Royal College of ursing

Gender and Nursing as a Profession

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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 ef ect 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 signif cant 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 def ned by high level technical, emotional and cognitive skills continue to inhibit ef orts 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 staf 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 f nances and economic growth. They also need to go one step further by emphasising the importance of nurses' voice and leadership in realising these benef ts.

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:

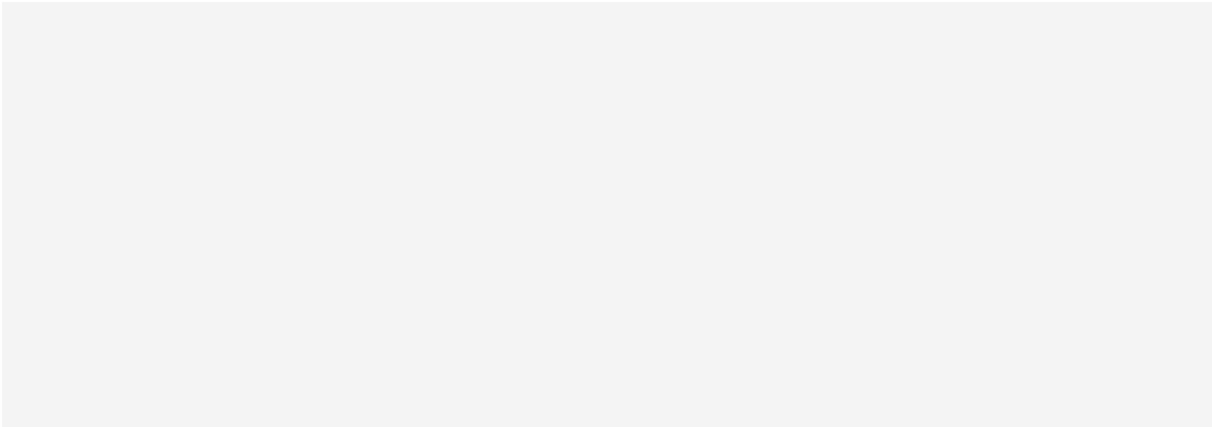
- the psychological contract in terms of the relationship between workers and employers and the mutual expectations for each side (including opportunities for growth, pay and reward, recognition, progression, managerial and peer support, f exibility, and job security)
- what members want from their union, 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.

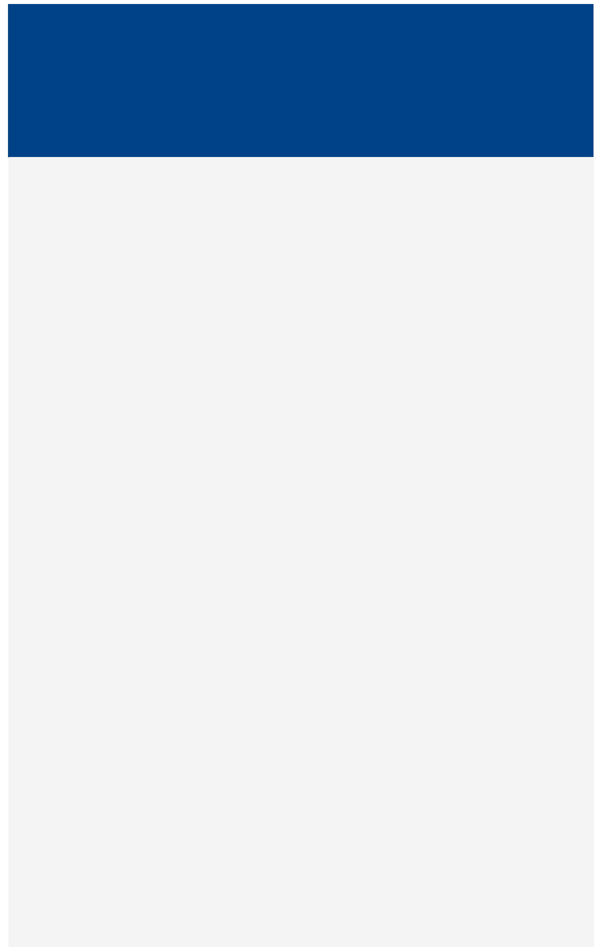
Not only is the RCN uniquely placed to lead research and engagement to understand these changes and trends, but it is imperative that it does so in order for it to continue representing its members and nursing.



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. Staf ng 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 conf dence 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 staf ng 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 understaf ed, nursing staf get sound more inos a>1.2 ailurwou onal pace



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 identif ed as a key risk for recruitment. Applications from f rst-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.

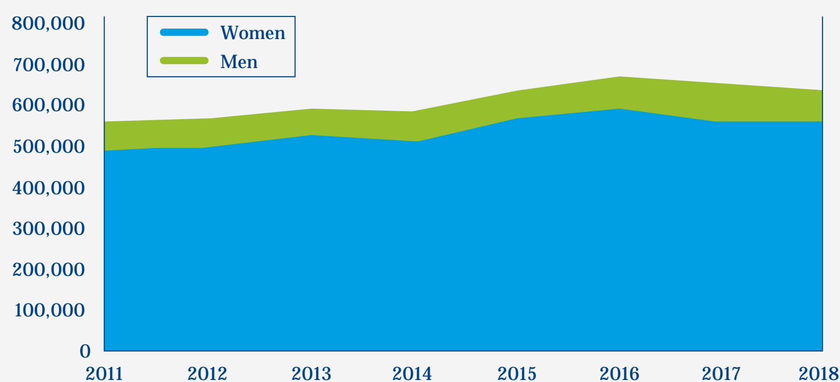
Demographic factors also play an important role in the recruitment and retention of nursing staf . With one-third of UK nurses due to retire by 2026, the current workforce is ageing. Yet a decline in birth rates has eroded the traditional pool of 18-year-olds which might now be applying for nursing degrees. 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 ef ect 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

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

Country	Ratio
Mexico	1.83
Chile[1]	1.81
Israel	1.49
Luxembourg	1.38
Spain	1.28
New Zealand	1.24
United States[1]	1.24
Greece	1.20
Australia	1.19
Netherlands	1.15
OE CD29	1.14
Germany	
Belgium	1.14
Canada[2]	
Japan	
Czech Republic	
Denmark	
Italy	
Estonia	
United Kingdom	
Ireland[1]	
Poland	
Norway	
Iceland	
Slovak Republic	
Slovenia	
France	
Finland	
Hungary	
Latvia	

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 specif ed	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).

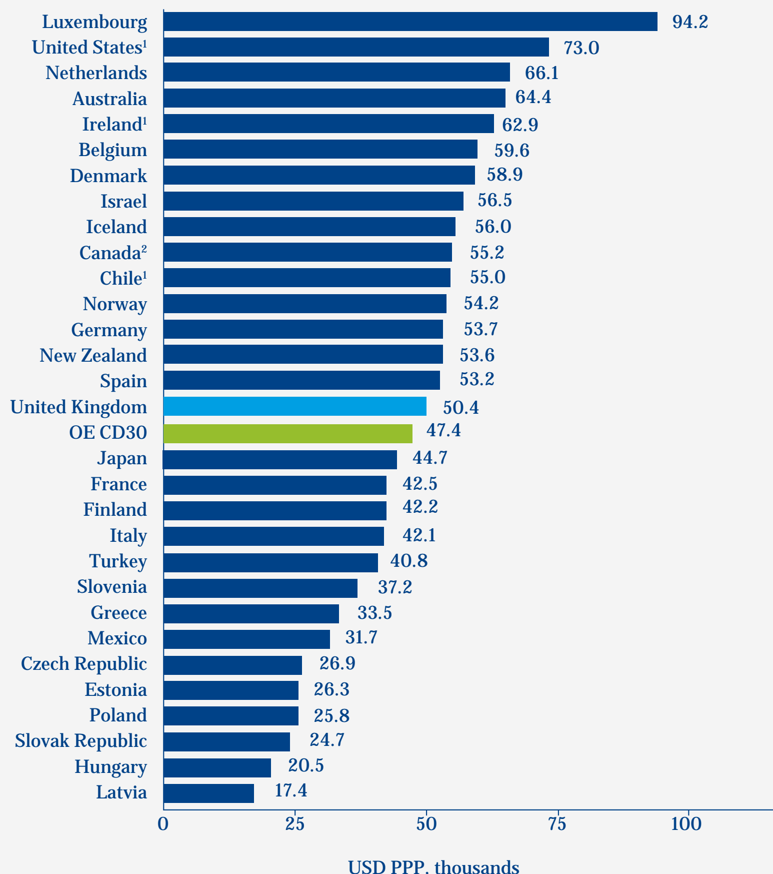
Furthermore, disciplinary rates for minority groups are higher than for white staf while discrimination at work, bullying and harassment are also proportionally higher for BAME staf . As there is little available data for NHS staf in other parts of the UK, it is dif cult to draw a full UK-wide picture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

Pay, working conditions and quality of care

The following f gures illustrate nurse salary levels across OECD (Organisation for Economic Cooperation and Development) countries in 2015. Figure 2 shows the relative f nancial 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, f ve 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.

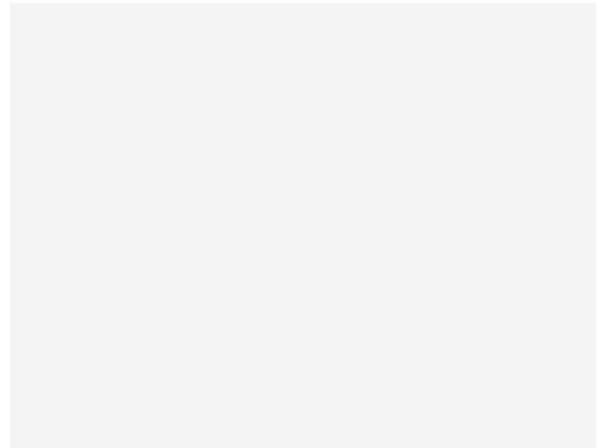
Exploring a range of issues impacting the nursing workforce, the
revealed a workforce that felt overworked and underpaid, and unable to give the quality of care their role demanded. The f ndings also show how nurses' pay does not equate with the level of responsibility and autonomy they hold, or their 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 f nancial 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 (tComputing)Tj0 -1.2 T.m0 5eu.2 Trtglrtgt ho.531 Tdw0BF00510nrcise ,£par e aof (eary)T(ears-1.2r.531 Tdank

Nursing work is also subject to increasing levels



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 identif ed as having distinct traits and abilities. As a result, medicine has been broadly def ned as work for men, and nursing as work for women; a social construction of gender roles that has left an enduring legacy.

Claims to expert, scientif c knowledge – in opposition to practical knowledge – continue to

large part because of its association with care.

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

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

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)

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

Table 10: Pay and earnings by di erent components in nursing

	Women			Men			Total		Sig.
N			n			n			£553.59
4,434	Median	£26,140.76†	577	Median	£30,569.34†	5,011	Median	£ 26,707.31†	Median £494.57
	Mean	£25,440.41		Mean	£30,113.77		Mean	£25,978.53	
	SD	£12,632.81		SD	£15,606.26		SD	£13,093.34	
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	
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	
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	
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	
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	
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	

Average gross weekly earnings are composed of f ve categories: basic pay, overtime, shift and premiums, incentive pay, and other pay (Figure 4). Dif erences 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 dif erent factors play. These factors included:

- basic paid hours and average weekly paid overtime hours worked - this controls for potentially dif erent 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 dif erent 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 fo hAbperf6.nistion o226

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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 prof t	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 dif erence 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 dif erence in the number of overtime hours, which was statistically signif cant ($p < 0.01$) 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.

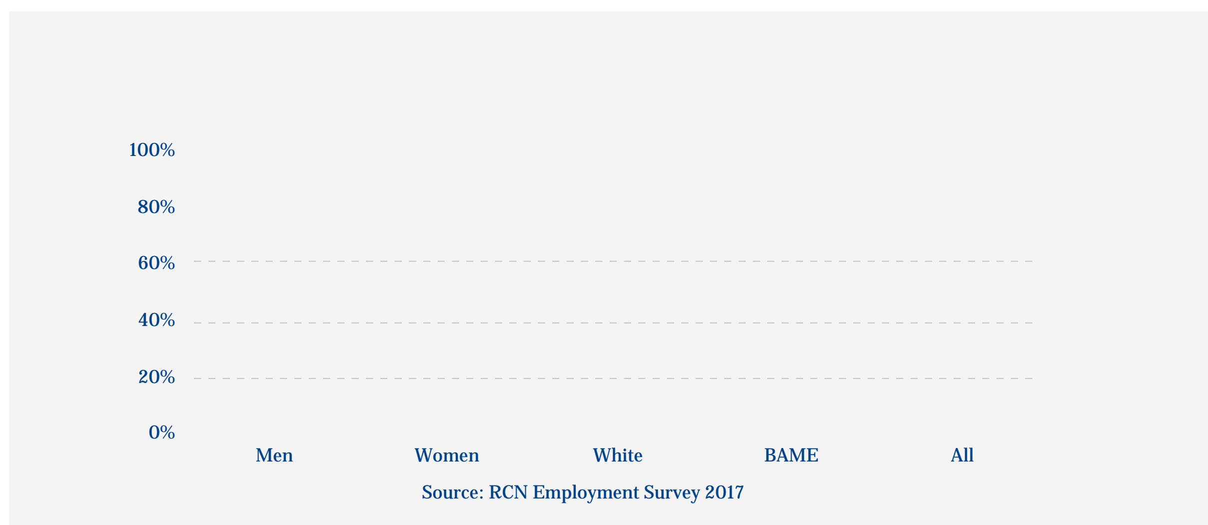
E idence s ggests that in n rsing, the gender pa gap is str ct ral rather than a direct discriminator e ect.

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 coef cients 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 signif cant ef ect on weekly nor gross wages. Other factors, such as being on a temporary contract, have signif cant ef ects on pay. This provides further evidence that in nursing, the gender pay gap is structural rather than a discriminatory ef ect and corroborates the f ndings obtained using data from the QLFS 2018 presented above.

E ects 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 f ve (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 f nancially. 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).



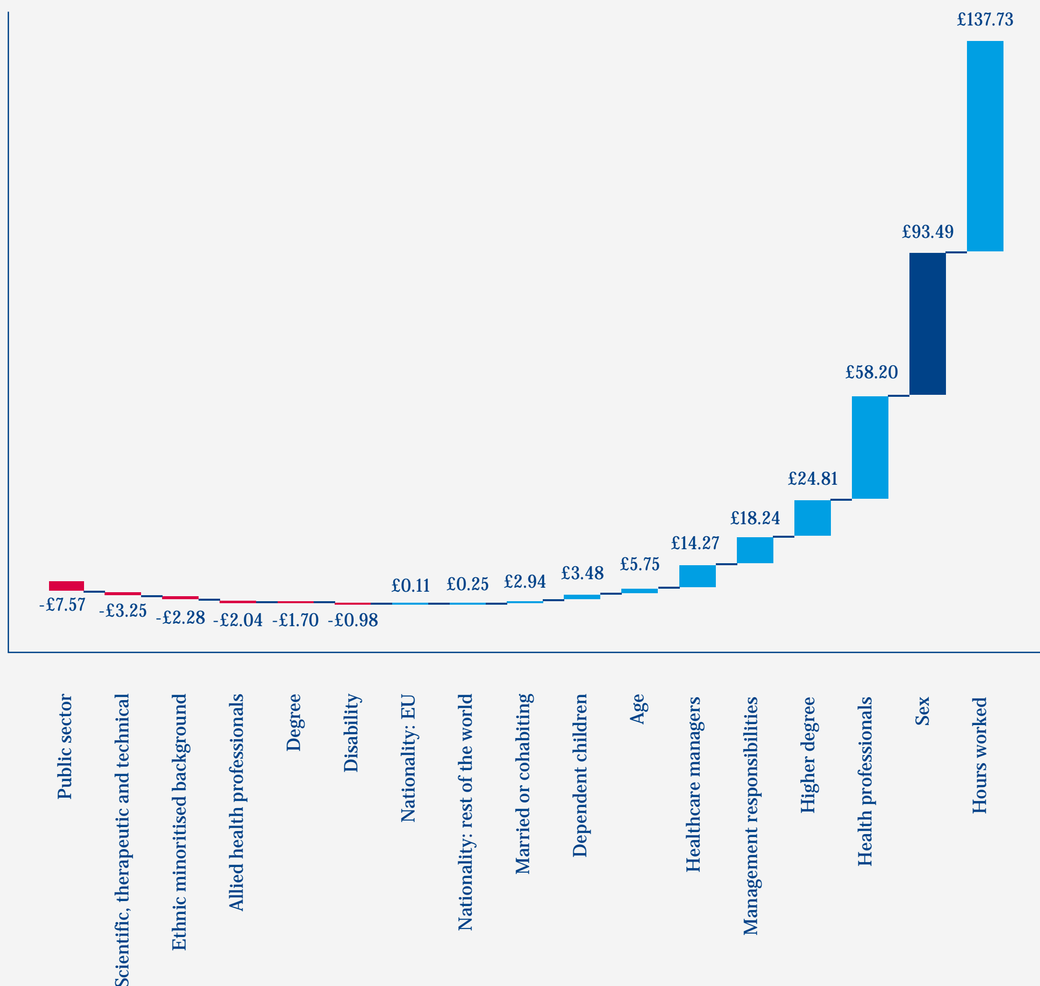
Source: RCN Employment Survey 2017

related to sex dif erences 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 ef ect and an indirect ef ect 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 ef ects 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 ef ect of being a woman or a man).

Several techniques have been used to decompose the gender pay gap into its explained (indirect ef ects) and unexplained (direct ef ect) 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 dif erence 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 dif erence 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 di erence for eekl gross pa are se , ho rs orked and orking 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 amounts to 27% ny basis (Figure representenotionas3 -eekow th discrimination amo,
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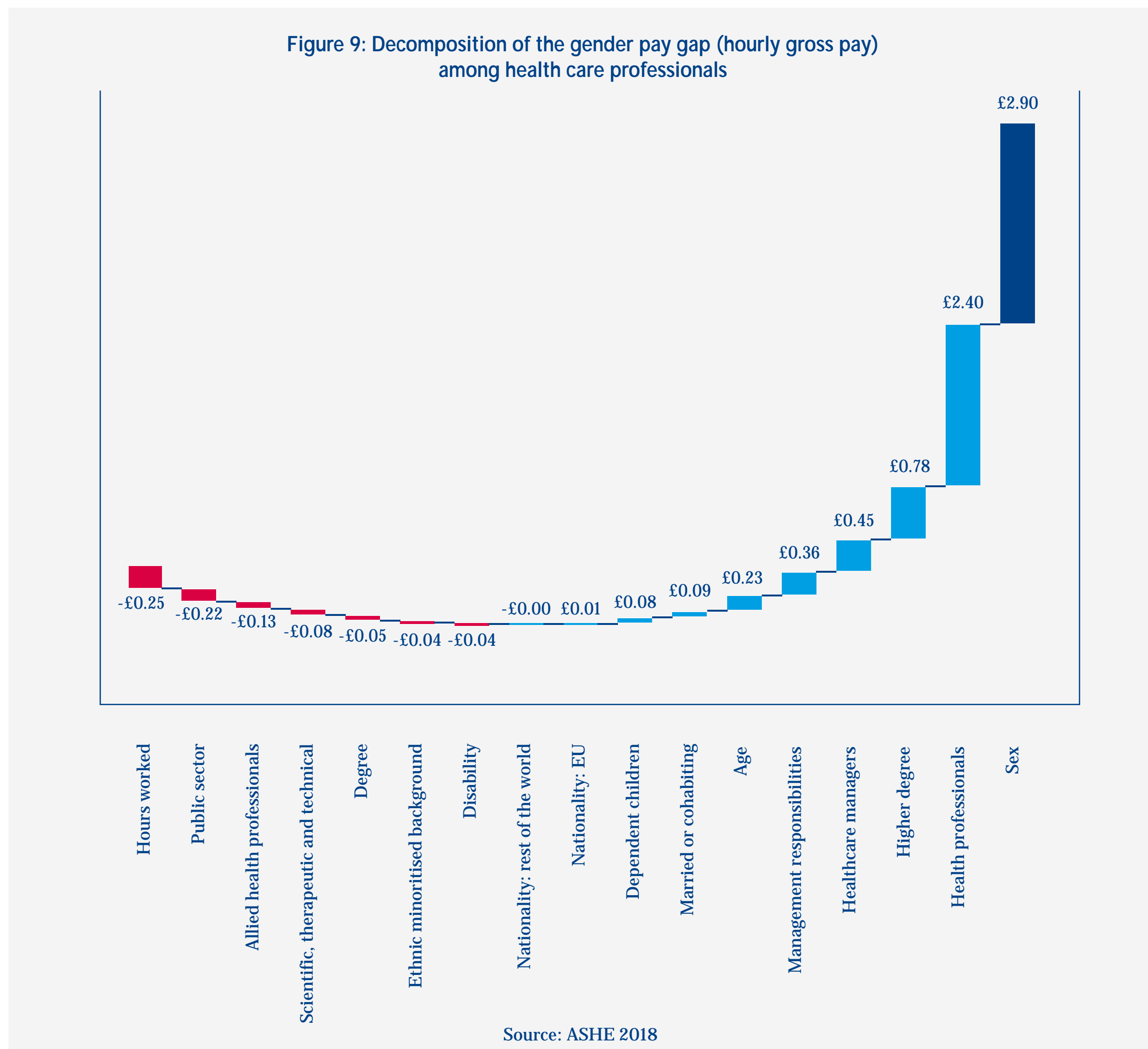
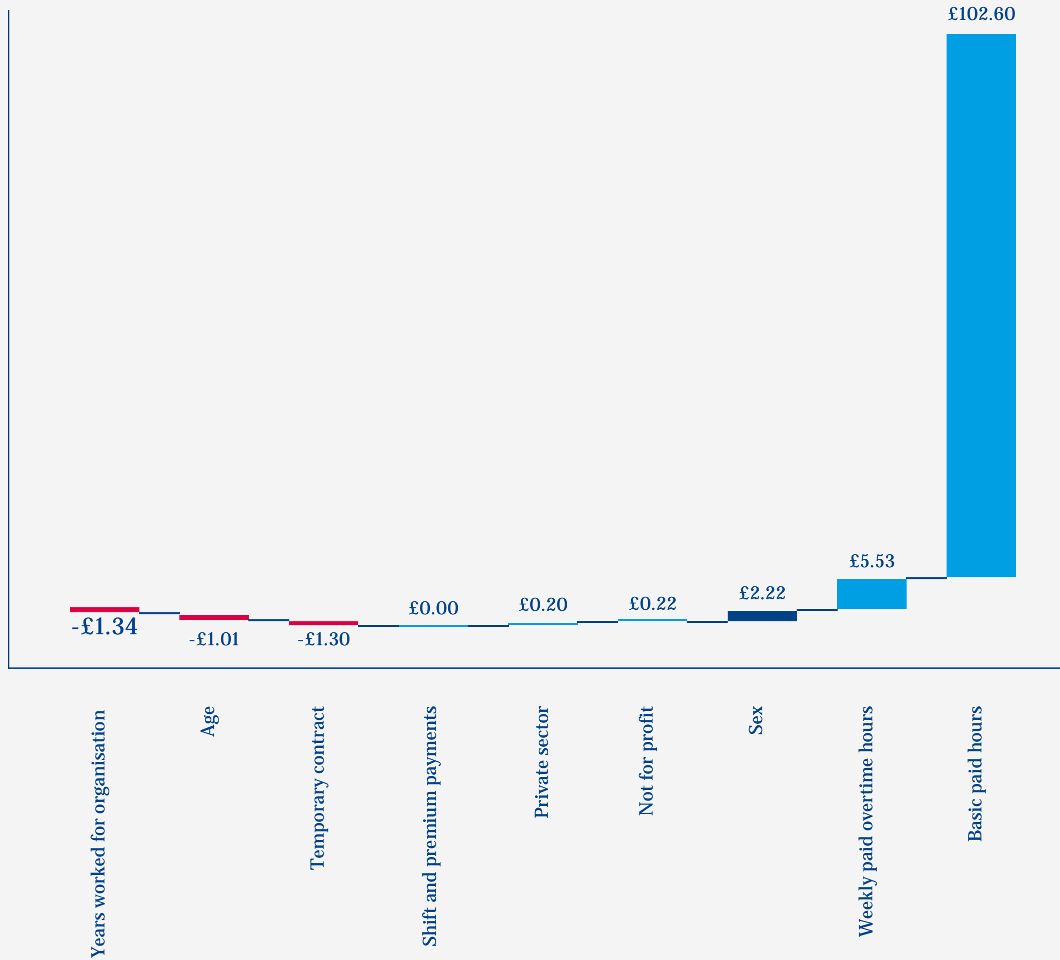
Figure 9: Decomposition of the gender pay gap (hourly gross pay) among health care professionals



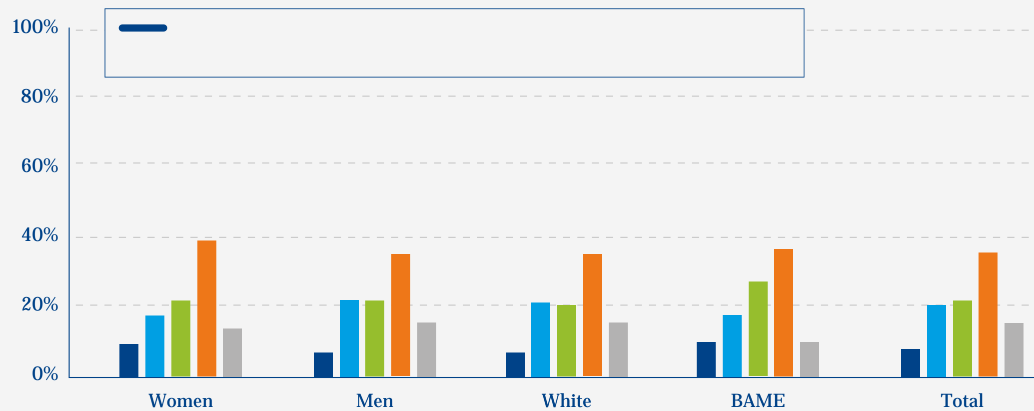
Source: ASHE 2018

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

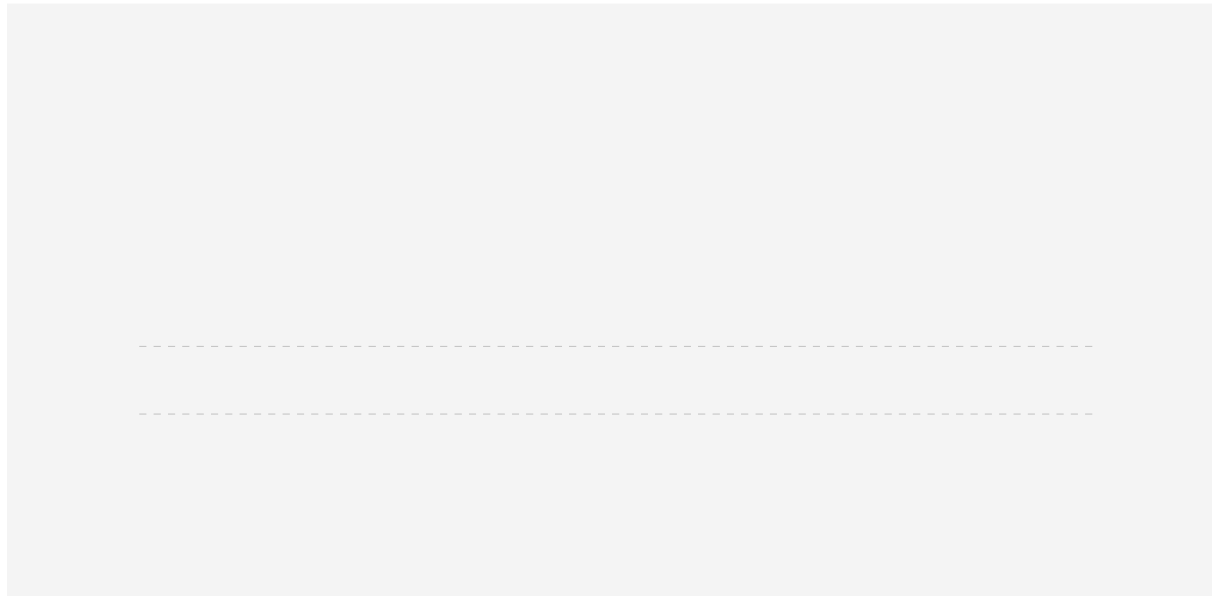


Source: ASHE 2018

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



Source: RCN Employment Survey 2017



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 f ve times. The most notable dif erence is that 29.5% of BAME nurses went to work more than f ve 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. Dif erences 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 (= 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 of er 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 signif cant dif erence (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, staf 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 satisf ed (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 ef ects of pay bands on perceptions of the standing of nursing as a career is only statistically signif cant 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 dif erence 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 ef ects of pay bands and dif erent grounds of diversity on the standing on

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 f nd 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 qualif cations, 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 f ndings 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 signif cant, 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. Dif erences arise because men benef t slightly from a glass elevator. On an hourly basis, men with managerial responsibilities earn signif cantly 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.

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. L of a d8s03005600440050004800035Tj/T0B

Women are also less likel to achie e positions in (senior) management, and their progression might therefore be associated ith 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 dif erence. 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 of ering opportunities, but not f nding it rewarding. That BAME nursing professionals are more positive might ref ect 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 oice of senior stakeholders in the n rsing profession

Introduction and participant demographics

This chapter reports on the ndings from q alitati e inter ie s designed to capt re the ie s of ke senior stakeholders. The majorit of er ieeis od(ranr)25 oi5.1 (is.ane)15 (od ction and

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 f eld 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

(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

(Director level nurse with commissioning experience).

However, many others argued that the view of a nurse who simply washes and changes people must be challenged, with one participant saying

(Nurse in senior academic/HE role). The advanced practice role was pointed to in particular as

(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 for the public which contributes to dif culties 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

articulate its value to health care in f nancial 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:

(Nurse in senior academic/HE role).

Participants went on to state that the profession needs to f nd a way to show the potential variety of roles and possibilities for autonomy, as it is often portrayed and misunderstood as being . One participant asked:

(Nurse, employment relations background). Careers with some similarities, such as the f re, 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: or

(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 or

(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 staf , while registered nurses take on more advanced tasks. Though aspects of this were generally seen as a positive development, allowing nurses to have inf uence 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:

(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 rather than a seamless way, and 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

(Nurse background, in senior academic/HE role) and despite

(Nurse background in senior quality improvement role). This exemplif es 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 , trying to keep hold of 'traditional', hands-on and rewarding work (often described as what attracted people to nursing in the f rst place), and that

(Nurse, background in senior leadership role).

While some acknowledge that nurses like to this can sometimes curtail advancement in the role. This underpinned repeated references to perceived incompatibility between caring and academic pursuit and that overall unless you are (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:

(Nurse, director level with commissioning experience).

While health care support workers deliver a signif cant 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:

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

One participant argued for more investment and support in education for health care support workers

(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.

Control and autonomy

Participants' responses referenced existing research that attributes high attrition rates in nursing to work pressure, intensity and unsafe staf ng levels. In particular, they expressed concern about the wellbeing of nurses, who are

So much so, it was argued, that the RCN had found it necessary to campaign to encourage nursing staf 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 identif ed, for example:

(Nurse, employment relations background). It was argued that such levels of emotional labour require resilience, and this

, where instead it

(Nurse, employment relations background).

Career flexibility, development and progression

Existing levels of career f exibility and the ability to move in and out of nursing were perceived by participants as a feature which can both attract and retain staf . This was primarily identif ed as a strength of the profession in terms of being able to attract women:

(Nurse in senior academic/HE role).

However, the ability to return is not always straightforward for some:

(Nurse in senior academic/HE role).

In relation to progression, a range of barriers and enablers to progression were identif ed and some said that that there has arguably

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 f nance director. This is exacerbated by high-prof le investigations and the pressure that nurse directors face to maintain quality. Subsequently, there is dif culty in recruiting nurses at directorship level.

Another interviewee felt that salary at that level was not the key issue, and that

(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

(Nurse, employment relations background).

At the present time, however, a number of participants identif ed that BAME staf are underrepresented at senior levels and overrepresented both in lower pay bands (of ering limited career prospects and training opportunities) and in disciplinary referrals. One participant recognised that for these people:

(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 f aws rather than coachable characteristics …if you make a mistake then that is somehow emblematic of all the mistakes and the fatal f aws 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

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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 identif ed as being inf exible, 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

(Nurse, director level with commissioning experience). Such inf exibility, 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 f exibility to ref ect nurses' dif erent needs across their life course in order to improve retention in the profession. One participant stated:

(Director level, strategic role).

Moreover, faced with an ageing workforce, health and social care organisations need to ref ect how they can retain older staf , 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 staf . One participant stated that as:

(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 conf dence.

High-level policy decisions, made both within and outside nursing, that af ect 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:

(Nurse in senior academic/HE role).

Representation of policy decisions in the media and wider public/governmental discourse m65

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events such as the 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 (Nurse, director level with commissioning experience). Though not necessarily negative representations, these reinforce the stereotypical roles which can be so inf uential. Some felt that there are missed opportunities for improving perceptions of the profession to show its need for intelligence and skill.

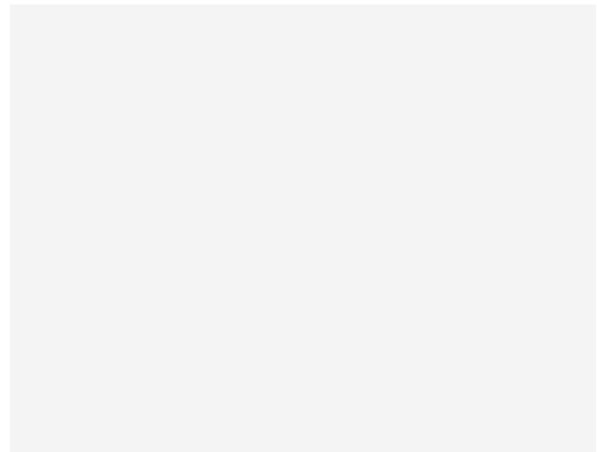
One participant suggested that (Nurse in strategic leadership role with employment relations background). It was felt that the RCN might work harder on its relationship with the media and suggestions included some nurses who are unafraid of speaking out are of ered media training to become representatives of the profession. One participant argued that:

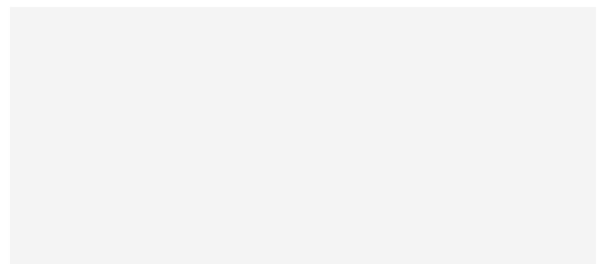
> "... we have to stop apologising for being nurses ... I think if we're bringing young people in to be nurses, and heaven only knows we need them, then we need to instil them with a sense of pride, and we need to instil them with, 'Actually, this is your disciplinary, specif c knowledge and be proud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

Some interviewees felt that senior leadership does not always speak with 'one voice', giving

(Director level, strategic role).

The way multigenerational teams work together, ensuring all approaches are valued equally was





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:

(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:

(Nurse, director level).

The narrati e of 'choice' as also pre alent, ith some arg ing that senior roles ha ing less 'hands-on' contact acts as a disincenti e to seeking progression, despite the higher pa .

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 dif erent professional background. It was identif ed, though, that pay at higher levels within nursing is dif cult to address: f rstly, 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 (rather than the pay) but also since executive-level nurses earn so much more than many others in their profession (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 f nancial rewards or recognition:

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

Conclusion

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

However, nurses face high levels of work intensity with unsafe staf ng 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 dif culty 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 conf icting 'knowledge claims' within the profession, potentially causing tensions between the profession def ned by expert, scientif c knowledge and the more practical, caring aspects of the role.

Senior highly experienced stakeholders identif ed key issues, which, it can be argued, undermine the construction and status of nursing as a profession. They identif ed 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 identif ed 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 identif ed 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 f exibility 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 identif ed in this report so that nurses are no longer . 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 fulf lment 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 s mmar and recommendations

At the heart of this report is the concept of al e: the al e of ork that is done and the care gi en, the al e of indi id als as n rses, and the al e gi en to the n rsing profession o erall. Not al ing n rsing, e contend, manifests itself thro gh a de al ation of its stat s, pa and a tonom hich is associated ith the constr ction of the n rsing profession as ork for omen.

Current perceptions of nursing ref ect a misalignment between past images and present reality; professionalisation sits in tension with the notion of nursing as a vocation. Ef orts 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 f nd a gender pay gap within the nursing profession which is caused by structural factors, such as working time. This low level of pay ref ects the fact that the profession is dominated by women, because of the broader gendered division of labour.

At f rst 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 dif erence 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 rst glance, a gender pa gap of 17% e ists on a eekl basis, b t hen pa is calc lated ho rl 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

While the health and social care sectors, and

some, the caring and technical aspects of the role
continue to be incompatible; an issue which was

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

N rsing s ers from an image that fails to match the realit of a professional life de ned b high le el technical, emotional and cogniti e 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, f exibility, 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

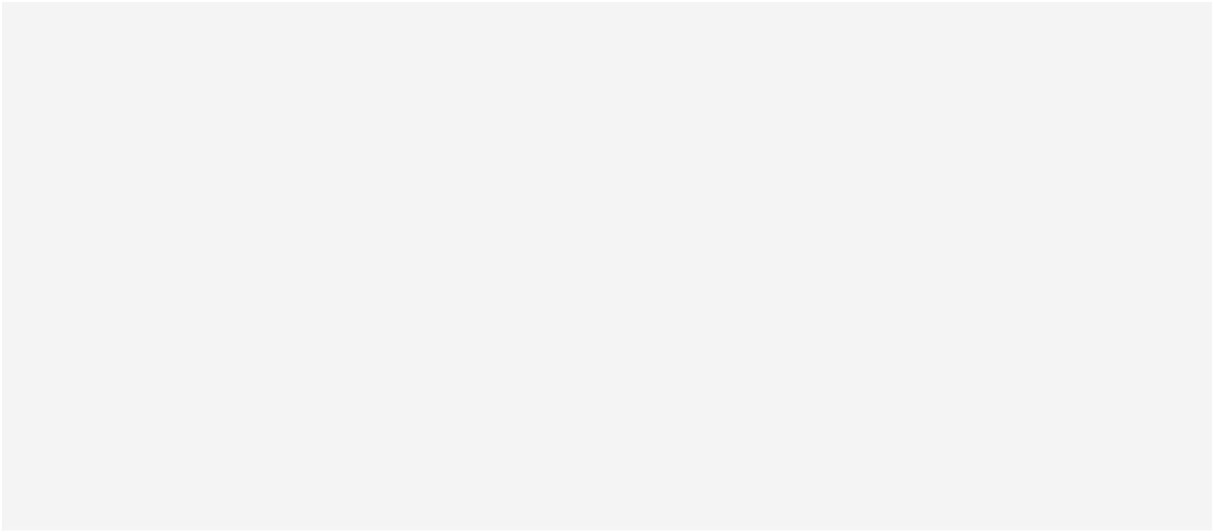
The research and engagement with RCN members should be undertaken to better understand the meaning of work for nursing as a profession against a changing world of work; and how the profession responds to future developments and changes.

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 af ecting the nursing profession.



nursing provides fewer opportunities for progression. Progression is often

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Glossary

Agenda for Change (AfC): the pay banding system for all NHS staf 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 staf except doctors, dentists and some senior managers, the AfC system covers more than one million staf . Many nursing staf 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 staf 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 prof les are used to match posts to pay bands, with staf matched either using a national job prof le 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 dif erent areas. For example, job prof les included in band 5 are: staf nurse; occupational therapist; midwife (newly qualif ed); speech and language therapist (newly qualif ed); of ce manager. Job prof les in band 6 include: junior sister; specialist staf nurse; paramedic; [illegible]

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 prof le 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 ef ective registration with the NMC.

Segregation: occupational gender segregation refers to the distribution of women and men across and within occupations. Horizontal segregation refers to dif erences 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

UN

- 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 prof ling.

Research instruments: participant consent form

Please initial boxes

1. I conf rm that I have read and understand the information sheet for the above study, including the statement about the legal limitations to data conf dentiality, 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 f ndings (delete as appropriate) ☐

Name of Participant	Date	Signature

Name of Researcher	Date	Signature

Research instruments:
inter ie q estions

Background

1

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

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 Ref ective Practice in Adult Nursing. Sue is co-editor of Ref ective 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 Of cer 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

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

		n			n			n
2231	Nurses	932	1181	Health services and public health managers and directors	88	2211	Medical practitioners	353
2232	Midwives	54				2212	Psychologists	49
						2213		73
						2214		26
						2215		57
						2217		39
						2218		23
						2219		96
	Total	986			88			716

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 ef ects:		SE	e	sig		SE	e	sig		SE	e	sig		SE	e	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 responsibilities					0.03	0.00	1.03	**					0.00	0.00	1.00	
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 ef ects:																
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			
Scientif c, therapeutic and technical	-0.35				-0.22				-0.33				-0.23			

Source: QLFS 2018 Q1 (n = 274)

Notes: † statistically signif cant at the 10% level * statistically signif cant at the 5% level; ** statistically signif cant 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							
		SE	e	sig		SE	e	sig		SE	e	sig		SE	e	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 signif cant at the 10% level * statistically signif cant at the 5% level; ** statistically signif cant at the 1% level

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

e.045

.006	-.004
-.524	-.117
.001	.001
.040	.045
.011	.020
.007	.006
.023	.050
.038	-.031
.018	.006
Yes	Yes
0.41	0.64
178.2	465.1
4,944	4,968

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

	Men	Women		Change factors (e)		Simulation ef ect (dif erence 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
Scientif c, 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 signif cant at the 5% level; ** statistically signif cant at the 1% level
Weighted by income weight 2017 (PIWT17)

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

	Men	Women		Change factors (e)		Simulation ef ect (dif erence 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
Scientif c, 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 signif cant at the 5% level; ** statistically signif cant at the 1% level
Weighted by income weight 2017 (PIWT17)
The models used for this analysis dif er slightly from the ones using above in the variables used, hence the small variation in coef cients.

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

Variables	Men	Women	Change		Sig.	Change factor	Simulation ef ect	Simulation ef ect 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 prof t	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		Sig.	Change factor	Simulation ef ect	Simulation ef ect 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 prof t	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.