps unsurprising that our quantitative findings show only half of nurses have a positive perception of the profession, given the challenges they regularly face. Nurses are amongst the lowest paid health professionals in the UK, with the least scope for progression or opportunities for boosting their pay through private practice. Our analysis suggests that the perception of nursing is also gendered, with fewer men than women rating it as a positive career option. We ponder that this may be because it is more difficult for some men to reconcile the feminine construction of the nursing profession with stereotypical expectations of masculinity.

These perceptions can have ramifications for current issues around recruitment and retention, since if nursing is a less appealing career to men this reduces the pool of potential recruits. The construction of care as feminine and management as masculine also feeds into the glass elevator phenomenon, as it offers a possible explanation for why men in nursing are progressing their careers into managerial roles at a higher rate than women. Nurses in higher pay bands were more satisfied with their careers than their colleagues at lower grades, but this was less likely to be the case for men in management suggesting the gendered perception of nursing is structural.

In parallel, nurses from a BAME background were more likely to have a positive perception of nursing as a career but did not consider it rewarding; a finding that was most pronounced for those working in pay grades 5 and 6. Whilst this could suggest that the nursing profession is more inclusive than other sectors in the labour market, dissatisfaction with the rewards associated with nursing amongst BAME staff is problematic for recruitment and retention.

Nurses from a BAME background appear to earn more on a weekly basis than white nurses, most likely because more nurses from this group work overtime. Paradoxically, when controlling for structural factors, BAME nurses earn 10% less (weekly and hourly) than their white counterparts. Women from BAME backgrounds are also more likely to be receiving tax credits in the form of benefits. Nursing has a long history of relying on BAME individuals and while many have a positive view of the profession our evidence shows that low rewards, particularly in terms of pay, are having a greater impact on the wellbeing of those from a BAME background. There were also indications of other diverse groups, such as older nurses or those with disabilities for whom negative experiences mean they exit the profession. This points to the challenges of creating an inclusive environment and opens up questions of how their needs might be better understood within the profession.

Professionalisation

When we spoke to senior stakeholders about prospects for the nursing profession, we heard different and often opposing views about how nursing could become more professional, while retaining the care at the centre of everything nurses do.

Our findings show an enduring tension in the profession between the need to emphasise and value the vital role of care in nursing and attempts to professionalise the practice through the development of education and expertise. For

some, the caring and technical aspects of the role continue to be incompatible; an issue which was thought to be compounded by the increasing diversity of roles and tasks across the profession.

Senior nurses are clear that the professionalisation of nursing should not detract from the value placed on care but rather care should be reoriented away from its undervalued feminine connotations — care should be recognised as a key human attribute and suitably rewarded as such. Ingrained stereotypes that position women as carers pose significant challenges to a re-conceptualisation of nursing and the rewards associated with it. However, recognising care as a human skill to be developed and to be rewarded, rather than a natural feminine attribute, may temper the conflict between the technical and care elements currently under debate within the profession.

Our findings suggest that nurses do not feel their voices are listened to by those with the power to make change happen.

The enduring legacy of this debate also risks detracting attention away from what and who really matter. Our findings suggest that nurses do not feel their voices are listened to by those with the power to make change happen – in terms of their education, their pay, their working conditions and how the profession is developed. Yet nurses say their views are rarely considered on issues from funding and resources to conditions and staffing levels.

For nurses, these are the key issues that affect them, influencing personal and public perceptions of their profession and ultimately impacting on retention and recruitment. Refreshing the perception and status of nursing has the potential to diffuse the current crisis in retention and recruitment as a lack of recognition and reward impacts both external and internal perceptions of the profession.

The senior stakeholders in our research feel that it is the job of leaders within the profession to renegotiate this position. For the perception of nurses to change, they argue, leaders should seek to understand the issues faced by those working in nursing, and encourage nurses to use their voices, support them in this and be prepared to listen to what they have to say. Furthermore, nursing leaders should advocate for and elevate the status of nursing as a profession. There was a strong sense that the new millennial nursing generation would drive the need for such change, because of their expectations to co-produce their work environment and be involved in inclusive industrial relations.

Summary and recommendations

This report has examined gender and value in the nursing profession in the context of historically high vacancies across the health and social care sector. It might be expected that these market forces would mean nursing could command higher wages. Instead, we argue that low pay can be understood by how it is devalued as both a feminised profession and as a care profession; wages are kept low by the fact that they are also set by social norms, which in this case gives low value to nursing. Another factor in low pay is the near monopsony created by the NHS as the main employer in the health sector. Even when individuals do not work for the NHS, its influence is such that it acts as a trend-setter and point of reference for wages throughout the whole sector. Finally, the macro-political context of austerity can also be understood as a contributing factor to low wages for nurses. To conclude, we reflect on various aspects of gender and nursing as a profession and offer possible actions.

Nursing suffers from an image that fails to match the reality of a professional life defined by high level technical, emotional and cognitive skills. This image, which is underpinned by gendered notions of nursing and nurses, will always stand in the way of any efforts to improve the standing and attractiveness of nursing as a career.

Over recent years, the RCN and others have built campaign, engagement and bargaining activities aimed at setting out a true picture of the realities and complexities of modern nursing. The RCN and other professional and representative bodies need to build on these activities to describe, publicise and recognise the impact nursing staff make through their work in practice, research, advocacy and innovation. This can be better achieved by working with allies and other unions. Campaigns, engagement and bargaining activities need to articulate the value of nursing on multiple levels – to patient safety, social mobility, public finances and economic growth. They also

need to go one step further by emphasising the importance of nurses' voice and leadership in realising these benefits.

Nursing suffers from an image that fails to match the reality of a professional life defined by high level technical, emotional and cognitive skills.

A key part of this work should include a new understanding of transformations in the economy, in society and particularly the world of work. These transformations are bringing new risks, challenges and opportunities to current and future generations of nurses. They will also impact on the meaning of work, what people want from their workplace, their careers and their representatives. Key areas for exploration include:

- changing views of the psychological contract, in terms of the relationship between workers and employers and the mutual expectations for each side, including such aspects as opportunities for growth, pay and reward, recognition, progression, managerial and peer support, flexibility, and job security
- changing views of what members want from their union, in relation to professional leadership, workplace representation and agents for social change
- changing views of how members wish to be their own advocates for change on professional and workforce issues.

Recommendations

1 **The research and engagement with RCN members should be undertaken to better understand the meaning of work for nursing as a profession against a changing world of work; and how the profession responds to future developments and changes.**

The RCN is uniquely placed to lead research and engagement to understand these changes and trends, and it is imperative that it does so in order for it to continue representing its members and nursing.

2 **RCN to create a platform for the nursing profession to articulate the full scope of nursing as caring, compassionate, evidence-based and safety-critical.**

The RCN is also uniquely placed to provide a platform to enable the profession, and particularly its members, to express and assert the full value of nursing. This will enable nurses to present clear descriptions of what nursing actually is and what it does, the value it brings, and the need for nurses' voices at key points of all decision making affecting the nursing profession.

3 **RCN to conduct further research (quantitative and qualitative) into the intersections of sex and gender with other variables such as ethnic background, disability, age and social class.**

Nursing is a diverse profession, and gains strength from this diversity. This research has gone some way to set out how the historical development of nursing and how gendered constructions have impacted on its development as a profession and by extension, its status and pay. This work needs to go one step further and understand the nature of work and outcomes for nursing staff from an intersectional perspective. It is crucial to also consider how other factors such as ethnic background, disability, age or social class can shape the experience of nursing as a profession and outcomes, particularly career progression and pay levels. Further research should consider these aspects in order to build a more complete picture and to inform the future.

4 **RCN to lead on the development of a clear and in-depth assessment of the mix of knowledge and skills in nursing – both on its own terms and in relation to other staff in the health sector – in current job descriptions and evaluation frameworks.**

5 **RCN to lead on the development of fairer and more realistic job evaluation frameworks for use in all settings and for the benefit of all of its members, followed by steps to ensure that nursing staff are employed on the correct banding to match their level of responsibility, skills and autonomy.**

This report has set out how nursing, compared with other groups in the health care sector, has struggled to establish itself as a profession. We recommend steps which appear on face value to be entirely practical, but which go to the very heart of what nursing is. This involves a review of current job evaluation structures and assessment of whether they are fit for purpose for a graduate profession, whether they accurately and fully measure the productive value of all aspects of nursing – emotional, productive, technical and cognitive – and whether these fully encapsulate new NMC standards. This relates most clearly to the AfC structure, yet any changes will have far-reaching consequences for nursing staff employed on other contracts. Any review of the registered nursing role also has clear implications for health care support workers. Care must be taken to avoid unintended consequences whereby higher status and pay for registered nurses results in poorer conditions for support staff. All support staff must be treated equitably and fairly, and their work fully recognised and rewarded. This review must go hand in hand with a programme of work to ensure that nurses are appropriately banded and that there are employed on a band that appropriately matches their level of responsibility, skills and autonomy.

6 **RCN to call for the development of a career framework which enables, rewards and supports horizontal and vertical progression.**

This research has demonstrated that, in comparison to other health care professions,

nursing provides fewer opportunities for progression. Progression is often associated with moving away from clinical roles, and away from 'care', as well as with an element of risk that is perceived to be inadequately rewarded or supported. Progression also leads to less flexible roles, which can be unattractive to nurses with family or caring responsibilities. There is a clear need to better understand and support progression in nursing.

7 **RCN to promote the need for a change in how work is organised and call for the NHS and other employers to use their reputational power and resources to enable women's and men's careers at all life stages.**

It is time that full recognition is given to the meaning of a health and social care workforce dominated by women. All efforts to address chronic shortages in nursing and other health and social care occupations, and to develop a highly skilled, highly motivated workforce must be placed within the frame of a workforce where women predominate. This means addressing how work and working time is organised. At every step, managers and union representatives need to ask the question — how does this new policy, change in service delivery or new way of working facilitate nursing staff to work to the best of their abilities? This also entails recognising the different needs of staff at different stages of their life course, different personal circumstances and capabilities.

For employers, this means fully engaging with this workforce, listening to their needs and building on their expertise. There is both a social justice and a business case for all employers across the health and social care sector to invest in the nursing workforce. They need to become employers of choice, while also ensuring high productivity. This includes fair pay for nurses and support staff, training and development, occupational health provision as well as decent working conditions.

This is particularly true for the NHS. As the biggest employer in the UK, it has huge influence nationally and in local economies, with the ability to exert reputational and economic power. Employers can use their buying power to enable practical solutions such as subsidised childcare as well as setting standards as an exemplar employer in enabling flexibility, career progression, inclusion and professional voice.

8 **RCN to invite members and nursing leaders to debate and support the recommendations of this report and engage them in becoming advocates for change.**

Our final recommendation entails a broad invitation to its members and nursing leaders to debate the main points and other recommendations made in this report. Through the RCN, members and leaders can be brought together to discuss and plan strategies for joint working.

This work has been carried out at point in time when it is more urgent than ever to ensure that nursing as a profession remains attractive and offers adequate rewards. Through this research, we hope to have contributed towards the path of critically evaluating where nursing in the UK stands as a profession, so that it can successfully move forward as a graduate and safety-critical profession.

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Glossary

Agenda for Change (AfC): the pay banding system for all NHS staff excluding doctors, dentists, and some senior managers; there are nine pay spine points, examples of those that apply to nursing are as follows:

- registered nurse – band 5
- specialist nurse – band 6
- advanced nurse practitioner – band 7/8
- matron – band 8.

Applying to all NHS staff except doctors, dentists and some senior managers, the AfC system covers more than one million staff. Many nursing staff working outside the NHS, for example, in GP practices or for independent sector employers providing NHS contracts, are also employed on AfC rates of pay and terms and conditions. AfC is also often used by non-NHS employers as a reference point in pay setting for staff employed on their own organisational pay systems.

Under AfC, posts are allocated to one of nine pay bands which are subdivided into points. National job profiles are used to match posts to pay bands, with staff matched either using a national job profile or through a local evaluation of their job. AfC is designed to evaluate the job and not the person undertaking the job and therefore ensure equity between similar posts in different areas. For example, job profiles included in band 5 are: staff nurse; occupational therapist; midwife (newly qualified); speech and language therapist (newly qualified); office manager. Job profiles in band 6 include: junior sister; specialist staff nurse; paramedic; health visitor; senior physiotherapist; senior occupational therapist. Job profiles in band 7 include: senior sister; advanced nurse practitioner; senior radiographer; qualified psychologist. Band 8 profiles include: senior nurse manager/ matron; senior chief clinical physiologist; assistant director.

Bank or agency nursing/contracts: nursing work provided through a private agency or NHS bank to fill vacant shifts or posts on a temporary basis.

Director of nursing: head of the nursing workforce in an NHS trust or board who sits on the executive board of that trust.

Francis Report (2013): investigation into the Mid Staffordshire NHS Foundation Trust which found a "failure to tackle challenges to the building up of a positive culture, in nursing in particular but also within the medical profession". The report recommendation, among others, included that the Mid Staffordshire NHS Trust should: "Enhance the recruitment, education, training and support of all the key contributors to the provision of health care, but in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything they do." Fundamentally, this investigation found a lack of commitment or good standards of care and a poor level of clinical leadership to be responsible for neglect and ultimately a failure of the system.

NHS foundation trust: since 2004, NHS trusts have been able to apply to become foundation trusts which have greater management and financial freedom.

Nursing associates (NAs): a new role that may also enable entry to a shortened degree level nursing programme in England. The nursing associate is a role designed to support registered nurses and they are trained and educated to provide a service in a specific context of care. Nurses are also supported by a variety of other support workers such as health care assistants.

Nursing apprentice: nursing degree apprenticeship introduced in England to enable people to train to become a graduate registered nurse through an apprentice route. The apprentice is released by their employer to study part-time in a higher education institution.

Nursing Bursary: in England, up until 1 August 2017, nursing students (and most allied health profession students) received a bursary to support them during their studies. Since August 2017, nursing students have to pay tuition fees.

Nursing Now: a three-year global campaign (2018-2020) which aims to improve health by raising the profile and status of nursing worldwide. Run in collaboration with the World Health Organization and the International Council of Nurses, Nursing Now seeks to empower nurses to take their place at the heart of tackling 21st century health challenges and maximise their contribution to achieving Universal Health Coverage.

NMC: Nursing and Midwifery Council. This statutory body holds the register of nurses, midwives, nursing associates and health care assistants.

Registered nurse: a person holding an effective registration with the NMC.

Segregation: occupational gender segregation refers to the distribution of women and men across and within occupations. Horizontal segregation refers to differences across occupations. Vertical segregation describes men's domination of the highest status jobs in both traditionally masculine and traditionally feminine occupations.

Methodology and ethics

A mixed methodology was adopted, encompassing both a quantitative and qualitative approach to provide rich data sources and allow both specific numeric analyses alongside more complex analysis of stakeholder perceptions. Using multiple methods can also help to achieve greater confidence in the research findings. A literature review was undertaken to provide background and context, and initial discussions took place with a number of industry stakeholders from the RCN, which formed a project steering group. This allowed the report team to identify some of the key issues facing women in the nursing profession, and assisted in the development of research instruments for data collection.

The analysis relied on secondary data obtained from official sources (for example, the *ONS Quarterly Labour Force Survey 2018 Q1* and the *ONS Annual Survey of Hours and Earnings 2018*) and from previous surveys ran by the RCN (such as the *RCN Employment Survey 2017* and the *Survey on Health, Well-being and Stress in the Nursing Profession 2013*). The data were analysed in Microsoft Excel, SPSS and R. The analysis used descriptive statistics, checking for statistical significance where relevant (for example, chi-square tests). Inferential methods were also used through statistical modelling. This included multi-level models as well as linear or logistic regression. Some variables measuring pay were log-transformed to account for skewness.

Themes surrounding diversity in the industry, particularly focused on gender, were further investigated through one-to-one, semi-structured telephone interviews with key industry stakeholders who had been invited to interview by members of the project steering group. Telephone interviews were chosen, in particular, because this method provides greater flexibility for the participants. This is especially useful when research participants are in senior roles with many demands on their time and may need to reschedule an interview at short notice. Men and women were asked to take part in both aspects of the research to obtain the widest possible range of perspectives. Minimal participant details were recorded (limited to gender, job role and number of years working in/with nursing) to ensure their comments were not attributable and maintain their anonymity. A thematic approach was adopted for the qualitative data analysis which reflected a) the topics identified in the preceding literature review (which influenced the questions asked during interviews), and b) themes identified inductively from systematic (re-)reading of data (including survey findings), followed by discussion and interpretation within the research team. The interviews were also analysed with the aid of QSR NVivo (v.12), which was used for data management and topic coding and helped to make further sense of a rich dataset.

This research was potentially sensitive since it involved contact with a number of key individuals from within and around the nursing profession, with participants often sharing their personal stories and viewpoints. For this reason considerations about research ethics were applied throughout the research process to ensure the work was carried out to the highest ethical standards. In particular, participants were provided with a full transcript for agreement before inclusion in the study and sent a copy of quotations used in the report, which was written in a way to ensure no participants are identifiable. Those taking part were provided with information about the purpose of this study, research ethics and confidentiality, as well as a link to the Oxford Brookes University Research Ethics Committee which had approved this research.

Documentation and examples of participant forms are contained in the Research instruments section which follows.

Research instruments: participant information sheet

The future of the nursing profession participant information sheet

OXFORD BROOKES UNIVERSITY

1. Introduction

We are undertaking a piece of research, the purpose of which is to develop understanding of current issues relating to the nursing profession. This research was commissioned and is being funded by the Royal College of Nursing (RCN). It is being carried out by the Centre for Diversity Policy Research and Practice at Oxford Brookes University (OBU) and will investigate a range of aspects that include current trends and the challenges and opportunities faced by the profession.

2. Who is undertaking the research?

The project is being conducted by an experienced team from the Centre for Diversity Policy Research and Practice at Oxford Brookes University in collaboration with the RCN. The team members leading on the research are Dr Anne Laure Humbert, Dr Kate Clayton-Hathway and Dr Sue Schutz.

3. What is going to be the outcome of this research?

A report will be produced presenting the general findings and recommendations. A copy of the report will be sent to all those who have taken part in this project and other key industry stakeholders. An electronic version of the report will also be made publicly available on the RCN website.

4. Deciding to take part

In order to develop our understanding on current issues and concerns relating to the nursing profession, and the factors which have shaped campaigns in the past, it is essential to draw on the expertise of key industry stakeholders. It is entirely up to individuals to decide whether to take part. If you decide to take part, you are still free to withdraw at any time without giving a reason (please see below for details).

5. What next?

If you decide to take part, we would like to set up a one-to-one interview with you at a mutually convenient time. The interview should last about 45-60 minutes. This can be face-to-face, via telephone or by Skype (either via video or audio, according to your preference). In advance of the interview we will send you a consent form so that you can confirm that you are happy to take part in this project. If you would like to see a copy of the interview schedule in advance, we would send this at the same time.

We should be grateful if you could sign the consent form and return it to us. If you agree, we would like to record the interview, to avoid having to write notes throughout (your express permission about this will be sought in the consent form). We shall send you a transcript of your interview for you to read. At this point, you will be given the opportunity to confirm that you are happy for the data from your interview to be included in this study or decide to withdraw from the study if you wish. Before publishing the report, we will, on request, send you the sections which include your input. If you decide to withdraw from the study, you do not need to give any reasons. The only cost to you for taking part in the study will be your time.

6. Confidentiality and ethics

All the information that you give us will be kept strictly confidential. If you would like your name to be used, or any of your comments to go 'on the record' to be included in the final report, this is possible (your express permission about this will be sought in the consent form). Alternatively, everything you tell us will be reported anonymously, and identified in generic terms so that you are not recognisable as a participant. The only persons who will have access to the interview records are members of the research team. While the research is in progress, the

interview transcripts will be stored securely in the researchers' computers, accessible only by password.

Unless individuals have consented otherwise anything that is written, once the project is completed, will protect the names and the privacy of the individuals involved. The findings of this study will be presented in an anoymous format in a report that will discuss the overall conclusions. In order to protect confidentiality no specific reference will be made to individual institutions, and other identifying features, such as individual's personal circumstances and disciplines will also be anonymised. The data will be kept confidential subject to legal limitations. The University Research Ethics Committee, Oxford Brookes University, has approved the research. If you have any concerns about the conduct of this research project you can contact the Chair of the University Ethics Committee at ethics@brookes.ac.uk (for more information you can check www.brookes.ac.uk/research/research-ethics).

7. Privacy Notice

For the purposes of data protection laws, RCN will be the data controller of any data that you supply for this research. This means that they have overall responsibility for your information and ensuring that it is used properly. OBU will act as data processor and is therefore responsible for processing personal data in compliance with data protection laws.

Legal basis for collecting this data is:

- you are consenting to providing it; and / or
- processing is necessary for the performance of a task in the public interest such as research.

If you are asked for sensitive data such as; racial or ethnic origin, political opinions, religious or philosophical beliefs, trade-union membership, data concerning health or sexual life, genetic/biometric data or criminal records these data will be used because:

- you have given explicit consent to do so; and / or
- processing is necessary for scientific or research in the public interest.

What type of data will be used?
The data collected from interview participants will comprise demographic data (such as gender), contact details to support correspondence relating to the study and interview transcripts. For the purposes of the final report, this data will be combined with anonymised statistical data.

Where will data be sourced from?
The interview data for this study is being obtained from participants with their full, informed consent. Statistical data will be obtained from the RCN survey data and other public sources, for example, the Office for National Statistics Labour Force Survey.

Who will your data be shared with?
In addition to RCN and OBU, interview recordings will be shared with a third-party supplier to prepare transcripts. This organisation will be subject to the same contractual obligations as OBU, according to Data Protection Laws.

Will OBU transfer my data outside of the UK?
No.

Are there any consequences of not providing the requested data?
There are no legal consequences of not providing data for this research. It is purely voluntary.

Will there be any automated decision making using my data?
There will be no use of automated decision-making in scope of UK Data Protection and Privacy legislation.

How long will your data be kept?
Once the research is completed, the electronic files will be deleted, and a paper record will be kept in a secure place in the principal investigator's (Dr Anne Laure Humbert) department within OBU. These will be kept for a period of 10 years, in accordance with university policy, and then securely destroyed.

What rights do I have regarding my data?

- You have the right to be informed about what data will be collected and how this will be used
- You have the right of access to your data
- You have the right to correct data if it is wrong

- You have the right to ask for your data to be deleted
- You have the right to restrict use of the data we hold about you
- You have the right to data portability
- You have the right to object to the university using your data
- You have rights in relation to using your data automated decision making and profiling.

Research instruments: participant consent form

OXFORD BROOKES UNIVERSITY

	Please initial boxes
1. I confirm that I have read and understand the information sheet for the above study, including the statement about the legal limitations to data confidentiality, ad have had the opportunity to ask questions.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.	☐
3. I agree to take part in the above study.	☐
4. I agree/do not agree to the interview being audio-recorded (delete as appropriate)	☐
5. I agree/do not agree to the interview being video-recorded (delete as appropriate)	☐
6. I agree/do not agree my name being used in the dissemination of findings (delete as appropriate)	☐

Name of Participant	Date	Signature
Dr Kate Clayton-Hathway		
Name of Researcher	Date	Signature

Research instruments: interview questions

The future of the nursing profession – key informant interview questions

Background

1 In your position as ... can you tell me briefly about your background and organisation(s) you have worked for or been involved with within/in relation to the nursing profession?

Trends and the current situation

2 From your own perspective, what are the key issues facing the nursing profession?

3 Have you seen any change(s) in the nursing profession during your time in the industry *(in your own area)*?

- do you think there has been positive progress? What evidence do you see for this?
- is this replicated across all levels, for example, are there differences between junior and senior levels/specialisms/communities etc?

4 What are the implications of these trends for the nursing profession?

5 In your experience, are there any areas where career development/progression for nurses might be constrained? Enabled?

6 What are your thoughts on pay structures?

Addressing the challenges

7 What more can be done, in practical terms, to:

- address the challenges and risks of the changing work environment
- bring more people into the profession?
- retain people in the profession?
- encourage and support those working there so that they can develop fulfilling careers?

8 In what ways can it be ensured that the nursing profession is valued and paid accordingly?

9 Are there ways in which we can try to provide a voice to:

- nursing leadership
- the wider nursing professional workforce?

10 Who do you see as the key allies to the profession in addition to core RCN constituents? What is the key opposition?

Conclusion

11 Do you have anything to add that you think is relevant to this research?

The team

Anne Laure Humbert

Anne Laure Humbert, PhD, is a Reader and Director of the Centre for Diversity Policy Research and Practice at Oxford Brookes University. Anne is very experienced in gender equality research at national and EU level, policy analysis and assessment as well as gender statistics. She specialises in applying advanced quantitative methods to comparative social and economic analysis, particularly in relation to work and organisations. She has worked both at EU level and in academia, with previous positions at Cranfield University and Middlesex University London. Anne is a regular public speaker on gender equality and she enjoys the opportunity to make connections between theory, practice and activism.

Kate Clayton-Hathway

Kate Clayton-Hathway, PhD, is a Research Fellow with the Centre for Diversity Policy Research and Practice at Oxford Brookes University. She has many years' experience as a qualitative researcher specialising in interviews and focus groups, and has a specific specialism in gender equality within organisational structures. With a long-standing interest in equalities issues, she spent several years working on a range of equality-related projects, in particular designing materials for and conducting equality impact assessments. Kate is also an activist, focusing mainly on women's rights, was a founder member of Oxford Fawcett and community outreach coordinator for Oxford International Women's Festival.

Heather Griffiths

Heather Griffiths joined the Centre for Diversity Policy Research and Practice as a Research Assistant after completing her PhD in Sociology at the University of Warwick. Her ESRC-funded doctorate explored how gender is embedded in flexible working practices, paying particular attention to the ways time and work are negotiated between employees. Heather's research interests are around gender and work, work life balance and feminist organisational theory and she is keen to extend these interests to include feminist theories on time, to critique the rhythms and routines of everyday life.

Rachael McIlroy

Rachael is the Senior Research Lead for Employment Relations at the Royal College of Nursing, responsible for the union's research into pay, terms and conditions and the working environment for nursing staff across the NHS and independent sectors. She has many years' experience working in employment and industrial relations policy and research, for universities, trade unions and in research consultancy. At the RCN, Rachael designs, conducts and commissions research projects to support the union's bargaining and campaigning activities to improve working lives for nursing staff.

Sue Schutz

Sue is a nurse by background and has worked largely in cancer nursing. She completed a Masters' degree in Nursing at Brunel University with a dissertation entitled *Giving Comfort to Patients: The Perceptions of Qualified Nurses* for which she received a distinction. Sue runs several modules within the Advanced Practice programmes, including Dimensions in Advanced Nursing Practice and Applied Research Methods. She completed her doctorate with the University of Southampton exploring Reflective Practice in Adult Nursing. Sue is co-editor of Reflective Practice in Nursing published by Wiley Blackwell.

Sue Ledwith

Over her academic career Sue has combined teaching at all levels, research, and feminist activism. She has taught at Oxford Brookes Business School and Ruskin College, Oxford where she ran the MA Women's Studies and set up and ran the MA International Labour and Trade Union Studies. Sue's principal research focus has been gender and equality and democracy in organisations; mainly trade unions. In 2016 Sue achieved her PhD by publication, re-analysing her published work from a feminist position and using a Gramscian framework of a 'long revolution' she concluded there was still a long way to go in achieving gender parity.

Jo Morris

Jo Morris is a Visiting Professor in Practice at the London School of Economics Gender Institute, following more than 40 years' experience of developing and implementing gender policies that laid the foundations for wider institutional change to improve the working lives of women. Many years working at the TUC as Senior Policy Officer in the Equality and Employment Rights Department, followed roles in local government and the civil service. She brings together practical experience of developing and implementing employment policy and practice at national, European and international levels. Jo currently provides independent research and social policy advice on gender and labour rights in the garment supply chain.

Tracy Walsh

Tracy Walsh has been a long-term trade union member and activist, working on recruitment, organising and campaigning in the health and education sectors. Her work as an educator has shaped the way she approaches research and teaching, allowing her to bring together theory and practice. She is working on her PhD at Greenwich University, which explores the relationship between gender, race and class in British trade unions, using Unison as a case study. Tracy is a founder member of the RED Learning Co-operative: Research, Education and Development for Social Change and the former Head of International Labour & Trade Union Studies at Ruskin College, Oxford.

Annex 1: SOC codes for workers in health-related sectors by broad category and associated sample sizes (QLFS 2018 Q1)

Nursing professionals		n	Health managers and directors		n	Health professionals		n	Allied health professionals		n	Scientific, therapeutic and technical staff		n
2231	Nurses	932	1181	Health services and public health managers and directors	88	2211	Medical practitioners	353	2221	Physiotherapists	92	3213	Paramedics	41
2232	Midwives	54				2212	Psychologists	49	2222	Occupational therapists	72	3216	Dispensing opticians	11
						2213	Pharmacists	73	2223	Speech and language therapists	15	3217	Pharmaceutical technicians	37
						2214	Ophthalmic opticians	26	2229	Therapy professionals n.e.c.	81	3218	Medical and dental technicians	55
						2215	Dental practitioners	57				3219	Health associate professionals n.e.c.	99
						2217	Medical radiographers	39						
						2218	Podiatrists	23						
						2219	Health professionals n.e.c.	96						
	Total	986			88			716			260			243

Source: QLFS 2018 Q1 (n = 274)
Notes: † statistically significant at the 10% level * statistically significant at the 5% level;
** statistically significant at the 1% level

Annex 2: Factors explaining variation in gross weekly and hourly pay in the health sector (n = 568)

	Ln gross weekly pay								Ln gross hourly pay							
Fixed effects:	β	SE	eβ	sig	β	SE	eβ	sig	β	SE	eβ	sig	β	SE	eβ	Sig
Intercept	6.61	0.13	742.48	**	5.48	0.42	239.85	**	2.96	0.11	19.30	**	3.06	0.43	21.33	**
Women	-0.35	0.05	0.70	**	-0.11	0.05	0.90	*	-0.18	0.05	0.84	**	-0.13	0.05	0.88	**
Age					0.01	0.00	1.01	**					0.01	0.00	1.01	**
Ethnic minority background					-0.05	0.05	0.95						-0.04	0.05	0.96	
Disability					-0.05	0.05	0.95						-0.07	0.05	0.93	
Nationality: EU non-UK					-0.02	0.08	0.98						-0.04	0.08	0.96	
Nationality: rest of the world					0.06	0.10	1.06						0.05	0.09	1.05	
Married or cohabiting					-0.07	0.04	0.93						-0.07	0.04	0.93	
Dependent children in the household					0.05	0.04	1.05						0.03	0.04	1.03	
Higher degree					0.19	0.05	1.21	**					0.21	0.05	1.23	**
Degree					0.09	0.04	1.09	*					0.09	0.04	1.09	*
Managerial and/					0.13	0.04	1.14	**					0.09	0.04	1.09	**
or supervisory					0.03	0.00	1.03	**					0.00	0.00	1.00	
responsibilities																
Basic usual hours					0.21	0.05	1.23	**					0.21	0.05	1.23	**
Private sector																
North East					-0.24	0.09	0.79	**					-0.21	0.09	0.81	*
North West					-0.03	0.07	0.97						0.01	0.07	1.01	
Yorkshire and the Humber					-0.18	0.08	0.84	*					-0.16	0.08	0.85	*
East Midlands					-0.19	0.09	0.83	*					-0.18	0.08	0.84	*
West Midlands					-0.27	0.08	0.76	**					-0.21	0.08	0.81	**
East of England					-0.19	0.09	0.83	*					-0.17	0.08	0.84	*
South East					-0.08	0.07	0.92						-0.06	0.07	0.94	
South West					-0.21	0.08	0.81	*					-0.18	0.08	0.84	*
Northern Ireland					-0.13	0.11	0.88						-0.05	0.11	0.95	
Scotland					-0.13	0.08	0.88						-0.11	0.08	0.90	
Wales					-0.06	0.10	0.94						-0.04	0.09	0.96	
London (reference location)																
Proportion of women in the occupation group					-0.70	0.55	0.50						-0.80	0.57	0.45	
Random effects:																
Nursing professionals	-0.10				0.04				-0.09				0.03			
Health managers and directors	0.32				0.11				0.21				0.11			
Health professionals	0.21				0.05				0.22				0.06			
Allied health professionals	-0.08				0.01				0.00				0.04			
Scientific, therapeutic and technical	-0.35				-0.22				-0.33				-0.23			

Source: QLFS 2018 Q1 (n = 274)
Notes: † statistically significant at the 10% level * statistically significant at the 5% level;
** statistically significant at the 1% level

Annex 3: Factors explaining variation in gross weekly and hourly pay in the nursing profession

	Ln gross weekly pay								Ln gross hourly pay							
	β	SE	eβ	sig	β	SE	eβ	sig	β	SE	eβ	sig	β	SE	eβ	Sig
Intercept	4.65	0.18	104.38	**	4.61	0.19	100.48	**	2.18	0.19	8.88	**	2.12	0.19	8.29	**
Women	-0.02	0.06	0.98		0.00	0.06	1.00		-0.05	0.06	0.95		-0.02	0.06	0.98	
Age	0.01	0.00	1.01	**	0.01	0.00	1.01	**	0.01	0.00	1.01	**	0.01	0.00	1.01	**
Ethnic minoritised background	-0.10	0.05	0.90	†	-0.11	0.06	0.90	*	-0.10	0.05	0.90	†	-0.11	0.05	0.90	*
Disability	-0.02	0.04	0.98		-0.03	0.04	0.97		-0.05	0.04	0.95		-0.06	0.04	0.95	
Nationality: EU non-UK	0.11	0.10	1.11		0.11	0.10	1.11		0.01	0.10	1.01		0.00	0.10	1.00	
Nationality:rest of the world	-0.08	0.08	0.92		-0.08	0.08	0.93		-0.07	0.08	0.93		-0.06	0.08	0.94	
Married or cohabiting	-0.01	0.04	0.99		-0.01	0.04	0.99		-0.03	0.04	0.98		-0.03	0.04	0.97	
Dependent children in the household	0.05	0.04	1.05		0.05	0.04	1.05		0.03	0.04	1.03		0.04	0.04	1.04	
Basic usual hours	0.04	0.00	1.04	**	0.04	0.00	1.04	**	0.00	0.00	1.00		0.00	0.00	1.00	
Higher degree	0.17	0.06	1.19	**	0.18	0.06	1.19	**	0.18	0.06	1.20	**	0.19	0.06	1.21	**
Degree	0.09	0.04	1.09	**	0.09	0.04	1.09	*	0.08	0.04	1.09	*	0.08	0.04	1.08	*
Managerial and/ or supervisory responsibilities	0.11	0.03	1.12	**	0.11	0.03	1.12	**	0.07	0.03	1.07	*	0.07	0.03	1.08	*
Women with managerial/supervisory responsibilities					0.12	0.12	0.89						0.19	0.12	0.82	*
Private sector	0.16	0.05	1.17	**	0.16	0.05	1.17	**	0.15	0.05	1.17	**	0.15	0.05	1.16	**
North East	-0.38	0.09	0.69	**	-0.37	0.09	0.69	**	-0.34	0.09	0.71	**	-0.34	0.09	0.71	**
North West	-0.08	0.08	0.92		-0.08	0.08	0.93		-0.03	0.08	0.97		-0.02	0.08	0.98	
Yorkshire and the Humber	-0.19	0.09	0.83	*	-0.18	0.09	0.84	*	-0.16	0.09	0.85	†	-0.15	0.09	0.87	†
East Midlands	-0.22	0.09	0.80	**	-0.22	0.09	0.80	**	-0.26	0.09	0.77	**	-0.26	0.08	0.77	**
West Midlands	-0.21	0.09	0.81	*	-0.20	0.09	0.82	*	-0.12	0.09	0.88		-0.12	0.09	0.89	
East of England	0.00	0.10	1.00		0.01	0.10	1.01		-0.05	0.10	0.95		-0.05	0.10	0.95	
South East	-0.14	0.08	0.87	†	-0.14	0.08	0.87	†	-0.13	0.08	0.88	†	-0.13	0.08	0.88	†
South West	-0.24	0.08	0.79	**	-0.24	0.08	0.79	**	-0.21	0.08	0.81	**	-0.20	0.08	0.82	*
Northern Ireland	-0.13	0.11	0.88		-0.12	0.11	0.89		-0.02	0.11	0.98		-0.02	0.11	0.98	
Scotland	-0.21	0.08	0.81	**	-0.21	0.08	0.81	**	-0.18	0.08	0.84	*	-0.17	0.08	0.84	†
Wales	-0.11	0.09	0.90		-0.10	0.09	0.91		-0.07	0.09	0.94		-0.05	0.09	0.95	
London (reference location)																
R-square	.634				.636				.320				.327			

Source: QLFS 2018 Q1 (n = 274)
Notes: † statistically significant at the 10% level * statistically significant at the 5% level;
** statistically significant at the 1% level

Annex 4: Regression models – log annual and weekly gross wages

	Log annual gross wages			Log weekly gross wages		
	β	e^{β}	Sig.	β	e^{β}	Sig.
Sex (being a woman)	.006	1.01		-.004	1.00	
Type of contract (being temporary)	-.524	0.59	**	-.117	0.89	**
Shift and premium payments	.001	1.00	**	.001	1.00	**
Basic paid hours	.040	1.04	**	.045	1.05	**
Average weekly paid overtime hours worked	.011	1.01	**	.020	1.02	**
Age	.007	1.01	**	.006	1.01	**
Private sector	.023	1.02		.050	1.05	**
Not for profit	.038	1.04		-.031	0.97	
Years worked for an organisation	.018	1.02	**	.006	1.01	**
Controls for regions	Yes			Yes		
R2	0.41			0.64		
F	178.2		**	465.1	**	
n	4,944			4,968		

** $p < 0.01$, * $p < 0.05$
Note: public sector taken as reference sector
Source: ASHE 2018

Annex 5: Decomposition of the gender pay gap (weekly gross pay) among health care professionals

	Men	Women	Δ	Change factors (e^{β})		Simulation effect (difference multiplied by change factors)	Simulated change as % of the pay gap	£ equivalent
Sex	0	1	-1.00	-0.11	**	0.11	27%	£93.49
Age	44.26	43.27	0.99	0.01	**	0.01	2%	£5.75
Ethnic minority background	26%	15%	0.11	-0.02		0.00	-1%	-£2.28
Disability	19%	17%	0.02	-0.05		0.00	0%	-£0.98
Nationality: EU	4%	5%	-0.01	-0.02		0.00	0%	£0.11
Nationality: rest of the world	5%	4%	0.01	0.02		0.00	0%	£0.25
Married or cohabiting	21%	27%	-0.06	-0.06		0.00	1%	£2.94
Dependent children	53%	46%	0.06	0.07		0.00	1%	£3.48
Hours worked	38.1	32.63	5.47	0.03	**	0.17	39%	£137.73
Higher degree	37%	22%	0.14	0.21	**	0.03	7%	£24.81
Degree	44%	46%	-0.02	0.10	*	0.00	0%	-£1.70
Management responsibilities	68%	51%	0.17	0.13	**	0.02	5%	£18.24
Public sector	78%	82%	-0.04	0.23	**	-0.01	-2%	-£7.57
Health care managers	10%	5%	0.05	0.34	**	0.02	4%	£14.27
Health professionals	51%	23%	0.28	0.29	**	0.08	19%	£68.20
Allied health professionals	5%	12%	-0.07	0.04		0.00	-1%	-£2.04
Scientific, therapeutic and technical	10%	7%	0.03	-0.13		0.00	-1%	-£3.25
Gross weekly pay	£926.66	£575.21						
Total							38%	£351.45

Source: QLFS 2018 Q1
Notes: * statistically significant at the 5% level; ** statistically significant at the 1% level
Weighted by income weight 2017 (PIWT17)
The models used for this analysis differ slightly from the ones using above in the variables used, hence the small variation in coefficients.

Annex 6: Decomposition of the gender pay gap (hourly gross pay) among health care professionals

	Men	Women	Δ	Change factors (e^{β})		Simulation effect (difference multiplied by change factors)	Simulated change as % of the pay gap	£ equivalent
Sex	0	1	-1.00	-0.12		0.12	45%	£2.90
Age	44.26	43.27	0.99	0.01	**	0.01	4%	£0.23
Ethnic minority background	26%	15%	0.11	-0.02	**	0.00	-1%	-£0.04
Disability	19%	17%	0.02	-0.07		0.00	-1%	-£0.04
Nationality: EU	4%	5%	-0.01	-0.05		0.00	0%	£0.01
Nationality: rest of the world	5%	4%	0.01	0.01		0.00	0%	£0.00
Married or cohabiting	21%	27%	-0.06	-0.06		0.00	1%	£0.09
Dependent children	53%	46%	0.06	0.06		0.00	1%	£0.08
Hours worked	38.1	32.63	5.47	0.00		-0.01	-4%	-£0.25
Higher degree	37%	22%	0.14	0.23	**	0.03	12%	£0.78
Degree	44%	46%	-0.02	0.10	*	0.00	-1%	-£0.05
Management responsibilities	68%	51%	0.17	0.09	*	0.02	5%	£0.36
Public sector	78%	82%	-0.04	0.23	**	-0.01	-3%	-£0.22
Health care managers	10%	5%	0.05	0.38	**	0.02	7%	£0.45
Health professionals	51%	23%	0.28	0.37	**	0.10	37%	£2.40
Allied health professionals	5%	12%	-0.07	0.08		-0.01	-2%	-£0.13
Scientific, therapeutic and technical	10%	7%	0.03	-0.10		0.00	-1%	-£0.08
Gross hourly pay	£23.82	£17.32						
Total							27%	£6.50

Source: QLFS 2018 Q1
Notes: * statistically significant at the 5% level; ** statistically significant at the 1% level
Weighted by income weight 2017 (PIWT17)
The models used for this analysis differ slightly from the ones using above in the variables used, hence the small variation in coefficients.

Annex 7: Decomposition of the gender gap in annual gross wages

Variables	Men	Women	Change	β	Sig.	Change factor	Simulation effect	Simulation effect as % pay gap	£ equivalent
Sex (being a woman)	1	2	-1	0.006		0.01	-0.01	-4%	-£190.39
Type of contract (being temporary)	9.00%	7.70%	0.013	-0.524	**	-0.41	-0.01	-4%	-£167.74
Shift and premium payments	29.5	29.5	0	0.001	**	0.00	0.00	0%	£0.00
Basic paid hours	34.4	30.4	4	0.04	**	0.04	0.16	110%	£5,164.46
Average weekly paid overtime hours	1.2	0.7	0.5	0.011	**	0.01	0.01	4%	£174.96
Age	43.4	43.7	-0.3	0.007	**	0.01	0.00	-1%	-£66.67
Private sector	16.90%	16.20%	0.007	0.023		0.02	0.00	0%	£5.15
Not for profit	3.80%	5.10%	-0.013	0.038		0.04	0.00	0%	-£15.93
Years worked for organisation	8.1	8.5	-0.4	0.018	**	0.02	-0.01	-5%	-£229.85
Annual gross pay	£30,114	£25,440	£4,674						
Gender gap in %		16%							
Sum						-0.26	0.15	1.00	£4,674
N	4,944								

Source: ASHE 2018

Annex 8: Decomposition of the gender gap in weekly gross wages

Variables	Men	Women	Change	β	Sig.	Change factor	Simulation effect	Simulation effect as % pay gap	£ equivalent
Sex (being a woman)	1	2	-1	-0.004		0.00	0.00	2%	£2.22
Type of contract (being temporary)	9.00%	7.70%	0.013	-0.117	**	-0.11	0.00	-1%	-£0.80
Shift and premium payments	29.5	29.5	0	0.001	**	0.00	0.00	0%	£0.00
Basic paid hours	34.4	30.4	4	0.045	**	0.05	0.18	95%	£102.60
Average weekly paid overtime hours	1.2	0.7	0.5	0.02	**	0.02	0.01	5%	£5.63
Age	43.4	43.7	-0.3	0.006	**	0.01	0.00	-1%	-£1.01
Private sector	16.90%	16.20%	0.007	0.05	**	0.05	0.00	0%	£0.20
Not for profit	3.80%	5.10%	-0.013	-0.031		-0.03	0.00	0%	£0.22
Years worked for organisation	8.1	8.5	-0.4	0.006	**	0.01	0.00	-1%	-£1.34
Weekly gross pay	£649	£541	£108						
Gender gap in %		17%							
Sum						-0.01	0.19	1.00	£108
N	4,968								

Source: ASHE 2018

Annex 9: Effects of pay bands and different grounds of diversity on the standing on nursing as a career

	I would recommend nursing as a career		I think that nursing is a rewarding career		Most days I am enthusiastic about my job		Nursing will continue to offer me a secure job for years to come		I would not want to work outside of nursing		I do not regret choosing nursing as a career	
Strongly disagree to neither	59.0%		26.4%		38.4%		56.6%		65.3%		43.7%	
Agree or strongly agree	41.0%		73.6%		61.6%		43.4%		34.7%		56.3%	
n	7,620		7,613		7,587		7,594		7,584		7,584	
	Exp(B)	sig	Exp(B)	sig	Exp(B)	sig	Exp(B)	sig	Exp(B)	sig	Exp(B)	sig
Constant	0.75	*	4.31	**	1.88	**	0.81		0.42	**	1.30	†
AfC pay bands 4 or below	0.98		0.87		0.73	**	0.82	†	1.31	*	0.67	**
AfC pay band 5	0.53	**	0.58	**	0.51	**	0.72	**	0.80	**	0.58	**
AfC pay bands 6 and 7	0.63	**	0.72	**	0.72	**	0.73	**	0.83	*	0.70	**
Women	1.16	*	1.60	**	1.45	**	1.13		1.39	**	1.29	**
BAME background	1.27	**	0.72	**	0.95		1.29	**	1.09		0.95	
45 or over	1.03		0.90	†	1.06		0.85	**	1.03		1.51	**
Disability	0.75	**	0.83	*	0.86	†	0.62	**	1.06		0.85	*
Cox and Snell R^2	0.01		0.01		0.02		0.01		0.01		0.02	

Source: Royal College of Nursing Employment Survey 2017
Notes: † statistically significant at the 10% level * statistically significant at the 5% level; ** statistically significant at the 1% level. AfC reference category taken as pay bands 8 and above.

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