Unions defending and promoting nursing and midwifery: workplace challenges, activity and strategies

A research report by:

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PART 1: INTRODUCTION

Background of the research

Healthcare systems around the world have been under immense pressure for some years now caused among other factors by shortages of trained staff, changing demographics and introduction of market-based approaches. In the UK, staff shortages in the NHS and an ageing population have combined to create a perfect storm within nursing with demand for nurses and midwives outstripping supply (NHS Improvement, 2016). In a recent study, an overwhelming majority of NHS Trusts reported that they were experiencing a severe shortage in supply of registered nurses (Marangozov et al., 2016). The unions estimate a shortage of around 40,000 nurses and 2,500 midwives. The impending likelihood of Brexit threatens to intensify NHS staffing shortages not least because of the dependence for healthcare professionals on non-UK EU nationals who are expected to become in short supply post-Brexit (Marangozov et al., 2016; RCM, 2018). For patients, understaffing can lower quality of care, compromise safety and increase clinical errors. These risks came into full public view with the publication of the *Francis Report* in 2013 that attributed the failings of one NHS Trust in part to understaffing of qualified nurses. The long-term crisis has also had an extremely negative impact upon the work environment and working conditions of healthcare employees globally. The five most common problems nursing staff experience globally are understaffing, health and safety, mandatory overtime, privatisation, and bullying (Clark and Clark, 2003). There is plenty of evidence that the UK is experiencing these problems where the staff supply shortages that self-evidently cause understaffing in workplaces, in turn lead to additional stress and greater work/workplace pressures for nursing staff in particular, and to some extent midwifery staff. The greater research gap exists on how unions are responding to these challenges and defending and promoting nursing and midwifery.

As far as UK unions are concerned, despite overall enormous membership decline since the peak years of the late 1970s, there continues to be a significant union presence in British public sector workplaces, and unions remain an important source of representation and voice for public sector workers. The RCN and RCM, doubling as unions and professional associations, have bucked the general trend of membership decline and have not faced the same difficulties as some other NHS unions in sustaining and building their memberships (Carter and Poynter, 1999). In fact, both unions have increased their memberships over the last 25 years or more. Respectively, RCN and RCM represent staff in the largest occupational group in the health sector and one of the small niche professional ones. The two unions describe themselves as the voice of nursing and midwifery respectively covering employment relations, professional and educational issues. Despite both unions having relatively high public profiles, there has been little academic research focused on these two professional unions that have withstood membership decline. In the face of the continuing pressures in the system, unions representing healthcare workers have orchestrated a large number of campaigns to safeguard the NHS, and organised a number of strikes by NHS staff as well as demonstrations around protecting health services. It is argued that public sector unions are generally taking a more militant stance in the face of a hostile state while being aware of the need to keep public opinion on their side (Coderre-LaPalme and Greer, 2018). This increased militancy was seen in the first ever midwives' (RCM) strike in 2014 and the junior doctors' strike in 2016. The present healthcare landscape makes it timely to redress the research gap and explore the role of the main nursing and midwifery unions (RCN and RCM) in defending their members' terms and conditions and in voicing publicly their professional concerns.

Research aims and themes

In broad terms, the research sought to explore the issues confronting and concerning nursing/midwifery union reps in their work and workplaces in order to consider how the two professional unions are responding on the ground to the current realities and challenges confronting nursing and midwifery staff. In order to address this aim, this report's findings cover two main themes:

1. **On the ground working lives in nursing and midwifery**
2. **Professional unions representing nursing and midwifery at the workplace**

The study

The research was funded by a British Academy grant and carried out in collaboration with Royal College of Nursing (RCN) and Royal College of Midwives (RCM). The study used mixed methods: interviews with RCN and RCM officers/staff and workplace reps, focus groups with RCN and RCM reps, and an RCN/RCM workplace reps survey. In discussing the findings, we privilege the voices of workplace reps.

RCN and RCM workplace reps

As stated earlier, RCN (England) has approximately 1,300 workplace reps (stewards, health and safety reps, learning reps) while RCM has approximately 745 nationally. The gender, ethnicity and age of reps are shown in Table 1 below. The gender and ethnic composition of the two unions' workplace reps is unsurprising as it broadly reflects the membership/workforces. The main point to note for the purposes of this study is the age profile of reps. 64% of RCN reps are aged 40-59 while only 19% are aged 20-39; similarly, 60% of RCM reps are aged 40-59, but 33% are 20-39.

Table 1: Gender, ethnicity and age of RCN (England) and RCM workplace reps

	RCN	RCM
Gender		
Female	75%	99.3%
Male	25%	0.7%
Ethnicity		
White	75%	77%
BAME	16%	6%
Unknown	9%	17%
Age		
20-29	4%	11%
30-39	15%	22%
40-49	25%	28%
50-59	39%	32%
60-64	12%	7%
65+	5%	0%
Unknown	0.4%	0%

Interviews and focus groups

Selected characteristics of research participants and their numbers are shown in Table 2. Our sampling strategy was purposive insofar as we were particularly conscious of the need to recruit BAME participants at least in proportion with BAME representation among workplace reps. Sample sizes in Table 2 show that this was achieved. In addition, we interviewed workplace reps across all age groups.

Table 2: Selected characteristics of research participants

Groups of participants	**RCN**	**RCM**	**TOTAL**	**% of each group of participants by selected demographic categories**
National/regional officer/staff member interviewees	**8**	**8**	**16**	**100%**
Female	4	5	9	56%
Male	4	3	7	44%
White	6	8	14	88%
BAME	2	0	2	12%
Workplace rep interviewees	**15**	**19**	**34**	**100%**
Female	13	19	32	94%
Male	2	0	2	6%
White	9	15	24	71%
BAME	6	4	10	29%
Workplace rep focus group participants	**38**	**38**	**76**	**100%**
Female	32	37	69	91%
Male	6	1	7	9%
White	22	28	50	66%
BAME	16	10	26	34%
Total participants	**61**	**65**	**126**	**100%**
Female	49	61	110	87%
Male	12	4	15	13%
White	37	51	88	70%
BAME	24	14	38	30%

Interviews and focus group discussions were carried out by the authors using guides containing themes, headline questions and prompts. This approach afforded some flexibility depending on participants' roles and experiences, but also a large degree of thematic consistency across the interviews/group discussions. Interview/focus group guides were tailored to suit the different union roles but all covered work context and conditions of nursing and midwifery; union context, structures and strategies. Interviews were of 60-90 minutes' duration, were digitally recorded and transcribed verbatim. Focus group discussions 60-120 minutes and were also digitally recorded and transcribed verbatim. Interviews and focus groups were conducted confidentially; therefore, we have made every effort to ensure participants' anonymity. To this end, national/regional officers and staff members are rolled into one category – senior officer – when quoting from interviews with them and because of the small numbers involved, particularly in RCM, we do not identify the gender or race/ethnicity of 'senior officers'. The main purpose is to distinguish officer/staff comments from those of workplace reps. When it comes to workplace reps, we show selected bio-demographic and other details beside quotations in order to provide some context (e.g. geographical location of workplace; role, band, etc.) and texture (gender, race/ethnicity, age) to their comments.

Survey of workplace reps

An online survey of all RCN (England) and RCM workplace reps (stewards, health and safety reps, learning reps) was carried out May – August 2019. The survey asked a range of questions that comprehensively covered union activity around the challenges facing nursing and midwifery staff:

- Reps' union roles and participation, including member-facing, employer-facing and union-facing activities
- Broader workplace/branch organisation and activities
- Union-management relations, relationships with other unions, union contribution to Trust policy-making, improving branch effectiveness
- Union strategies for tackling member's concerns
- Views on the support and services provided by national RCN/RCM

The survey attracted 300 respondents: 77 RCN and 223 RCM; 95% of RCM and 74% of RCN respondents were female; 84% of RCM respondents were white and 10% BAME; equivalent figures for RCN were 84% and 11% respectively. 93% of RCM respondents had trained as midwives in the UK; the figure for RCN respondents was 91%. 84% of the RCM rep respondents had been members of at least six years and almost 50% for at least 16 years. The figures for RCN were 83% and 57% respectively. Despite being longstanding *members,* 55% of RCM reps had been active (holding a workplace position) for only 0-3 years. For RCN the figure was 59%. The majority of rep respondents in the unions had no dependent children (below 16 years) – 59% of RCM and 70% of RCN respondents.

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PART 2: RESEARCH CONTEXT

Introduction

In order to provide some background to the study, this part of the report briefly reviews relevant academic and policy literature. Reflecting the focus of this study on the nursing and midwifery workforce as workers, professionals, and trade unionists, we draw mainly on literature in the work and employment relations field. We acknowledge existence of a large literature in the nursing, healthcare and health policy fields addressing such issues as occupational stress/burnout, job motivation/satisfaction, working environments for nurses in different healthcare settings. While these issues undoubtedly come into view in our study, the nursing/healthcare/health policy literature tends to have a primary interest in the impact of negative/adverse conditions on quality of patient care, incidence of clinical errors/patient safety, rather than sharing our primary focus on nursing staff as workers, professionals and trade unionists. However, we do refer to a number of studies in the nursing literature addressing themes within the equality, diversity and inclusion space, particularly discrimination experiences of overseas BAME nurses. The section covers three main themes that provide the context for our research: (1) working conditions in nursing and midwifery; (2) equality, diversity and inclusion for BAME staff in nursing and midwifery; (3) nursing and midwifery trade unionism.

Working conditions in nursing and midwifery

Before outlining various aspects of working conditions in nursing and midwifery, it is important to state the obvious that both are highly feminised professions at 88.6% and 99.7% female respectively. It is widely acknowledged that feminised occupations typically share several characteristics pertinent to nursing and midwifery including providing care for other people and lower pay relative to male dominated occupations requiring similar level education, qualifications and skills. It can be said that the gender of the workforce defines nursing and midwifery as occupations as well as the working conditions nurses and midwives experience.

Research commissioned by RCN paints a picture of a nursing workforce under severe pressure with nursing staff feeling over-worked, underpaid, and grappling with staff shortages, abuse and low morale (Marangozov et al., 2017). Headline findings from this study include:

- Long working hours: 71% worked additional hours at least once a week, but only half were paid for those hours
- Staff shortages: 79% felt that staffing levels at their workplace were insufficient to meet patient needs
- Poor morale: only 41% would recommend nursing as career
- Lack of career opportunities: 54% felt that they did not have opportunities to progress

Similarly, RCM's survey (RCM, 2016) as part of its ongoing 'Caring for you' campaign also revealed some alarming working conditions for midwives:

- 62% of respondents delay using the toilet at work because they don't have time
- 62% of respondents find they are dehydrated at work because they don't have time to drink
- 64% of respondents had felt unwell as a result of work related stress

- 71% had come to work in the last 3 months despite not feeling well enough to perform their duties

NHS organisations deal with the staffing shortage issue partly by utilisation of agency and bank staff and partly by recruiting from other EU countries and internationally. However, these measures have proven insufficient to solve the problem (Marangozov et al., 2017; Baker, 2018). The upward trend in utilisation of agency and bank staff dates back to the mid-1990s and reliance on these temporary external sources of labour has raised public policy concerns around rising costs and quality of care (Tailby, 2015). Meanwhile, nurses and midwives themselves often do bank shifts in addition to their full-time job in order to increase earnings in the context of low pay; others work only bank shifts in order to accommodate childcare. For some, agency nursing is a response to dissatisfaction with pay and working conditions even though in theory it is an insecure form of employment (Tailby, 2015). Tighter immigration controls, the impact of Brexit and a global shortage of nurses are making it difficult to recruit from abroad. It seems unlikely that the present staffing shortage will be resolved in the near future especially when after the end of the nursing/midwifery student bursary the number of students applying to study nursing at university has fallen (Marangozov et al., 2017).

In addition to the extreme pressures in the working environment, pay is a critical issue in nursing and midwifery although a recent NHS staff survey suggests a slight increase in pay satisfaction among midwives. Marangozov et al.'s study (2017) of nursing revealed very high levels of pay dissatisfaction among nursing staff, in particular, 61% of respondents felt that their pay band/grade was inappropriate relative to their responsibilities, duties and intensity of the job**.** It appears that pay dissatisfaction among nursing staff at least has not dissipated since the 2019 pay deal. Pay is a particular concern given the increasing numbers of nursing staff who are the primary earners in their households (57% in 2017 compared with 48% in 2007 according to Marangozov's study); this applies disproportionately to BAME and male nursing staff. In the same study, over half of nursing staff (56%) struggled to make ends meet and media reports claim that low pay means that some nursing staff are using food banks.

Another longstanding concern is that NHS hospital employment has not adequately accommodated the work-life-balance needs of its predominantly female workforce (Tailby, 2015) and most nursing staff feel unable to balance their home and work lives (Marangozov et al., 2017). This contrasts with midwifery where in one study staff reported relatively high work-life-balance satisfaction (Hunter et al., 2017). However, in an RCM survey (RCM, 2016) 37% of responding midwives who asked to change their hours had their request declined, indicating that flexible work arrangements are not readily available to all. Moreover, a recent study highlighted tensions and divisions between full-time and part-time midwives and midwifery managers over the use and effects of flexible working (Prowse and Prowse, 2015), fuelling flexibility stigma and co-worker resentment. The complexities and tensions around flexible working in midwifery are at least in part a function of the 24/7 nature of the service. Interestingly, there are relatively low rates of part-time work in nursing (while midwifery has higher levels) compared with other feminised occupations, which to some extent explains the differences in work-life-balance satisfaction between nurses and midwives. In addition, nurses taking career breaks for maternity leave, especially those who return part-time, are seen to be at a disadvantage in terms of career progression since few managerial level jobs in nursing are available on a part-time basis (Davey et al., 2005). Development of family-friendly policies was part of the NHS modernisation agenda under the Improving Working Lives initiative of 2000 and in its infancy at the time of Davey et al.'s research, but even more recent research finds a 'motherhood penalty' for nurses in terms of career progression (McIntosh et al., 2012).

Last, but not least, bullying and harassment practices are recognized as a major issue within NHS Trusts. Management insecurity, lack of training and inexperience are major factors in the excessive use of discipline (Cooke, 2006). As well as being defensive, a culture of unfairness and dishonesty has spread in the NHS, leading to many resignations and dismissals. According to recent research in a London hospital (Lewis, 2018), 35% of respondents reported observing bullying and harassment mostly emanating from managers and colleagues. The research highlighted a lack of senior manager commitment to do anything when issues were raised and to challenge inappropriate behaviours. It also pointed out the limited effectiveness of existing anti-bullying and diversity policies, insisting on the need to support managers lacking in experience in managing conflict as well as promoting a more robust leadership style.

Equality and inclusion for BAME staff in nursing and midwifery

While academic research frequently deploys gender as a lens for understanding nursing and midwifery as feminised professional occupations, race/ethnicity is the primary focus of policy debates around equality, diversity and inclusion. The NHS has depended on BAME labour, particularly from developing countries, in various job categories since its inception, but race/ethnic inequalities have endured. For example, Likupe et al. (2013) contend that Black African nurses recruited from overseas are placed on the lowest nursing grade regardless of qualifications or experience relative to British colleagues. Today, nursing is more ethnically diverse than midwifery: 26.5% of nurses are of BAME background compared with 13.7% of midwives (NMC, 2019) and the overall number and proportion of BAME staff across NHS Trusts is increasing (WRES, 2018). The "snowy white peaks" metaphor coined by Roger Kline in his 2014 report (Kline, 2014) has proved as enduring as it has powerful. Kline analysed discrimination in governance and leadership in the NHS and its potential impact on patient care in London and England. The analysis identified that BAME people were underrepresented on Trust Boards and among senior and very senior managers, a situation that denies the NHS the potential contribution of a diverse leadership (Kline, 2014).

In addition to BAME underrepresentation in NHS governance and leadership, there are a number of other longstanding and persistent indicators of race/ethnic inequalities in career outcomes. These are highlighted by the annual reports of the Nursing and Midwifery Council for nursing and midwifery specifically, and by the Workplace Race Equality Standard (WRES) Reports for the NHS generally. The WRES (covering all categories of NHS staff) came into force in 2015 requiring NHS organisations to demonstrate progress on workforce equality. Although according to the most recent WRES report (WRES, 2018), the majority (71.5%) of BAME NHS staff believed their Trust provides equal opportunity for career progression and promotion, the data indicates persistent, and in some respects worsening, career outcomes for BAME nurses. BAME nurses are overrepresented at band 5 and under-represented across all other pay bands, while only 3.4% of directors of nursing are from a BAME background.

Several studies reveal the negative workplace experiences of nursing staff of a BAME background. Alexis et al.'s (2007) study of 'overseas' BAME nurses (meaning those trained outside of the UK/wider EU), identified six themes in the experiences of such nurses, five of which were negative. Participants reported (skills/education/abilities) devaluation processes in the workplace; they seemed to self-blame for negative experiences (for being from overseas / BAME); they experienced discrimination/lack of equal opportunity (in promotion); they felt invisible (frequently ignored, bypassed by managers); they experienced fear (as insecure migrants), but also reported some benefits of being in the UK (better pay, overseas work experience). Similarly, Likupe et al.'s (2013) Black African research participants trained

overseas felt that their nursing experience and knowledge were not respected; they experienced disrespect from colleagues and felt they were stereotyped as confrontational and arrogant if they asserted their opinions or rights. They also described how they were discriminated against in terms of promotion, professional development and duty rotas, as well as in the way any mistakes they made were dealt with. NMC diversity data seems to corroborate this earlier study with the most recent report showing that people of black African ethnicity are more likely to be referred (12% of referrals) than expected given their proportion on the register (7% of people on the register) (NMC, 2019).

On the latter point, of particular concern to the unions is the evidence that both nurses and midwives of any BAME background are more likely to be referred to the NMC (Fitness to Practice Process) than their white counterparts (NMC, 2019). In addition, data published by RCM shows that BAME midwives are disproportionately more likely to face internal disciplinary proceedings as well as more likely to be suspended and later dismissed while facing such proceedings. In addition, WRES 2018 finds that like midwives, BAME NHS staff generally were 1.24 times more likely to enter the formal disciplinary process compared to white. Aggergaard Larsen et al.'s (2005) study of overseas nurses reported that they felt looked down upon, not respected and discriminated against by their UK colleagues, managers and patients. Recent research in ethnically diverse hospitals in Ireland showed evidence of "ethnic grouping" in the workplace, as well as "subtle bullying", being assigned less favourable shifts or being asked to perform tasks irrelevant to job description (Bobek and Devitt, 2017)

There are various studies that have specifically explored bullying and harassment in NHS workplaces, looking at types of harassment, prevalence, staff affected, impact on 'victims' as well as workplace cultures. WRES 2018 reveals that in a 12-month period, 29% of BAME staff experienced harassment, bullying or abuse from patients, relatives, or the public and 27% from other staff. One study situated in the Whittington Trust found that staff of Pakistani and other Asian backgrounds were the most likely to report exposure to incivility and disrespectful behaviours. Bullying and harassment negatively affected the workplace culture, specifically organisational citizenship behaviours, willingness of staff to speak up, communications and job satisfaction (Lewis, 2018). Similarly, Deery et al. (2011) found that verbal harassment was widespread for BAME nurse and workplace aggression and harassment had an impact on their job burnout and turnover intentions. Harassment perpetrated by patients/relatives had a greater effect on job burnout, while harassment by managers and colleagues had a much greater effect on turnover intentions. Outside of the British NHS, in a study undertaken in Ireland, respondents repeatedly referred to bullying as a cultural norm in nursing workplaces but employees frequently remain silent on the issue out of fear of management retribution and a sense of futility around reporting incidents. In the case of midwives specifically, 51% had experienced harassment, bullying or abuse from services users and/or their families in the past 12 months and 31% from managers (RCM, 2018).

Despite a plethora of campaigns, policies, events, etc. around equality, diversity and inclusion, race/ethnic inequalities in workplace experiences and career outcomes in the NHS generally and nursing and midwifery specifically, continue to be a widespread problem that affects quality of working life of BAME nurses and midwives and ultimately patient care. The NHS unions, RCN and RCM among them, are active and visible in this national policy domain.

Nursing and midwifery trade unionism

In 2018, union membership in the public sector fell by 50,000 and density declined slightly to 51.8%. However, it remains strong compared to the private sector (13.5%). The NHS itself has always been characterised by high union density (Seifert, 1992; Lloyd, 1997), albeit declining, sustained by the growth of numerous specialist unions, representing specific occupations/professions (nurses, midwives, physiotherapy staff, radiographers, doctors) and the presence of large general unions such as UNISON. The two unions investigated – the Royal College of Nursing (RCN) and the Royal College of Midwives (RCM) – are part of the numerous unions - some very small - that make up the NHS union landscape.

Although other public services unions, most notably UNISON, can claim nurses and midwives among their healthcare sector members, RCN and RCM are the main trade unions representing nurses and midwives respectively. Albeit different in terms of size and constituency, RCM and RCN fall under the category of "professional unions" (Burchill 1995), which have the characteristic of formally pursuing both occupational and economic aims. While the professional dimension was paramount in the creation of the two Colleges with the idea of promoting the education and training of professionals, as well as the establishment of registers of authorized professionals, the trade union dimension has gradually developed around issues of pay determination and collective bargaining (Seifert 1992). The institutional arrangements that organize the distinct and sometimes competing (Kessler & Heron 2001) aspects of the unions – industrial relations, education and professional – differ somewhat from one organisation to the other.

Founded in 1916 as a professional association and registered in 1976 as a union, the non-TUC affiliated RCN represents around 435,000 nurses, nursing students, midwives, and healthcare assistants (around 90% female). RCN has around 1,300 workplace representatives (learning reps, health and safety reps, stewards) in England. RCN Council, comprising 17 elected members, is the governing body; there are a number of committees that advise Council and carry out its work, including the Professional Nursing and Trade Union committees. RCN rules have allowed industrial action since 1995 as long as it does not harm patients, but in practice the union has never taken strike action and in fact authorised the first ever strike ballot of members in January 2019 (of nurses in Jersey).

RCM was founded originally in 1881 and established under its present name in 1947; it represents around 48,000 midwives, student midwives and maternity support workers (around 99% female). RCM has 745 workplace representatives nationally (learning reps, health and safety reps, stewards). RCM Board, comprising 12 elected members, is the governing body. Importantly, for the union's identity, all members of the RCM Board are practising midwives or maternity support workers elected to the Board by members of the RCM. Like RCN, RCM has also allowed strike action since 1995. In contrast to RCN, it has taken strike action: it held its first strike in October 2014. RCM affiliated to the TUC in 2015.

There are few industrial relations studies focusing on RCN and RCM as trade unions. The literature on industrial relations in the NHS tends to look at the group of healthcare sector unions together or focus on UNISON as arguably one of the more 'unionate' and militant unions in the sector. Industrial relations studies have appeared at certain points in time following those major changes in the structure, organisation and management of the NHS with significant implications for unions. Such studies, while not necessarily focused on RCN and RCM, provide insights in the organisation and activities of NHS trade unions. For example,

the 1990s introduction of self-governing Trusts and with them the decentralisation of employment relations that brought about many challenges for all NHS unions accustomed to a highly centralised industrial relations system dependent on unions' regional and national full-time officers rather than on workplace unionism (Bryson et al., 1995; Heaton et al., 2000; Lloyd, 1997). Studies show that not all unions responded to decentralisation by granting more autonomy to lay officers as might perhaps have been expected (Carter and Poynter, 1999). Bach and Givan's study (2008) of New Labour reforms in the NHS showed that public service managers tended to put more pressure on staff to achieve targets, deterring union members from taking on additional union responsibilities. The implementation of complex HR matters devolved to local level also increased union reps' and full-time officers' workloads. Further, Lloyd (1997) found that workplace union-management relations tended to be influenced by particular individuals on the management and union sides.

Nevertheless, while there were some issues around which items were included in bargaining and which in consultation, studies identify Trust managers' continued commitment to pluralism and the industrial relations framework remained firmly collectivist (Carr, 1999). James and Kyprianou's (2000) survey of RCN health and safety reps reached a similar conclusion that NHS management had not used decentralisation to adopt a more aggressive and hostile approach to the activities of unions generally or those of safety reps specifically.

The 'modernising agenda' of the late 1990s/early 2000s has also been studied in terms of effects on employee participation and union voice (e.g. Bach, 2004; Tailby et al., 2004). This involved partnership working which obliged unions to cooperate with management in order to achieve reforms deemed as of universal benefit for all NHS stakeholders (Tailby et al., 2004). According to Bach (2004), within the new approach the traditional structures of union-management consultation became less central to the management of employment relations, with a shifting balance between direct and indirect forms of participation, which had uneven effects on unions across Trusts depending on senior managers' approaches in context of the new structures and partnership ideals. In the main, managers used communications to keep employees informed rather than involve them in decisions (Bach, 2004; Tailby et al., 2004). Thus, as Munro (2002: 288) points out, her research and other studies demonstrate that 'there is a delicate balance for unions where management sets the partnership agenda and the parameters of discussion'.

What is clear from available studies whether older or more recent, is that for effective workplace union organisation within the decentralised partnership framework, unions require management to be willing to provide facilities, to engage in constructive negotiations, and respond to union concerns (e.g. Lloyd, 1997; Munro, 2002). When it comes to facilities, even with the existence of good formal agreements, accompanying major changes within the NHS were increased workloads and staff shortages. This made it difficult for workplace union reps, who now needed to play more of a role in local bargaining and consultation arrangements than formerly, to get the paid release necessary to perform their union duties effectively (Bach, 2004; Bryson et al. 1995; Heaton et al., 2000).

Kessler and Heron's (2001) research offers one of the few studies to provide insight into how RCN shop stewards coped with the structural and policy changes in the late 1990s NHS environment. Similar to other public service unions used to a centralised framework, they characterise the RCN's steward organisation as late and slow in developing. They observe that the industrial relations and professional 'faces' of RCN were used in combination to stimulate greater member involvement, although the emphasis was on the professional. With regard to

stewards, while the study found them to be considerably reliant on regional officials, stewards had developed the capacity to deal with individual grievance and disciplinary actions, and their involvement in bargaining on non-pay issues had increased in importance. The majority of stewards felt that their employer's attitude towards their role was supportive/quite supportive and few had problems in getting time off to carry out their duties. Thus, this study focused on RCN paints a relatively encouraging picture of steward activity although overall there was a greater focus on member-facing activity relating to individual issues rather than management-facing collective activity.

Looking at the nursing occupation internationally, a small number of studies have explored nurses' willingness to engage in industrial action. While a traditional view among industrial relations academics is that an ideology of professionalism (such as that held by nursing and midwifery staff) tends to discourage collective organisation and militancy (Carter and Poynter, 1999), some studies show that this is a simplification of the contemporary reality. McKeown's (2009) study of a strike by UNISON mental health nurses in Manchester demonstrated such willingness, which is consistent with international evidence that nurses will take strike action in certain circumstances, particularly when quality of patient care is under threat (Briskin, 2012; Henttonen et al., 2013). However, McKeown also notes an emerging 'privatization' of union membership partly caused by members' relative disconnection from their peers, which can mitigate development of solidarity and collectivism. On the other hand, Briskin (2012) claims that professionalism has provided a basis for an occupational solidarity among nurses that can also be a basis for union mobilisation and organising. The case of nurses' coordination in France, which emerged in the 1980s on the fringes of generalist trade unions, underlines the extent to which these forms of organisation have been able to take advantage of the sharing of a strong professional identity to organise a (rare) wave of strikes, but without succeeding in becoming an institutionalized organisation (Kergoat et al. 1992). Collective mobilisation in public hospitals in Great Britain and elsewhere remains more often the domain of doctors who arguably benefit from greater resources to make themselves heard, particularly through the media and political networks, and to speak "on behalf of all", because of their hierarchical position and moral authority over staff who are professionally subordinate to them (Sainsaulieu 2012).

Although some of the major developments in the structure, organisation and management of the NHS studied in the industrial relations literature now seem like 'old news', the ramifications for the trade unions were far reaching. The extent to which the unions developed the 'organisational capacity' (Hyman, 2007) to respond effectively is certainly worthy of study in the current period of crisis as is the union identity of nurses and midwives and how that interconnects with the unions' organisational capacity.

Conclusion

This brief review of existing literature and evidence must necessarily conclude by underscoring the gravity of the pressures within the NHS and specifically the adverse impact on the nursing and midwifery workforce. In regards to nursing, pay and working conditions are poor rendering it a not particularly attractive occupation, which spells both recruitment and retention problems especially as the nursing workforce is ageing (Marangozov et al., 2017). When it comes to midwifery, there is a dual trend insofar as the proportion of midwives in their 20s/30s has increased from 34% in 2010 to 45% in 2017, but at the same time the proportion of midwives in their 50s/60s has also risen (from 28% to 32%) (RCM, 2018). The prevalence, persistence and pervasiveness of race inequality and discrimination in NHS workplaces is troubling and

solutions seem to evade policy-makers even though an abundance of statistics is collected. The context is a challenging one for the professional unions who have faced decades of upheaval and crisis. Nevertheless, the starting point for our research looking at working lives and unionism on the ground is that both RCN and RCM now have a relatively well-developed workplace reps framework that shows potential in terms of giving voice to nursing and midwifery staff and defending nursing/midwifery as professional occupations.

PART 3: RESEARCH FINDINGS

The findings part of the report comprises two main sections. The first section – Working Lives in Nursing and Midwifery – provides a portrayal of the workplace conditions nursing and midwifery staff currently face as depicted by nurses and midwives themselves. This section serves as a backdrop for Section 2's discussion of unions representing nursing and midwifery. Section 1 adds to the existing evidence base exposing the erosion of many aspects of working conditions and job quality in nursing and midwifery. The second section – Representing Nursing and Midwifery – discusses workplace reps' perspectives on RCN/RCM purpose as well as the challenges of organising nurses and midwives and representing them at the workplace in the context of current pressures. With its focus on the two main nursing and midwifery professional organisations/unions' workplace activity, as opposed to national strategies, this section represents the major contribution of the study.

SECTION 1: WORKING LIVES IN NURSING AND MIDWIFERY

This section of the findings discusses five major dimensions that shape, if not define working lives in nursing and midwifery identified by this and previous research: staffing levels; bullying and harassment; working hours; low pay and undervaluing; equality and inclusion for BAME staff. These dimensions interact and combine to create an extremely testing environment. We devote more space to the latter two dimensions – low pay and undervaluing and equality and inclusion for BAME staff – firstly because these were much talked about by research participants and secondly, because there is less discussion of these two issues in the wider public domain. Table 3 below shows how workplace reps rated the seriousness of problems implicated in these five dimensions.

Table 3: How serious are the following problems for midwifery/nursing staff in your workplace/Trust/Health Board? Tick the THREE most important.

	RCM		RCN	
	%	N	%	N
Work-related stress	13.44%	50	15.15%	20
Working bank shifts to make ends meet	2.42%	9	4.55%	6
Unpaid additional hours	5.11%	19	3.03%	4
Too much responsibility relative to pay band	3.49%	13	7.58%	10
Too few opportunities for development	9.41%	35	5.30%	7
Staffing levels	26.88%	100	28.03%	37
Race discrimination	1.34%	5	2.27%	3
Pay dissatisfaction	4.57%	17	7.58%	10
Other types of discrimination	0.81%	3	0.00%	0
Other	1.34%	5	0.76%	1

Lack of access to flexible work arrangements	8.33%	31	5.30%	7
High workloads	15.86%	59	5.30%	7
Bullying and harassment	6.99%	26	15.15%	20

In general, research participants' qualitative accounts painted a picture of two professions under pressure with low levels of job satisfaction commonplace; widespread stress-related ill-health in particular mental health problems; excessive and sometimes potentially dangerous workloads; a culture of blame that has destabilised collegial staff relations; high levels of burnout and intention to quit especially among nurses. These conditions have many implications for RCN and RCM, which we discuss in more details in Section 2; Table 4 shows the three main casework issues that workplace reps were dealing with (capability, sickness absence and bullying and harassment for RCM reps and clinical errors, sickness absence and bullying and harassment for RCN reps).

Table 4: Thinking back over the last year, what are the THREE main casework issues you have dealt with? Tick as appropriate.

	RCM		RCN	
	%	N	%	N
Capability	17.56%	49	11.11%	8
Clinical errors	11.47%	32	12.50%	9
Sickness absence	28.67%	80	30.56%	2
Bullying and harassment	12.19%	34	22.22%	16
Discrimination	6.45%	18	4.17%	3
Health and safety	5.38%	15	8.33%	6
NMC revalidation	4.66%	13	4.17%	3
Other	8.96%	25	2.78%	2
I haven't had any casework in the last 12-18 months	4.66%	13	4.17%	3

We begin this section with the question of staffing levels: staffing shortages and/or lower staffing levels (than formerly) create the pressure pot conditions that in turn give rise to many other indicators of poor quality working life in nursing and midwifery currently. As we make this latter statement, we must acknowledge that many of our research participants were older, long-standing nurses and midwives who could remember times when staffing ratios were higher.

Staffing levels

Staffing levels in nursing and midwifery have major implications for working lives: so many

of the current challenges currently facing the professions intersect with this fundamental issue. However, it needs to be acknowledged that shortages in terms of vacant posts and /or staff supply problems are more acute in nursing compared with midwifery. Interviewees consistently reported that they and their co-workers/members struggled on a daily basis to cope with all the demands that essentially arose from a creeping work intensification linked to lower staffing levels that even longstanding nurses and midwives struggle to cope with:

> … you've got people like me that are old school struggling in the workplace, me and another sister we've been there 25 years and we struggle. We struggle on a daily basis trying to manage a 40-odd bed neonatal intensive care unit with staff that the skill mix is being driven down, so you've got clinical support workers that have been brought in to backfill Band 5 nurses because they can't recruit and retain staff in specialist intense areas like ours. We've got a national shortage of midwives. They're trying to reduce bank rates of pay to save money. So we get paid lower. If I do another extra shift, we get paid lower in our band, at the bottom of our band, so we get paid less than a Band 5 with all our level of experience. So people are going to agencies where they can earn three and four and five times the amount of money to do one shift and not take the responsibility ⋯. if you do an extra shift on the Trust bank, they know what you are capable of, but if you' re a new nurse from an agency, they don't know so they would only give you the minimum to do. (*Steward, senior nurse, band 7, female, white, 46-55, hospital, urban England*)

As can be seen from the above quotation, the narrative of daily struggle is entangled with professional concerns about quality of care. A concern around safe staffing levels and around availability of an appropriate skill mix was one of the main issues that research participants raised time and again:

> The main issues out there at the moment are a lack of nurses, so skill mix, safe staffing levels. We regularly hear about our members where say they're doing a nightshift and there are supposed to be two nurses and two healthcare assistants ⋯ you might actually have one nurse and two healthcare assistants or one nurse and one healthcare assistant. There just are not enough people. (*RCN, senior officer*)

The following nurse interviewee spoke about a critical incident that had occurred while her ward was short-staffed. The quotation highlights a widespread experience of hospital wards frequently lacking an appropriate nursing/midwifery skill mix to deliver safe and effective care:

> We didn't have enough staff when we started the shift ⋯ and I was like spinning plates ⋯ as the shift leader everybody wants a piece of you and I was trying to support the staff in all those different rooms and I haven't got over that. And before then I was saying to the staff something big is going to happen before anything is done around staffing and skill mix and it did. (*Steward, senior nurse, band 7, female, white, 46-55, hospital, urban England, RCN*)

For many nurses and midwives, these professional concerns come above concerns about their own pay and working conditions:

> [The main concern] is definitely staffing levels. I think everybody moans about the money and it is relevant… but actually, I think if there was more staff available to take

> on the pressures I think people would be a lot happier and that's what people discuss in work more than anything. When I came into nursing I can remember staff nurses saying "we're so short staffed" and I'd be on a ward of forty patients and there'd be six or seven qualified nurses and they were short staffed. Now you're lucky to have one qualified nurse… and midwifery the same. I came into midwifery and people used to say how short staffed we were. We have even less staff now looking after more women and the workload has increased. (*Steward, midwife, band 7, female, white, 46-55, hospital, Wales, RCM*)

However, working conditions and safe patient care are inextricably linked as the following quotation from a midwife interviewee illustrates:

> I said to the girls about the break, you take the risk by yourself because you need to go to the coordinator, tell her you don't feel safe to practice anymore, you need your break. The more you work, the more likely you're making mistakes and you provide poorer care. You need your break. (Steward, midwife, band 6, female, white, 36-45, teaching hospital, non-urban England, RCM.)

Interviewees described many possible consequences of being continually short-staffed including nurses/midwives retiring as soon as possible, quitting the profession altogether, opting for agency work so as to have less responsibility, high levels of sickness absence, migrant staff leaving for other countries where they believe things will be better:

> There were a lot of nurses who came to the UK from for example Spain, Portugal and Greece when they were at the worst of their financial crises, but the opportunities are opening up again for them back home so some do go back to their home nation. But others also seek to go to for example Australia or the USA where whether they are or not they perceive that they may be more welcome, have more certainty about what the next few years will bring for them. (*RCN, senior officer*)

When it came to sickness absence, many reps observed higher rates of mental health issues than earlier in their careers:

> … now there's a lot of mental health issues and a lot of stress related [sickness absence] where before, maybe if you're talking ten years ago, it would be more like they're long term sick because of this and that physical issue but now I feel it's more like mental health and more like stress and stuff. (*RCN focus group participant*)

Health and safety risks were another problem exacerbated by staffing shortages and can lead to sickness absence, which compounds the staffing shortages causing the problem:

> They are having less down-time so there is a higher risk of burn-out as well as like muscular injury because if you're rushing around doing more than one job you start taking shortcuts, like if you should be hoisting the patient it would be very easy to think oh, I'll just quickly get someone and transfer them in a different way and obviously you've then got a higher risk of back injury, which then you go off work with stress which then impacts. (*Steward, RCN, nurse, female, white, 46-55, hospital, non-urban England*)

Stress and pressure pushing staff to the limits was a recurrent theme. Nurses and midwives

unable to stop even to drink water or use the bathroom came up frequently as research participants described the everyday challenges they faced:

> So then we had a huge increase of workload, means that we didn't have a break. When you're having no breaks you can work only certain time until it breaks you and you become ill. Even a small cold it will push you and you become ill and then suddenly there'd be only four or five of us across the two wards, five midwives at night who will be working and that's very unsafe. (*Steward, RCM, midwife, band 6, female, white, 36-45, teaching hospital, non-urban England*)

The following quotation continues this theme and reveals the vicious circle of inadequate staffing levels, poor working conditions and sickness absence:

> Sickness rate at this moment in time is okay, it's about 3% so at this exact moment in time it's okay but we have been as high as 12% sometimes and that makes it extremely difficult on everybody else that's working. Our staffing is extremely tight, it's very, very lean, there is no resilience in the staffing level. So as soon as one person is off sick on short term or long term sick it impacts on the entire service. We open it out to bank staff and to agency staff and then you just hope that somebody fills it… (*Steward, RCM, midwife, band 6, female, white, 26-35, teaching hospital, non-urban England*)

In the face of tight staffing conditions, managers often take a hard line, some reps called it aggressive, when dealing with sickness absence even as sickness becomes more widespread and complex. There was immense pressure on individuals to return to work and on managers to bring an end to long term sickness:

> … gone are the days when you can just be off sick like that ⋯ I'm dealing with far more cases where Trusts are terminating contracts because they got to the end of the line managing people on a long term sickness basis. (RCM focus group participant.)

> There's a national drive to reduce sickness absence stats, the length of time someone is on absence, so employers are trying to move people through sickness absence processes more, get people back to work if they can. But we're also seeing our members living or working more with long-term health conditions themselves and so more cases requiring greater input and greater thought around reasonable adjustments at work, managing disabilities in the workplace … (*RCN, senior officer*)

Bullying and harassment

In context of the pressures created by staffing shortages, bullying and harassment – generally, but particularly of BAME staff – was seen as endemic in the NHS, especially hospitals and other larger workplaces. Table 5 shows high levels of agreement among workplace reps with the proposition that there is a bullying culture in healthcare workplaces.

Table 5: There is a bullying culture at my workplace/Trust/Health Board

	RCM		RCN	
	%	N	%	N
do not agree at all	1.63%	2	2.27%	1
do not agree	20.33%	25	9.09%	4
neutral	29.27%	36	29.55%	13
agree	34.96%	43	31.82%	14
strongly agree	13.82%	17	27.27%	12
Total	100%	123	!00%	44

Many participants had current or previous managerial experience and called forth the high-pressure conditions under which NHS staff, including managers, now work:

> If middle managers are being squeezed, no wonder the staff are being bullied, they certainly feel bullied and harassed because what they are being asked to do is impossible. (*RCM focus group member*)

Some longer-standing nurses/midwives talked about personally experiencing bullying and harassment or observing it in the workplace recently, for the first time in their careers implying again that it was a product of the more pressured conditions in many NHS workplaces:

> The current culture of management within our profession is to bully midwives. I'd never encountered it and I've been on the job for a long time, and this is the first time in the health service that I can say I am being bullied. And I've said it at meetings. I have asked a question and three people jumped in to give me an answer of "you don't need to know that". I said I'm finding this very threatening but the really funny thing was when you say I'm finding this really threatening not one of your colleagues who are supposed to be in a caring profession can say well, I'm sorry you find that or maybe we need to … No, it's like, it's accepted in some ways. (*RCM focus group member*)

The high-pressure conditions could also spill over to affect patient/family member behaviour around staff. Many reps reported that they were experience more aggressive and even violent behaviour than previously. Senior staff then have to manage such incidents adding to the stress under which they operate:

> This is [inner London] so the violence and aggression towards you as a health professional … Well, I never saw that years ago. Now I have to say to people, can you stop shouting at the midwife, stop shouting at the doctors, can you be calm, all of that … (*Steward, RCM, midwife manager, band 8, female, white, 46-55, teaching hospital, urban England*)

Sometimes, patient/family member bullying and harassment was also racialized and disproportionately experienced by BAME staff whose judgement and skills might be questioned or who might be overtly racially abused by patients and families. The critical issue for reps was the extent to which affected staff received appropriate managerial intervention and

support as and when incidents occurred. Inevitably, this seemed to be uneven and somewhat dependent on the interpersonal skills of managers as well as their sensitivity to the issues at play. The following nurse manager's account exemplifies a zero tolerance approach that many nurse/midwife managers shared:

> We had a couple of patients say 'I'm not having that black so-and-so …' and I go up to them and say look, this is not private healthcare, I appreciate you have your views but this nurse is trained, knowledgeable and experienced to look after your baby. If you do not wish to have said nurse look after your baby then I suggest you go and seek private healthcare, but I am not allowing you to refuse that nurse to look after your baby because as the nurse in charge I take full responsibility for every member of staff, every patient on this unit. That is not acceptable. *(Steward, RCN, nurse, band 7, female, white 46-55, teaching hospital, urban England)*

Reps named it a 'culture' of bullying and harassment because they saw it as normalised to the point where there was some acculturation to it among nurses and midwives, almost acceptance, with staff shrugging off incidents whether emanating from other staff or patients/families as 'just the way it is' which reps believed contributed to under-reporting:

> Yes. If you look at the statistics it's very, very, very underreported as we well know. And a lot of them do not want to raise it because of the fear of losing their job, the fear of them being ostracised, fear of them being victimised or made to feel even worse than they feel already. (*RCM, Steward, midwife, band 6, female, black, 46-55*)

Further, some reps felt that BAME staff had an even greater reluctance to report bullying and harassment:

> I think a lot of it is cultural. I think as a black woman, a woman of colour I think quite often we do not report things in the same way that our Caucasian colleagues report them. We tend to just get on with it. And I think sometimes when we seek help it's already gone down the rocky road already. (*RCN, steward, nurse, band 6, female, black, 46-55*)

Manager-to-staff bullying was the most common source reported and generally consisted of undermining behaviours such as staff being unfairly criticised, shouted at privately and/or publicly, having practices or decisions questioned without due cause, being pulled up for minor conduct issues, acts of incivility, escalation of minor issues. A participant's account is illustrative:

> I am quite often put in charge of the ward – I've been qualified four years now – because we've got a lot of preceptor girls, they consider me as senior. Recently, I've been in charge on night shifts and we've been very busy so I've been trying to communicate with the Band 7 on the delivery suite to make sure they know what's going on. We gave them a midwife so we were actually short staffed because they needed someone and what I got back was somebody shouting down the phone at me, hanging up the phone twice on me, telling me it was nothing to do with me, she's dealing with everything, I don't need to know what's going on there … and she escalated it to the midwife manager on call. *(RCM focus group participant)*

The bullying culture that develops as these types of incidents become commonplace could metamorphose into a culture of fear and end up silencing staff:

> … sometimes people talk when they're having their tea break, they do talk a little but they have also found that that discussion is going straight to the matron, so at the moment people are so sceptical of who to talk to, because what she has done it's like she's looking out to hear who is saying what against what she's done. So people are so scared to talk. If they start talking and then they hear their name being called, come here, matron wants to speak with you, they won't talk, they won't talk. And that is what is going on. *(Learning Rep, RCN, nurse, band 5, female, black, teaching hospital, urban England)*

> I think as stewards we are equipped to deal with it, but the person being bullied is often very vulnerable, very anxious and very frightened and is already scared of this person, is worried about the repercussions. So it's getting the confidence of that person to have the courage to say this was done to me. [As a rep], you can have this conversation, this is what I feel I can do, and this is what our bullying and harassment, our HR policies are, I can take this forward but obviously you will be asked questions, you might have to make a statement. And they often don't want to do that. So that's where it ends. Because they just don't want to pursue it. *(RCM focus group participant)*

As well as disproportionately impacting upon BAME staff, many participants also saw that the culture of bullying and harassment disproportionately affected older nurses/midwives:

> One of the things that I've noticed is that women of my age because I'm 55 now, we know that we're more likely to be disciplined. We know that we're more likely the ones that are put down the route of capability. We know that we're more likely the ones that are going be moved from somewhere that we feel fairly comfortable with to somewhere else. We know that we're more likely as one of my colleagues said that they'd been, hadn't worked for nights for years and they told her to work nights at the age of 57. You know, we know that for a fact. And although we're not talking about the general, although we're not talking about non-clinical areas, you see it in non-clinical areas as well, it's not just maternity. It's not just nursing, it's in the non-clinical areas as well. (*RCN, Steward, midwife, band 6, female, black, 46-55)*

While bullying was more often manager to non-management staff, several reps made the point that senior managers were sometimes bullied too by their subordinates and this could lead to ineffective managerial performance and ultimately to a stasis that perpetuated the bullying culture:

> Staff are very stressed, especially middle management so Band 7s, they feel that they're being stressed from below and above. Some complain that they're being bullied by the lower bands and that's led to their lack of confidence… (*RCM, senior officer*)

Further, there are also incidences where bullying from below is racialized with black staff sometimes experiencing push-back, even if not hostility when managing white staff:

> I have seen it on my unit … I had a case recently where this particular person she obviously doesn't like to take orders from a black nurse and we came on the night shift and as soon as the Band 5, which is a white nurse, saw that the Band 6 was a black

> nurse, that she was in charge, well, she was chuntering and chuntering and chuntering and saying I don't see why I've got to take orders from her and stuff like that. *(Steward, RCN, nurse, band 6, female, black, 56-65, hospital, urban England)*

While reps and officers acknowledged the problem of bullying and harassment, in individual cases they were reluctant to leap to the conclusion that the reprimanding of a nurse or midwife necessarily amounted to bullying. One nurse manager related a personal experience of being accused of bullying:

> The only time I've ever had any conflict in the whole time I was manager, I had a very, very poor senior sister, I thought she was very poor at the job. I really tried to work with her with capability and then she had some sickness … And I asked for confirmation of a health report, opened up the report and she said she was being bullied by her manager, which was me. And seeing that word there I was absolutely distraught, I rang my manager and said you need to investigate me, please investigate me because there is no way I am bullying this woman, I am just managing her for poor performance. And I was totally vindicated. *(Steward, RCN, nurse, band 8, female, white, 56-65, hospital rural England)*

As professionals committed to upholding the standards of their profession as well as simultaneously union stewards, RCN/RCM reps/officers felt it was important to unpack carefully the member's story in order to differentiate cases where an individual's poor performance and/or errors were being appropriately managed from cases of bullying:

> If somebody comes to us and says my boss is bullying me … sometimes their boss is managing them because they're rubbish at their job but that's another entirely different … But also we say we need the evidence, so what have they done, when have they done it, blah, blah, blah. And then we have to have the difficult conversations that are either that's not bullying, that might be that you're being managed and quite strongly but it's not bullying because you had made that mistake ... Or we might go, wow, that's not good. OK, let's pull together something formal and we'll get a process started. (*RCN officer*)

Table 6 shows that workplace reps have fairly high confidence in their ability to handle bullying and harassment cases, but clearly there is still work for the unions to do on ensuring that capacity is increased.

Table 6: How confident are reps in handling bullying and harassment complaints/cases?

	RCM		RCN	
	%	N	%	N
not at all confident	2.86%	4	1.92%	1
not confident	12.86%	18	15.38%	8
neutral	27.14%	38	15.38%	8
confident	32.86%	46	30.77%	16

very confident	10.00%	14	19.23%	10
Not relevant to RCM/RCN role	14.29%	20	17.31%	9
Total	100%	140	100%	52

Working hours

Working hours and work-life-balance are twin issues that also need to be situated within the pressured healthcare context. One of the main topics raised around working hours was the implications for work-life-balance and service delivery of the widespread norm of three 12-hour shifts comprising the standard working week in hospitals and some other healthcare workplaces. On the one hand, reps recognised that compressed working hours afford staff the opportunity to manage childcare or earn extra money doing bank shifts:

> A lot of them want to do the long shifts because they can then have an extra day at home where they don't have to travel in … you literally see some staff hobbling at the end of twelve hours but they don't always make that connection that actually if you did regular hours, it might be healthier for you. But for some of them it's not practical because they've now arranged their childcare around working these long shifts, asking them to work five days a week, 7.5 hours it just won't work for them now. (*Steward, RCM, midwife, band 7, female, other ethnicity, 46-55, clinic, urban England*)

Other reps had seen how twelve-hour shifts could make it more difficult for staff to organise caring arrangements. The main problem was that most staff in most workplaces lacked choice:

> Well, 12-hour shifts are a discrimination in and of themselves because so many people having caring needs or whatever, children, parents … for a lot of people that means a twelve hour shift is virtually impossible to manage and yet, we have Trusts everywhere absolutely saying no, that's the only shift pattern you can work. It's ridiculous. So they are losing nurses hand over fist because they can go and earn almost as much money at their local Lidl working whatever shifts they want to work. (*RCN, senior officer)*

On the other hand, some longer-standing nurses and midwives saw this change in working hours as more negative than positive for staff and linked to many of the problems now experienced by so many such as sickness absence, work-related stress, incidence of clinical errors, inability to access training. As two midwife reps explained, the 12-hour shift routinely becomes 13 hours or more on the ward with no breaks:

> When I look at it as both a manager and as someone that represents, I see us only doing long shifts, we do 12.5 shifts, it's exhausting, it's relentless and we do it day or night. So it's not surprising people are sick because what we say to people is oh, you are resilient, blah blah blah, but that's like wearing a badge of honour and resilience isn't a badge of honour, resilience is something that we should draw on in hard times, not as a consistent daily presence, you know. So I think what we've made as standard is a level of stress, physical, emotional, social, and we forget also that most of our workforce are women. Women have caring responsibilities, be it children or family, or whatever. And when you do these huge long shifts and you're exhausted people have got this other

> area of their life … And then some people go sick. So sickness in this Trust is really high and we're not unique. (*Steward, RCM, midwife manager, band 8, female, white, 46-55, teaching hospital, urban England*)

> I just remember when we were all on 7.5 hour shifts. It was always relief at the end … you'd struggle on and finish at 7.5 hours without a break. But now sometimes the staff are expected to struggle on without a break for the whole 13 hours. Which I feel is so dangerous and so unhealthy. So even if the staff are willing to do the 12 hour shifts, they're actually on site for 13 hours, but even if they're willing to do that because they value an extra day at home I don't think it's healthy and I don't think it should be encouraged. But why they introduced it locally was because they wanted to get rid of the overlap. So we used to have an early shift, a late shift and then there was about 1.5 hour overlap in the afternoon. And they knew that they could save money if they could get rid of that overlap but what they didn't realize was that overlap gave us time to take our breaks but also allowed for things like in-service training and looking after our students or whatever. We got rid of that and it's just pressure all the time now on the shift. (*Steward, RCM, midwife, band 7, female, other minority ethnicity, 46-55, clinic, urban England*)

On the question of extra bank shifts, reps reported that staff were sometimes under pressure from managers struggling to staff wards to volunteer for extra shifts and in view of the pressures, the 48-hour maximum rule was not always monitored:

> Very occasionally, the managers don't know the number of hours in a working week [an individual has worked]. So sometimes I've had members come to me and say "I'm working an awful lot of shifts, is this okay", and I calculate it and sometimes I've had to say to them no, that's not okay, you've been allocated over 48 in your seven day period, you have to go to the manager and say you need to change something to protect you [in case of making errors]. (*Steward, RCM, midwife, band 6, female, white, 26-35, teaching hospital, non-urban England*)

Some Trusts require all staff to work night shifts on a rota system, but this was another requirement that could be particularly problematic for people with caring responsibilities:

> Some people have children to look after so they do their night shift, they have to take them to school, they then get into bed at, I don't know, at ten o'clock but then they might have to pick up another child at one o'clock because they've got small children in a nursery or something so it's very, very difficult and then they're expected to work again the following night. It's extremely difficult when the new contracts are saying that all staff have to work 50% nights. (*Steward, RCM, midwife, band 6, female, white, 26-35, teaching hospital, non-urban England*)

In addition to long, busy, tiring shifts, reps reported that many nurses and midwives regularly work through breaks and do unpaid overtime to cover for last minute staffing shortages:

> We know that many of our members work significant hours every week unpaid. And you know, they don't have a break or they stay an extra half an hour or they come an extra half hour or a combination of all of those. So they can be working two, three, four, five, six hours extra a week that aren't paid. (*RCN, senior officer)*

Reps expressed ambivalent views on the question of breaks. On the one hand, some were adamant that people should demand their breaks, rather than just tolerate working through them but all understood that in practice this was extremely difficult as one RCM rep highlights below:

> There's no reason why you should not be getting your breaks. But it's impossible, we all know it's impossible on some shifts, where you have half the staff that should be there, it's impossible to give them a proper hour's break in the night. You might be able to get ten minutes but that's not enough. People have been awake 24 hours, they're driving home the next morning, anything could happen to them, they're so tired, it's against the law. It's got to be stopped. (*RCM focus group participant*)

Many reps we interviewed were of the view that the younger generation of nurses and midwives are more conscious of their rights and they expect and demand better working conditions. Flexible work arrangements are among their expectations, yet according to reps, hospitals at least are taking a hard line on flexible working and turning down most requests. While some reps saw implications for retention of women during the child-rearing phase, others (particularly those in management positions with the difficult task of organising rotas and ensuring safe staffing levels) were less sympathetic believing that the needs of the service had to come first. The quotation below illustrates the dilemma facing nurse managers who as managers need to consider service needs, but as union reps are conscious of staff needs:

> Although I believe flexible working should be offered I think personally that you should put something in place … so the Trust should give you a maximum of 12 months to get your life sorted - I know that's really harsh – because there's what about people who can only work a Monday, Tuesday, Wednesday because of childcare or whatever. I get it, it's expensive, childcare, I've been there, I've done it but you either come to work or you don't. I know that's not going to help recruitment and retention but when I deal with flexible working issues and I do get quite a few of those especially when they have another change and they don't get what they want, but I say the Trust have to manage the staffing, you have to look at it both sides. (*Steward, RCN, senior nurse, band 7, female, white, 46-55, hospital, urban England*)

In addition to those with childcare responsibilities, migrant nurses are another group who may seek some flexibility, but who in the current context find little sympathy for their requests. For this group, flexibility is about having the ability to take three to four weeks continuous annual leave in order to visit home countries. Refusal, which is commonplace according to reps who spoke about this issue, pushes some into full-time agency work giving them greater individual control over the organisation of their working hours:

> … so many of my friends like me too leave the NHS as when you want your holiday okay … I am entitled to four weeks in a year. Can I take my four weeks in a row? No. If you want to take your four weeks, you need to write a letter the reason why… I mean, pff, I am a grownup woman, I don't need to explain. So I mean, all these policies are contributing to us, to people like me to say I can't take this hassle no more because I want to go home, I can't pay £1,200 or £1,500 to go back home and then spend like two weeks or one week. It's not worth it for me. (*Learning rep, RCN, nurse, female, black, 46-55, agency*)

Low pay and undervaluing

Low pay and undervaluing are longstanding and deeply structural issues that strike at the heart of the professional project within nursing and midwifery. Compared with other public sector professional occupations, nursing and midwifery are certainly not highly paid, although average (median) pay is higher for midwives than nurses. Very worryingly, some participants said that they were aware of nurses and midwives using food banks. More often, nurse participants said that working bank shifts in order to earn extra money, sometimes merely to make ends meet is commonplace among full-time nurses especially in London and South East England where living costs are high. Despite an increased reliance on bank staff, participants saw that Trusts routinely pay a lower rate than the individual's regular Band, a practice that can be read as exploitative:

> They're trying to reduce bank rates of pay to save money so we get paid lower. If I do another extra shift, we get paid at the bottom of our band, so we get paid less than a Band 5 with all our experience. So people are going to other agencies where they can earn three and four and five times the amount of money to do one shift and not take the responsibility because if you do an extra shift on the Trust bank, they know what you are capable of, but if you're a new nurse from an agency, they don't know so they would only give you the minimum to do. *(Steward, RCN, female, white, 46-55, band 6, urban hospital, England)*

Beyond these specific issues, general pay dissatisfaction has become a critical issue in nursing, and to a lesser extent in midwifery. Even though both nurse and midwife interviewees were at pains to stress that people do not go into these professions motivated by money, many felt that relative low pay is a function of undervaluing, particularly of nursing. Many nurse participants believed that staff were leaving nursing over pay and with frustration that there has been too little action on the part of government/NHS to redress the issue. Migrant BAME participants trained outside of the UK spoke about how friends had left the UK in search of better pay and conditions:

> When I came here, way back in 1999, I heard it from the grapevine that the NHS paid about £3,000 per head to bring us here and that is taxpayers' money. In [my] Trust, I estimated that there were about 36 of us that were recruited and this year it' s only about 7 of us who remained here in this country. Most of them are in America or Canada, Australia. Why? Because they are being paid good. I had communications with them, and they said the working conditions are much better than here. The respect that the nurses have in those countries that I've mentioned is tremendous rather than here. (*RCN, focus group participant)*

Alongside concerns about low pay for staff on regular contracts, participants struggled to make sense of how much the NHS spends on agency staff overall and by the hourly rate they have to pay for such staff:

> In terms of pay look at it, OK, some agencies will pay £35 an hour for a nurse; why can't the NHS put this money into the permanent staff? Pay them more, entice them with the pay. And then, OK, they bring people from overseas. They do like four, five years, then they go out of the NHS, to an agency. What's the use, what's the sense? (*RCN focus group member*)

Yet precisely because it is better paid, agency work is attractive for some nursing staff. For example, some BAME individuals, particularly those who were recruited internationally and/or were main breadwinners, felt that the financial benefits of full-time agency work outweighed the disadvantages it involves of moving around hospitals and even around the country.

Despite concerns around pay, one participant named pay a 'dirty issue' for nurses capturing the widespread ambivalence surrounding complaining about pay in a caring profession. There was much discussion about the vocational nature of nursing and midwifery and the extent to which it was appropriate for individuals to be motivated by pay. Some longer-standing nurses and midwives were concerned that if pay were much higher, people might be attracted to the professions for the wrong reasons. The quotation below typifies the ambivalence of older nurses and midwives:

> Traditionally nursing and midwifery has never been that well paid, has it. Well, I certainly didn't come into it thinking I was going to be a millionaire. It was more, oh God, I hate saying that, vocation, but you're either naturally going to go towards that sort of role, or you're not. (*Steward, RCM, midwife, band 7, female, white, 46-55, hospital, Wales*)

At the same time, a widespread view was that it was time for nursing and midwifery to get past the gendered caring stereotype of the self-sacrificing female and demand a level of pay reflecting the contemporary skill level demanded as well as the intrinsic value of the work:

> I don't care if it's a vocation, it might be a vocation but I am doing my job and I deserve to be paid adequately for the training and the responsibility that comes along with that job. Just because it's a vocation doesn't mean you do it for free. (*RCN focus group participant*)

Despite higher levels of pay dis(satisfaction) for nurses compared with midwives, the general belief among most research participants was that both nursing and midwifery are undervalued and underpaid relative to the required level of responsibility and skill as well as education and training. One nurse participant who had retired at 55 but who had continued working part-time expressed, like others, an exasperated resignation:

> I choose to work because I like working as a nurse. But even so the pay, when I go home and think about what I've done that day and what I'm getting paid ⋯ you don't do this job for the money. And I think actually I' m at the top of my band ⋯ it's not good. (*Steward, RCN, nurse, female, white, 55-64, hospital, rural England*)

Participants with many years' work experience spoke about how nursing and midwifery have become more complex and skilled over time. For example, with regard to midwifery, pregnant women often have complex pre-existing health conditions (e.g. associated with obesity or poverty); having babies via fertility treatment is more commonplace and can involve complications. Such complexities need monitoring and managing during pregnancy. For nursing, the trend of shorter hospital stays and outpatient treatment amid shortage of beds and other factors means that patients who do find themselves hospitalized often have complex needs and are often unable to care for themselves even in the most basic ways. These complexities intensify nursing work at the same time as staffing shortages and reduced staffing levels. There was a strong feeling that those at higher levels of the NHS hierarchy have little appreciation of how nursing and midwifery have changed.

The undervaluing of feminized professions and jobs is a major debate in academic literature and certainly the gender stereotyping embedded in nursing and midwifery came up in many discussions with research participants. The quotation below highlights the interconnections between female predomination, gendered assumptions and pay/value:

> You do wonder if that's why this idea of pay being lower is because actually you're probably going to get your mid-twenties and you're going to go off and have a couple of babies and then you come back and do a couple of night shifts to keep your hand in… But actually this is people's career, their professional life; these are women who are providing for households, they may be the main bread winners, they may be on their own, society is a very different place, isn't it. (*RCN, Senior officer*)

The quotation above also highlights how the pervasive gender stereotypes about nurses and midwives no longer have the same purchase now that society and women's lives have changed and diversified. Yet according to some participants, the NHS Agenda for Change (grading and pay system introduced 1st December 2004) had not entirely resolved the undervaluing problem, in particular due to "downbanding" practices linked to the austerity policies implemented by the government since 2010 and that particularly affect women professionals from abroad:

> I've noticed as the years have gone on there's been a very big erosion of that agenda in relation to midwives particularly, nurses particularly. Those female roles where historically they've been undervalued and even though the Agenda for Change job evaluation has been delegated to a local Trust, I've got very serious concerns about the erosion… And I have to say, I find it very upsetting that our professional heads and I'm well aware that they've got a lot of challenges in relation to budgets, staff management, are actually colluding with this devaluation of midwives' roles. For example, some of our specialist midwives, which back in the day were Band 6, that's been dropped down to a Band 5 now. *(RCM focus group participant)*

> You've now got Band 5 midwives. We recruit globally for healthcare workers and we get these fantastic midwives from all over the world, Japan, Sweden, we've got them all here and they start off as a Band 5 in this hospital. So their previous experience also hasn't been acknowledged even though it should be under Agenda for Change. There's a national profiles, and it's down to individual really to highlight their qualification. When you come from another country it's different. If English is not your first language, you don't necessarily understand the terms and conditions of your NHS contract either. So they're not in a position, it's just over time, as I speak to them and I do ask the question but they don't often want to raise it as an issue because then they become victimized. (*Steward, RCM, midwife, band 7, female, white, 46-55, hospital, urban England)*

Further, because of the size of their professional group, nurses have never been evaluated as highly as other small professions within the NHS for fear of the costs involved:

> One of my issues around fair pay is things like when a speech therapist qualifies or physio generally they start on Band 6. Nurses start on Band 5. I have never seen a rationale why newly qualified physios should earn more than newly qualified nurses. Three years of study, degree level, but far less responsibility as a physio than a nurse. And whenever you raise that it's oh, you'd bankrupt the NHS because there are so many nurses you can't just pay them Band 6. But that's just not a good enough reason for me.

(Senior officer, RCN)

New roles, such as maternity support workers, are also the subject of devaluation strategies by managers in some Trusts, which some interviewees are trying to combat using the NHS job evaluation handbook. Unions are encouraging and training reps to challenge dated job descriptions and beware of evolving roles and add-in tasks, notably following the introduction of new work organisation patterns such as continuity of care for midwives. Some Trusts might be tempted to introduce new "inclusive" pay systems that aim to reduce the cost of unsocial hours and undermine Agenda for change:

> Im putting together a grievance that will be taken against my line manager and head of midwifery and HR and I will be asking for renewing, re-evaluating the job descriptions. So Ive already contacted HR that any job descriptions at all, especially within new pay scheme not Band 1 is Band 2, so which before was Band 1 and was cleaners. And all the job descriptions are done on a point scale, points scoring different what you do. So suddenly, Band 1s score extra points to be Band 2, but Band 1 cleaners they don't even wipe the blood from the floor or from the beds. Whereas maternity assistant [does] unit observations, maternal observations, bloods, assists in the theatre, cleaning up, loads of clinical skills, yet they're still Band 2, we don't have a single Band 3 in our hospital in our departments at all. Shocking. (*Steward, RCM, midwife, band 7, female, white, 36-45, hospital, rural England)*

The recent and difficult negotiation of a new pay deal, after years of pay freeze, was therefore much awaited by nurses and midwives, but also raised many questions, especially within RCN. Some interviewees expressed dissatisfaction with a pay deal that they considered insufficient with regard to their responsibilities:

> It's insulting. It's really insulting. I had members of staff who got pay rise of £10. We provide one-to-one care on delivery suite on a day in day out, it's £15 but if you pay the taxes so minus taxes and everything it's £10 per hour, I mean, providing one-to-one care, we deliver high risk ladies, prescribe the medication including morphine, we suture, we do all that by ourselves… (*Steward, RCM, midwife, band 6, female, white, 36-45, hospital, rural England)*

Others tended to put nurses' pay in a broader perspective arguing that entry wages are comparable to other sectors for graduates and that opportunities for advancement are possible. Going back to the fact that *jobs* are evaluated not individuals, this argument underestimates the fact that not all women are in a position to comply with the norms of a linear full-time career, given their individual circumstances:

> When this deal is finished in three years at the end of this period, newly qualified nurses will be on £27,000 a year. At the moment it's about £24,800. So it will be £27,000 plus if they're working shift patterns they'll be getting unsocial hours which can be £3,000-£4,000 a year. Now as a graduate, that is a decent starting point compared to most graduate salaries I would say. And I don't think nurses realise that. And there are opportunities to earn decent wages, even more decent wages in nursing. A Band 8A after four years at the end of this pay deal will earn £52,000 a year. Now that is a really decent wage compared to any profession. Obviously nursing being a female dominated profession what happens is the discussion gets distorted maybe because – and this is where I might be wrong in what I think actually – a lot of our members may well be

> single parents and if they're single parents traditionally it's the mother that is going to have the main caring responsibility so they may be under more financial pressure than, equivalent people in other jobs earning the same money if that makes sense. But should people be paid according to their social circumstance or should they be paid based on what the job is? (*Senior officer, RCN*)

Further, the abolishment from 2017 of the student nurse/midwife bursary covering university degree fees was also seen by some participants as symptomatic of the undervaluing of nursing and midwifery even though there is not universal agreement in the professions that this was necessarily detrimental (see Watson, 2018):

> We couldn't persuade Mr Hunt that it was worth paying the bursary because you would get the nurses in, because you attract a lot of slightly older nurses, perhaps had their children already. Children are at school and they think now is my time to do something but I can't afford to do it, can't live on just my husband's money. So seen a huge drop and that is such a shame. So the bursary was one thing. And obviously that ties with pay, the pay situation is absolutely diabolical. *(Steward, RCN, nurse, band 6, female, white, 55-65, hospital South East England)*

Moreover, the end of bursaries is likely to have secondary consequences on staff shortages by limiting the diversity of new cohorts, whether in terms of age, race or social background:

> The average age of a nurse in training is in her late twenties, so some of them will have commitments already. Sometimes it will be a second career, and so on. We've worked out they'd end up with potentially £45,000, £50,000 debt at the end of their studies and so forth. But when you're on an average salary of £25,000-£30,000 you'll never pay that off. And so it's a major disincentive to anybody who wants to go in nursing. It's going to not attract people from the diverse groups, that we want our members, our nurses to come from. (Senior officer, RCN)

For participants, amid societal change, wrapped up with broader concerns about low pay and undervaluing, was the practical question around retention, particularly of younger and newer entrants to nursing. Like the nurse below, many research participants told us that they would not encourage their children to go into the professions, especially nursing, but some midwife participants felt the same. This was something that participants usually bitterly lamented while expressing some seemingly irresolvable dilemmas around pay and value:

> We cannot attract the younger generation … I've got three children. My wife and I are nurses but we cannot encourage them to take up nursing. Not because of pay. Probably yes, but at the same time whenever they see us, we come home so tired, so stressed. And aside from that are nurses really compensated? When I was looking for a job I came across my Trust who is recruiting for nurses to work in a particular ward for £14 an hour … and then I stumbled across a department store or a supermarket, they're offering £13 to £17 an hour. So where would the young generation go? (*Learning rep, RCN, nurse, male, other minority ethnicity, 46-55, hospital, urban England*)

Equality and inclusion for BAME staff

In view of the negative picture of race/ethnic equality in the NHS England painted by the Workplace Race Equality Standard (WRES), the research focused on this equality dimension

in some detail. The WRES seems to have succeeded in raising awareness among RCN and RCM reps about race and ethnic inequalities in NHS workplaces, particularly in the larger cities in England where concentrations of BAME people exist. Reps' on-the-ground experiences typically reflected the national statistics on under-representation of BAME nurses and midwives in senior grades/roles:

> The majority of the working population [in the inner London hospital she worked in recently], at least 80% were from a BME background but when you got to my level and above … I was the second senior nurse from a BME background in that hospital. There was no one above me in that hospital from a BME background. (*Steward, RCN, senior nurse, band 8, female, black, 46-55, hospital, urban England*)

Part of the problem is that BAME staff may not be as well positioned for promotion because of unequal access to development opportunities and a general lack of recognition of skills and contribution. The following rep's comments exemplify this problem:

> … lots of equality issues [for BAME staff]. You've got people who don't always get the same opportunities to go on courses. And so that makes it very difficult. Sometimes, somebody has done a good job … Not that you want it flagged up all the time but you know, occasionally. Some people are pushed forward and promoted very quickly and actually they couldn't have done what they've done without the team and there is no acknowledgement of that, and some people never get acknowledgement. (*Steward, RCN, staff nurse, band 7, female, white, 56-65, hospital, non-urban England*)

Many reps, particularly those who were themselves BAME, had observed that BAME nurses and midwives are frequently passed over for promotion even when they possess the relevant skills and training:

> But this [white British] girl that just came she hasn't done mentorship training, she hasn't done this, she hasn't done that, but you give her Band 6. Now the black girls that have been there for more than five or six years you told them you are not qualified enough to become Band 6. And these black girls you ask them to take charge of the ward and they do it perfectly. We also have European girls that have been there before her as well, they are also not happy with what is going on … they have done their mentorship, they have done a lot of training, they still [do not get the opportunities]. (*Learning rep, RCN, staff nurse, band 6, female, black, 56-65, hospital, urban England*)

The often informal or opaque nature of promotion processes and the central role of (white) mentors in career development fuel preferential processes biased both in terms of race and nationality. In a very diverse environment, white British professionals seem to get better career opportunities without even noticing their privilege. Interestingly, when the interviewee below complained about the lack of promotion, she was told that she was not proactive enough:

> And also the fact that training and development we're the last to find out. Somehow there are all these jobs somewhere but we never get to know about them. You just hear that oh, one of your white colleagues has become the new manager of this and that and that something is created out of nowhere and you're like what? Does that role even exist? When was the job advert? How did it happen? But you just see everybody getting promoted and you are stuck on your Band 6 forever and ever (*Member, RCM, midwife, band 6, female, black, 26-30, hospital, urban England*)

There was a feeling among some BAME reps that black nurses, particularly ones of a migrant background, often retreat to agency nursing in order to escape the stress of racism in career progression even if it was something they still faced in the everyday. Rising up the hierarchy does not necessarily insulate BAME nurses/midwives from workplace racism as manifest in undermining behaviours. The following quotation illustrates:

> I had a case recently where this particular person she obviously doesn't like to take orders from a black nurse … we came on the night shift and as soon as the Band 5 which is a white nurse saw that the Band 6 was a black nurse, that she was in charge, well, she was chuntering and chuntering and chuntering and saying "I don't see why I've got to take orders off her" and stuff like that. (*Steward, RCN, nurse, band 5, female, black, 56-65, hospital, urban England*)

BAME managers might then choose to be less vocal about racism or discrimination in order to "fit in" and not be suspected of any favouritism:

> So currently we have two BME line managers. And my experience is people tend to be … It's almost like the higher up the ladder you're now under a microscope so you're careful … So for instance a particular one of our BME line managers I know certainly when she was down like on our level she was somebody who I would say was an advocate for BMEs, she was very vocal and outspoken. But ever since she moved on, she's more silent than I remember. So I don't know if it's about okay, when you're up there oh, you have to be careful, you don't want to lose your job or you don't want to be scrutinised. (*Member, RCM, midwife, band 6, female, black, 26-30, hospital, urban England*)

Again, reflecting national statistics, many reps have seen for themselves over-representation of BAME nurses and midwives in disciplinary cases and referrals to the NMC:

> I've been to the NMC with no less than four midwives in my career. Whenever I go one of the things that really saddens me is in the morning you have two cases, in the afternoon you have two cases and out of all of those cases the majority of them are black. (*Health and safety rep, RCM, midwife, band 7, female, black, 46-55, hospital, urban England*)

A common rep experience was that minor issues involving BAME staff are often escalated and put into the formal disciplinary process before any attempts to resolve issues informally. Some white reps attributed this to lack of confidence among senior white staff about how to handle BAME performance or conduct; a certain nervousness around the possibility of being accused of racism could make it appear safer to push minor performance/conduct issues (e.g. punctuality or complaints about manner of speaking to staff/patients) upwards by formalising them:

> I still believe that we have to do some more work there [handling of BAME performance/conduct], but when you look at the context and someone is afraid to say to [a BAME nurse] "don't come into work late" because they're afraid of being accused of racism so they go straight to formal … it's why we need to have the conversations. (*Steward, RCN, senior nurse, band 8, female, black, 56-55, hospital, urban England*)

One BAME rep's thoughts on this highlight the interconnections between the underrepresentation of BAME people in higher management positions and a lack of understanding at the workplace of the more subtle dynamics of racism and its effects on BAME staff:

> Mainly the cases I was getting were disciplinary cases against a lot of black nurses, a lot of African nurses … some of it was sickness related, but I could see where the sickness was attributed to the stress and the strain they were under … they get so stressed and down about it [feeling and being treated like they do not belong] and haven't got nobody really to talk to. Some of them are so happy when they see another black face come to represent them because they think I'm not on my own, someone understands … Therefore that's the way as a steward I looked at it. So when I was going into disciplinary with managers and HR, sometimes I started asking should this have been a disciplinary matter. They would say to me well, yeah, because she spoke to me in an abrupt manner, but I said sometimes what you need to understand is it's probably a cultural issue… So sometimes, it will just become like a warning or we'll leave it and we'll monitor it, we'll put in an action plan to see … (*Steward, RCN, nurse, female, black, 56-65, hospital, urban England*)

The above example also demonstrates how the effective intervention of a rep may be able to de-escalate an issue. However, the survey results in Table 7 indicate that the unions have some way to go in ensuring that workplace reps are confident at handling discrimination cases.

Table 7: How confident are reps at handling discrimination complaints/cases?

	RCM		RCN	
	%	N	%	N
not at all confident	3.62%	5	1.92%	1
not confident	15.22%	21	19.23%	10
neutral	28.26%	39	13.46%	7
confident	27.54%	38	32.69%	17
very confident	10.14%	14	13.46%	7
Not relevant to RCM/RCN role	15.22%	21	19.23%	10
Total	100%	138	100%	52

The two accounts below illustrate how once in the disciplinary process, reps found that BAME nurses and midwives often received harsher treatment and punishment compared with their white counterparts:

> Definitely it's been harsher [punishment in BAME disciplinary cases]. Somebody was suspended, didn't need to be suspended for what they had done. She was black. I'm remembering more people now … the people who have lost [appeals] or have been

> sacked have been black. Nobody has been white. (*Steward, RCM, midwife, band 7, female, white, 46-55, teaching hospital, urban England*)

> The length of time it was taking to address the issues with black and minority people was longer. So if you're suspended, you're suspended for a very long time … Managers were very slack in ensuring that the case is actually dealt with swiftly and easily. There was inequality in addressing some issues to such an extent that in my Trust the black and minority people started taking notes of each incident that happened, who was involved and what was the outcome … because they felt if anything happened, I need to show management that actually you're not being fair. Similar thing happened and you dealt with this person totally different to what you were dealing with me. That was one of the reasons why I became a rep to actually make sure that things are being done equally with everybody across the board. (*RCM focus group member*)

One rep had also seen a BAME midwife blamed, inappropriately in her view, for a clinical error that had occurred, but for which she was not alone in being responsible:

> But management just would not let it go; it felt like they needed a scapegoat and somebody to blame for the case and I felt that compared to some of the other appalling cases we've had, you know, why was this midwife being treated like this? And this is comparing to like cases where women have been given the wrong intravenous drugs, you know, really dangerous things like that and they just walked away with nothing, you know. No blame, nothing. And maybe if that midwife wasn't from a particular culture, maybe had been more articulate, maybe she wouldn't have been such an easy target. (*Steward, RCM, midwife, band 7, female, other minority ethnicity, 46-55, clinic, urban England*)

According to reps, feeling like an 'easy target', awareness of inequalities of treatment in disciplinary processes and lack of confidence in procedures among BAME staff leads to under-reporting or late reporting of issues, including discriminatory incidents/treatment. BAME staff may fear that they will become the 'problem' rather than being the 'victim' and they may therefore prefer to 'keep their heads down':

> … in my department at the moment we have a lot of the older black midwives and then the very young ones who don't tend to stay. They come and they see the situation of things and they move on, either they try other hospitals or they try other departments. And then the older black midwives they've built resilience, they've tough skin, they don't care anymore, they're on their way out, they're not bothered. They can't be bothered to fight. (*Member, RCM, midwife, band 6, female, black, 26-30, hospital, urban England)*

> If you look at the statistics, it's very, very, very under-reported as we well know. A lot do not want to raise it because of the fear of losing their job, the fear of being ostracised, fear of being victimised or made to feel even worse than they feel already. Also, as black women we just get on with it … we're meant to do the work and you're not really meant to complain. I think sometimes by the time we've got our heads together to report it, it's already gone really bad. (*Steward, RCM, midwife, band 7, female, black, 46-55, hospital, urban England*)

Therefore, as suggested in the above quotation, some reps were of the view that the WRES statistics do not capture the full scale of race and ethnic inequalities of treatment, including racial bullying and harassment, in the NHS and in nursing and midwifery specifically. In addition, many believed that the NHS bullying and harassment policies are not working in all workplaces to protect those most at risk (i.e. BAME staff in the lower bands), including protection against blatant and recurrent forms of racism from patients:

> So you see a lot of discrimination, you know, when you have patient contacts so some patients would frankly say look, I don't want you looking after me. If you are young and if you are young and black, they'll ask you funny questions: Are you married? Have you had any children? Do you mind me asking how old are you? You know, all these very degrading questions. And then sometimes they can come in the form of they just snap at you. The attitude to us is just very unpleasant. They might not out rightly say from the very beginning I'm sorry but I don't want you looking after me because you're a black midwife or whatever but you can see that they don't want you looking after them. The threshold for so then they say I want another midwife, it's very slim. So you could, it could literally be a tiny wrong move or you are trying to do a blood pressure and it's tight, it's too tight, oh, I don't want you looking after me, take it off, it's too tight, it's hurting me, get me another midwife, you know. (*Member, RCM, midwife, band 6, female, black, 26-30, hospital, urban England)*

Instead of formal policies and dedicated training or networks, which may be seen as "patronizing" and/or segregating, most BAME interviewees would expect the support of their manager who, sometimes, fails to provide it, preferring avoiding confrontation with patients:

> Some managers would simply swap. Like one of my experiences the manager said to me somebody that's unpleasant do you even want to carry on looking after her. Please, save yourself the headache, let's swap and give them what they want. So rather than face it head-on and saying look, this is your midwife, she's a good midwife, she's qualified, she's more than qualified to look after you or whatever, rather they would just kind of come and maybe say something to make it sound as if they're trying to protect you. (*Member, RCM, midwife, band 6, female, black, 26-30, hospital, urban England)*

Interestingly the struggle against these informal and relational forms of discrimination is central to the RCN diversity and inclusion policy, notably through "social leadership" training courses and the establishment of "cultural ambassadors" in some regions whose role is to sit on disciplinary or grievance panels and to pay attention and report any spectre of racism:

> The way in which discrimination now is showing up in the workforce, the subtleties of it, I think there is a struggle there. So I know the team is really working really, really hard to begin to learn the language around micro-aggression and addressing that. We have traditionally done which is fair enough has been to focus on what the rules say so, and fitting into particular kind of patterns, so you know, if this behaviour fits a legal definition of what discrimination looks like that's where we step in, if this behaviour, the experience fits some organisational definition of what bullying feels like or looks like, that's where we step in. But below that kind of conversational waterline is what I would call instability and micro-aggressions so that's less about the logic, less about the pattern, more about the emotion, more about the context and more about the personal dynamic which is where everybody lives. And I think what we're seeing is that team now beginning to turn their attention to that like most unions. So you know, we can do the thing that's really obvious

> but I think they're starting to recognise that it's the subtle and the insidious that is equally as deadly as the very overt and obvious forms of discrimination. So I think there's a lot of work to do. (*Senior officer, RCN*)

RCM has also made the fight for equality and diversity its priority for 2020, calling for the union to become "an organization for all". The union is also promoting the development of a culture of kindness and compassion as an extension of its *Caring for You* campaign to fight bullying and calling out workplace micro-aggressions.

SECTION 2: REPRESENTING NURSING AND MIDWIFERY

This section of the findings part of the report explores the dynamics of representing nursing and midwifery from the perspectives and experiences of RCN and RCM officers and workplace reps. It presents discussion of how officers and reps perceive the dual role of RCN and RCM as professional organisations and trade unions; it explores the challenges of organising the two occupations, and the activity of workplace unions. Thus, the discussion speaks to the question of how well equipped the two unions are to tackle the issues highlighted in Section 1.

RCN and RCM: professional organisations and trade unions

The dual role for RCN and RCM as professional organisations *and* unions is a major 'selling point' promoted via the unions' web-based statements of purpose below. The dual role – professional organisation and union – also attracts people to participate and become workplace reps.

RCN https://www.rcn.org.uk/about-us/what-the-rcn-does

We represent: professional interests of nursing staff including pay, terms and conditions
We support: free confidential advice and support on employment matters, career development, immigration, welfare and more
We influence: government and other bodies to develop, influence and implement policy that improves the quality of patient care
We develop: promote and engage in nursing research
We maintain: we strive to be a sustainable member-led organisation

RCM https://www.rcm.org.uk/

Promoting: midwifery, quality maternity services and professional standards
Supporting: members individually and collectively
Influencing: on behalf of members and the women and families they care for

Most of the reps interviewed have a long history in the profession and in their union roles. As well as reflecting a desire to give voice to the nursing and midwifery workforce, this dual commitment to union and profession can be explained by the many benefits of their union role. These include union training and the acquisition of transferable skills, increased self-

confidence, a better understanding of the work environment ("getting the big picture") and access to and influence on senior management and HR. A set of things that constitute an "empowering experience" in itself, but that can also be useful in the development of a professional career:

> We do get cases of people that are doing it for their CV. RCM is regarded as a very good, solid organisation. We haven't got that reputation of like a table thumping trade union like UNISON that has the bad reputation sometimes with some of their reps or some of their regional officers being a bit awkward. We tend to be the softly diplomatic, and that's what I try and instil in our reps. It's building relationships with the people at the Trust that you're supposed to be working with. At an interview, there will be a panel normally. If you were going for a Band 7 post, there would be somebody from HR there, somebody from maternity management there. If you've been a rep, you've had to deal with the disciplinary policies and all of those things and you know what it's like to accompany members to meetings, and you know the processes. If you've done all that as a rep and you were going to apply for a matron's post that would be seen that you knew the processes better. (*Senior officer, RCM*)

Most of the officers and reps who participated in the study also saw this dual professional-union function as a major asset for members. In addition, maintaining a "single voice" for the profession and the workforce was seen as crucial for the two unions' credibility and legitimacy *vis-à-vis* employers.

> I think in terms of our dealings with employers … they value our input more on professional issues like staffing levels and development because we're unique in providing that for nursing staff. We have staff in the region who can help provide professional learning and development … I think the professional trade union function works really well. I know there's always talk of separating it. I think that would be disastrous. (*Senior officer, RCN*)

Officers and reps recognised that not all nursing and midwifery staff would perceive this strength as a deciding factor for attracting members in context of the significant presence in the workplace of other generalist unions, such as UNISON, with a stronger reputation for robust defence of collective terms and conditions and even militancy:

> UNISON is a much bigger organisation so their members run into the millions but they're across all sorts of different walks of career, profession. And whereas we might have one or two reps in a Trust, UNISON may have 15 or 20, but they'll be porters and nurses and ancillary staff of all sorts. And there would be no guarantee that who would turn up to a nurse's disciplinary meeting would be a nurse. But some members aren't that worried by that. They want to be part of that bigger, more left wing union, trade union type organisation. (*Senior Officer, RCN*)

In addition, BAME reps reported that in some Trusts, BAME staff turns to UNISON in the belief that as a trade union solely UNISON represents and advocates for BAME staff – whose representational needs are around discriminatory treatment – more effectively. BAME reps were particularly keen for RCN/RCM to develop opportunities to reach out to BAME midwives/nurses to show them that RCN/RCM was the union for them; some reps saw BAME RCN/RCM networks as having potential to mobilise interest and engagement. Some BAME

reps described how they had robustly dealt with BAME issues in their Trust/workplace such that they had seen nurses leaving UNISON and joining RCN with greater confidence and trust.

Beyond the notion of dual function, the professional dimension of RCN/RCM membership becomes inseparable from the union dimension for nurses and midwives potentially facing a multitude of threats from many different sources:

> I think bottom line is if you join the RCM, you're joining it for the representation in the workplace and you're joining it for NMC professional representation if you get referred to the NMC. Unless you've got several thousand pounds sitting in a bank account to spend to employ a barrister or a lawyer to represent you there … The rules were changed about three years ago. Anybody can refer a registrant to the NMC and this is why the number of referrals went up. (*Senior officer, RCM*)

From a steward's point of view, being part of the same profession as the members they represent also adds value to the quality of representation members receive in cases of capability and disciplinary issues, as well as clinical errors:

> I think the other thing that is being highlighted at the minute now is that there are some capability issues and if people are in the unions, like UNISON are a big thing, they're not being represented by midwives or even clinicians and we have an awful lot who switch straight afterwards because we can't represent them if the incident has happened and then they're realising now the value of having a midwife to support them when it is a capability issue. (*Steward, RCM, midwife, band 7, female, white, 46-55, teaching hospital, Wales*)

Yet, apart from mandatory professional development requirements – such as revalidation or training – it seems that most members do not make frequent use of the resources made available by the two unions, at least according to reps' perceptions:

> They do have strong professional values but if you were to walk across the Trust and ask them why they joined the RCN they'd say for indemnity insurance and protection if I do something wrong. They wouldn't talk about the library. They do their professional stuff, they do their revalidation, they update, they do their mandatory training and that's it. The only time they use the professional side is "I need to research that project" so they ring the library up and ask them to send them whatever they've got on that particular subject. But it's the only time they ever use them. (*Steward, RCN, nurse, band 7, female, white, 56-65, general hospital, non-urban England*)

On the contrary, other staff, such as maternity support workers, seem to be more attracted by the professional development resources – training, eLearning, access to library – they can get out of their union membership. Both unions provide numerous e-learning tools such as RCM i-learn or RCN Health+Care:

> We've got a growing number of people that are in my job role, maternity support workers, that are joining the RCM and I think the reason they're joining the RCM as opposed to another union like UNISON or the GMB is because the RCM and the RCN are recognised as that professional body element as well as being a trade union and I think there is a lot of advantages to that for members. So I do think that's why we've seen a growing number of maternity support workers joining. (*Maternity Support*

Advocate, RCM, maternity support worker, female, white, 36-45, district hospital, non-urban England)

Overall, in both professions, members' expectations offer a mixed picture that combines different professional and union expectations depending on the individuals, the circumstances in which they find themselves and the difficulties they face. A potential fault-line is race/ethnicity and the extent to which BAME nurses and midwives feel that RCN and RCM represent them effectively. However, it seems clear that both organizations are clearly identified as a means of personal protection in a similar way to other unions:

> We know from our regular surveying of members that the majority joins for the trade union 'protection', in inverted commas, as they would see it. In the past that might have been related to indemnity insurance and that knowing that there's someone there to support you if you get into bother. That said we also know that there are a significant proportion who are perhaps less interested in that … and are more interested in engaging with us over the professional agenda than over the trade union agenda. So it's a very mixed picture. But the evidence is that the majority of members do join us for the trade union protection. (*Senior officer, RCN*)

Even with the possibility of some nursing and midwifery staff turning to general unions, neither RCN nor RCN seems to have any problems recruiting new members. The survey shows that respondents are confident or very confident in their abilities to recruit members (Table 8).

Table 8. How confident are you in performing the following RCM/RCN activities? Recruiting members

	RCM		RCN	
	%	N	%	N
not at all confident	2.16%	3	0.00%	0
not confident	4.32%	6	1.92%	1
neutral	23.02%	32	19.23%	10
confident	33.09%	46	44.23%	23
very confident	34.53%	48	34.62%	18
Not relevant to RCM/RCN role	2.88%	4	0.00%	0
Total	100%	139	100%	52

At local or regional level, recruitment campaigns are systematically organised, in universities or during other professional events. While RCN has more competition than RCM, particularly from UNISON, and can compete with RCM when it comes to midwives, new unionization targets such as maternity support workers and health care assistants, offer opportunities for renewal within an ageing workforce:

> It's not declining. It's plateaued because we had an increase whereas the other unions are obviously declining but I think it's because we are a professional organisation as well. And also because of the fact that we've got this source of members of the MSWs to give them support in the workplace really. Well, anybody that works in maternity can join the RCM. So that's the workforce that we need to tap into if we're going to increase our membership. But at the moment we're just trying to keep it steady which is better than some unions are managing obviously. (*Senior officer, RCM*)

However, many long-serving union reps and officers share the impression that the new generations of nurses and midwives lack awareness of the role of unions in general, are more individualistic and feel more entitled to their individual rights, while being very passive and instrumental towards their unions:

> Nursing has this feeling of entitlement. So take flexible working for example. I demand flexible working because I have a child of nine and a child of eleven and I need to drop them at school and I need to pick them up. Fine, absolutely. Understand that. But when the application maybe is turned down because of service need it then becomes well, it's about me, it's not about the job that I do. So they don't see the patient and they don't see the job that they're signed up to do. Now I'm making that sound as if I'm being hypercritical about our members and I'm not, but there is this feeling of entitlement that they can't be refused anything. But they're workers at the end of the day, they have a contract of employment and they're professionals. If I think about the more mature member, so fifty/sixties, they don't have this belief or this feeling of entitlement. Again, that may go back to when this region was more politicised, more industrial. And of course now nursing is degree entry. (*Senior officer, RCN*)

> When we look at our turnout from our elections, for our governing bodies, and our Council and our Presidents and so forth … our members' responses to national changes…there was a big review of pensions a couple of years back, and you know, we're very lucky if we can get fifteen thousand members, or ten thousand members responding to some consultation exercise or whatever it might be. And yet we have 440,000. There is a huge disengaged section who just join for…I don't know why they join…well, for the pressure or the insurance in a very broad sense if things go wrong, and so on. (*Senior officer, RCN*)

While the relationship for younger generations between unionism and work is certainly different than for older ones, notably because of the transformation of the labour market and the conditions for entering the professions, both unions continue to attract new members. Whether this attraction is a sign of strong occupational identities (Ackers 2015) or an increased fear of being sanctioned for professional misconduct remains an open question.

Workplace organising challenges

Historically both RCN and RCM have functioned with what can be described as a 'servicing and partnership' approach where via paid officers the union provides a range of individual services to members and builds bargaining and consultation relationships with employers/management. As a consequence, both unions, most notably RCN, were relatively late in implementing a network of reps relative to other public service unions (Carter & Poynter 2001; Lloyds 1997). Although the approach changed about 10 years ago in RCM and has begun to change in RCN, the two unions long operated on a model of professional or managerial

unionism that relied on paid officers sometimes together with a small number of full-time stewards/branch convenors, to serve a largely passive membership (Heery & Kelly, 1994). Shifting from the historical approach is a huge task and a long journey.

RCN organising approach and experiences

With regard to current approaches to organising at workplaces, RCN describes itself as a member-led organisation and while this is evident in member participation in various national and regional structures, the vitality of workplace unionism is uneven. At present, nationally RCN has approximately one workplace rep for every 217 members. The union recently announced that it will be recommending to its Council a new organising strategy for 2020 with the intention of revitalising workplace unionism. Even in the absence of an articulated and co-ordinated organising strategy, RCN strives to build active workplace unionism starting with recruitment of reps:

> Regionally they're always trying to recruit more reps. You have existing reps in the workplace having tables [at events]; every learning event that the branches run they're always trying to encourage members to become a rep. At congress there's a massive stand that is encouraging people to sign up to become a rep. (*Health and Safety rep, RCN, nurse, female, white, 46-55, general hospital, non-urban England*)

Inevitably, outcomes are uneven and some workplaces have an active and highly impactful RCN branch while others struggle to recruit reps and to establish visibility and voice for a large nursing workforce:

> The issue here is that in my organisation we seem to feel RCN is not strong enough. We are a few RCN because in my Trust only two reps for 9,000 staff … we have been able to make a lot of difference by the way we interact with management and everything. (*Focus group participant, RCN*)

The most active branches meet 4-6 times a year, but the perimeter of a branch often exceeds that of a Trust and includes members in councils, schools, etc. as well as hospitals, and dispersed sites can add to the difficulty of sustaining an active branch. Despite the challenges, we found a strong desire among officers and reps alike to change members' concept of the union as a service organisation towards a participative membership one:

> I think one of the biggest problems is to get members to engage with you. They only ever turn up when there's a problem to the union. If we could have regular attendance at usual meetings, it would help. I think when people turn up and say to you what are the RCN doing for me, what are you doing for me and I say what are you doing for yourself. You are an adult, you are a professional and you need to have the interest in your own community, your own profession that you have to do something for yourself. You can't always rely on that being somebody else doing it for you, you have to empower people. It's not all about spoon-feeding, you have to make sure that you can say to people this is how you can do things, this is how you make change, so now you can go and do that and make that change yourself (*Focus group participant, RCN*)

Reps' selection and training processes have been reviewed and made less bureaucratic in order to gives RCN a focus on the imperative of getting representatives. However, apart from the servicing-partnership legacy, other structural factors do not make the RCN's task any easier.

The general situation in the NHS of staff shortages, high staff turnover (particularly in London hospitals) and on-going restructuring processes render it demanding to identify and train more reps:

> London has struggled a bit to get stewards, partly because I think we've got some of the worst nursing vacancies and again, despite the guarantees of time out and everything for trade union duties, it still takes quite a lot if you're a nurse on a ward to say I'm not going to be here tomorrow – people, wouldn't give that little notice but you know – I'm in, but I'm not working with you for that day, I'm doing union stuff. I think that's a particular challenge. I think in the climate where it's a very pressured system within the NHS, shop floor NHS workers are a lot less comfortable or feel a lot less secure in their work than maybe when I trained as a nurse and worked clinically as a nurse a long while ago. I think there is a lot less job security, a lot less job satisfaction and probably a lot less dialogue with management informally. I think people are often scared despite the promises of partnership working about being in an adversarial relationship where they've got to one day say to a manager, you know what, you've really made a mess of that and then the next day go back and be seen in a different role as a clinical nurse. Because we are quite well resourced as a region in terms of our staff, we have picked up work that almost certainly local stewards could and should be dealing with, but there's obviously a big culture change on both sides where we've got to encourage some of that. (*Senior officer, RCN*)

Further, nurses operate in a very hierarchical environment, mostly with little autonomy, which leads some to fell apprehensive about making their voice heard individually and collectively, of not "wanting to put their heads above the parapets":

> They're not empowered, pretty un-empowered. Because of the nature of who they are and what they do, they don't want to be activists, they don't want to, they don't like confrontation. It is very difficult when they think they're going to get repercussions or it could make their life very difficult because their manager then won't give them the request that they want for off-duty or their holidays when they want it or maybe not get onto a training programme that they want to do. There's no autonomy in nursing. There's high expectation of a registered nurse, which is good. But actually they don't want to treat you as a professional. It's almost like they want to sit on you. (*Steward, RCN, nurse, band 7, female, white, 56-65, specialist hospital, non-urban England*)

Unlike hospital midwives who generally work in specialist maternity units, hospital nurses work in many different departments, in more or less technical roles. They form a heterogeneous group, operating within working environments that encourage supportive and stable working communities, such as in operating theatres or intensive care units (Sainsaulieu 2012), but also in large and more individualized forms of organisations. Further, the nursing profession is evolving in an increasingly pressurized work environment (lack of time, high workload and stress, staff shortages), with the erosion of communicative formal and informal spaces (Edwards, 2009). Such conditions do not allow nurses very easily to build a collective work and union experience:

> It's very individualistic. If you're a nurse on a 30-bed acute medical ward, you perhaps got responsibility for six patients and your focus is those six patients. So it can become quite individual task orientated or patient orientated … but you know you've got a set of tasks and duties that you've got to complete. It always seems to have been the case

> that nurses are their own worst enemy. And I think that's got worse because of everything from the workforce shortages and the increased demand on hospital beds, so you know comparing it to when I nursed on an adult ward I think probably the worst days we had are probably the norm now. So we had more time together, we did have more time to interact with each other. (*Senior officer, RCN*)

Moreover, compared to some other public service unions in some areas, RCN has no quota of facility time per member and very few reps are now full-time (we only encountered two full-time convenors out of all the RCN participants):

> My husband is a UNISON member and a UNISON rep but he works in the local authority. So I find it quite funny because I watch how he deals with UNISON from being in the local authority, which is very different, very branch orientated and workplace orientated and they have masses of facilities time. So they have a mandate that they would want a steward for every fifty members, that's what they aspire to. I can't see that UNISON reps in general are going to get that bigger better deal than RCN although some of them are not in frontline jobs so it might be slightly easier. (*Steward, RCN, nurse, band 7, female, general hospital, 46-55, non-urban England*)

As shown by the survey results, most RCN (and RCM) reps receive less than 10 hours of facility time per month (see Table 9), which is less than what they spend on their union work (see Table 10).

Table 9: How much facilities time do you receive on average per month?

	RCM		RCN	
	%	N	%	N
Less than 7 hours	40.97%	59	43.14%	22
7-10 hours	20.83%	30	13.73%	7
11 – 20 hours	8.33%	12	13.73%	7
21 – 30 hours	4.17%	6	5.88%	3
More than 30 hours	2.08%	3	11.76%	6
None	23.61%	34	11.76%	6
Total	100%	144	100%	51

Table 10: How much time do you spend on RCM/RCN work on average per MONTH?

	RCM		RCN	
	%	N	%	N
Less than 7 hours	39.16%	56	23.53%	12

7-10 hours	28.67%	41	19.61%	10
11 – 20 hours	24.48%	35	25.49%	13
21 – 30 hours	4.90%	7	9.80%	5
More than 30 hours	2.80%	4	21.57%	11
Total	100%	143	100%	51

However, we found little appetite for a return to full-time convenors in the current decentralised employment relations context:

> Our model is still very much a servicing model whereas other unions, they're much more organising models but UNISON and others have full-time officers who are like convenors. We just don't have that model anymore. It's quite an old-fashioned way to do things in some ways so they have petered out over time. We just don't see that is the way we would deliver in full-time roles in that way anymore. It used to be there were all kinds of all agreements about payment but the organisations have paid them in more recent years because our organisations do see the value of having good trained union relationships but we would rather that we had a number of people, more greater infiltration if you like who've got decent facilities time. So you know, if you replace a convenor, whatever, 150 hours a month and give that out in facilities time that's a lot of representatives getting a day or two in facilities time a month instead and you get much better spread then. (*Senior officer, RCN*)

Nevertheless, the lived reality is that a lack of member participation and the difficulties encountered by reps in the performance of their duties has contributed to reinforcing the weight of regional and national structures in terms of full-time officers' participation in local consultation bodies and representation of members, and the development of centralized services such as RCN Direct. Moreover, RCN has the biggest in-house legal department of any union, comprising 45 lawyers and 25 support staff. Interestingly two-third of these professionals are employed on the regulatory side, representing more than 1500 nurses before the NMC per year:

> All calls go to RCND and if a call is about "I've been referred to the NMC", the call centre will put it through to our regulatory team wherever that member is based and then we'll pick up the case. If you have got a query about something that we can't help with in-house then you'll get transferred to RCN Law who provides 30 minute free legal issues on primarily family issues because that's the number one thing people want advice on but it's nothing something we specialise in. Or it goes to RCN Law if you've got a potential personal injury claim and you want advice about that. If you want employment law advice that has to come from the rep to the regional officer and then the regional officer will ask the lawyer for advice about it and if we think it's got prospects of success, then the lawyer will take the case on and then liaise with the member. (*Senior officer, RCN*)

The number of legal cases, including criminal cases, has grown significantly over the past years because of adverse publicity following various incidents of alleged poor care:

> Nursing has not had a very good public relations profile, if you like, in recent years. There've been a number of significant scandals, as the press would like to call it, involving hospitals. I mean, you may have come across them. There was the Mid Staffs hospital where there was a major investigation into allegations of poor care, patients not being looked after properly. Patients dying through inadequate care, and so forth. So there was a lot of adverse publicity. And the perception of nursing has, I think, diminished. As a result of which, people have become more aware of the routes by which you can complain if you're unhappy with the care you get. (*Senior officer, RCN*)

Nowadays, these support structures are perceived as very professional and efficient:

> I feel more professional. I think we are more professional. I think it's just the job that we do. Of course we do the collective representation, so campaigning and the national agenda, the national negotiations. And of course we follow whatever the outcome of that might be. But when we're dealing with a single organisation for example, so a Trust and you're in there, supporting, representing your members either on a collective basis or on an individual basis, it's far more professional, it's far more evidenced, there's objectivity to it. (*Senior officer, RCN*)

Most RCN full-time officers are experienced former activists and many are former nursing staff (and will have to be moving forward). They deliver a mix of casework, directly representing individuals or groups of members in workplace disputes, and they also have a strategic remit as part of their function to advise Trusts with their local Joint Staff Consultative Committees. Their wider role and their experience sometimes lead to employers' refusal to let them intervene instead of local reps:

> Some employers who don't want full-time officers there, partly because I think it's seen as too much of a challenge from the employers side and why should they expose themselves to that much scrutiny or that much challenge. I think it's partly knowledge, partly because our officers oversee a number of Trusts, they can say well, actually you're doing this but your neighbour is doing that, so why are they achieving better results than you? I think often in terms of dialogue it's a lot easier maybe for full-time officers to go in and really push a point and advocate very strongly on behalf of members whereas a rep or a steward understandably despite all the legal protection can feel very nervous of putting their head above a parapet and calling out the Trust for wrong or ill behaviour. (Senior officer, RCN)

However, this leaning towards a "managerial unionism" approach (Heery and Kelly, 1994) seems little contested by the interviewees, who would certainly deplore the disappearance of branches, but sometimes find that the resources dedicated to union activities versus professional are not sufficient:

> Most of my members are nurses so any reps or somebody wanting to be a rep they're all frontline whereas UNISON workers can be anybody, so they have a much bigger area that they can dip into. And where there aren't shortages. Because they've got so many more members they have a lot more funding so they can promote it more. We have restrictions because we're a professional union so I think they need to separate because a lot of the professional side which is brilliant sometimes pulls resources from the union side and there's a little bit of conflict I think. When I look at what my [UNISON] colleague has achieved in two years of being a rep, what I've achieved, it's

> resources, money, accessibility to ACAS. All her courses are being paid for. She's done a diploma in employment law. I've had none of that because they just won't pay for it because they haven't got the resources to pay for it. And it makes a lot of difference. (*Steward, RCN, nurse, band 7, female, white, 56-65, specialist hospital, non-urban England*)

Work pressures also have repercussions for the propensity of reps to undertake union training and maintain their union commitment over time. RCN has an extensive learning and development programme for reps that is highly appreciated, but which some find difficult to attend because of their professional constraints:

> What I find in my area is it's easy to recruit, we find it easy to recruit when we have nurses and they would have RCN section and we recruit members. But we can't retain them because they can't get time off to go for their training or get involved. In the last few months, we have been heavily under-staffed and we were overworked. So even when they got the package to read through they said oh, my God, I haven't even looked at it because I haven't had time, I've worked five straight long days, I've worked four nights, I'm tired, I'm exhausted. So with this case people are exhausted, they haven't got time to put into RCN work and they won't get time off from their employer to go for training. Two people I recruited in the last two years they haven't been able to go for their training, they can't get time off. It's really a big problem. (*Focus group participant, RCN*)

Overall, for RCN workplace unionism resilience seems to depend on the unfailing investment of experienced older reps (with a few exceptions) who manage to juggle their professional and union roles quite successfully while their managers are more or less sympathetic to, and in some cases even appreciative of their union role.

RCM organising approach and experiences

RCM has a relatively longstanding organising strategy (since 2010) that officers believe has evolved into an organising *culture* within the union. Nationally, RCM employs a team of seven organisers with prior experience of union organising who are tasked with helping workplace reps to build active branches with regular events, an Annual General Meeting, a team of trained reps, proactive recruitment initiatives and such like. The union is able to point to a number of branches where the organising strategy has had considerable success in building workplace unionism, but at the same time national and regional officers acknowledge that organising is a continual process rather than a series of one-off events/actions. Currently, RCM has approximately one workplace rep to every 64 members.

However, the distribution of reps is uneven. While some branches can speak of huge success in recruiting reps, others have had difficulties and they find that the branch comprises just a small number of people such that they sometimes struggle to reach the quorum necessary to operate not least because of the pressured environment depicted in Section 1:

> It's very difficult to get attendance. It's incredibly difficult because people have to come in their own time. It's not paid time. They will have to travel to work to be able to attend it. When we do them, we do evening meetings because we found that to do a meeting at say 6, 7pm is better attended than anything in the daytime when people are still working. So we do that but it's very, very difficult to get people to attend. It's extremely

> difficult. They feel like they've given 100% already and more, so they don't want to give anything extra, they want to protect their time. People are working through their breaks, then working after the end of their shifts, they don't want to come in and do anything extra and it's very, very difficult to get attendance at meetings (*Steward, RCM, midwife, band 6, female, white, 26-35, teaching hospital, non-urban England*)

Further, branches may have a somewhat dispersed membership, including for example, community midwives some of whom may have more difficulty going to branch meetings held in hospitals possibly quite far from their patch. Still, despite acknowledging the many pressures on members that militate against union participation, reps found member passivity very frustrating:

> Apathy! I mean, last year we organised the AGM, we hadn't had one for two years, organised the AGM and we couldn't even be quorate between the branch members, you know, there's positions that are vacant. It was so funny, the only person that turned up out of what I thought was the membership and swiftly got voted in as a branch officer turned out not to even be in the RCM but was too embarrassed to just say it at the moment. It was like a comedy script. And it wasn't until the next day that I found out that she wasn't even a member and everybody thought it was totally hilarious and you know, it just really left a bad taste in my mouth (*Steward, RCM, midwife, band 6, female, white, 46-55, district hospital, urban England*)

The activity of branches varies, sometimes linked to national campaigns launched by the union nationally such as Caring for You. Some branches also organise social events (sometimes fundraisers), or other issue-based events that speak to members' concerns such as menopause, money issues, health and wellbeing:

> So the next one is December, it's about menopause and money. Because those were the two issues that the staff were like they were really affecting them. So money, I guess it is things around say for example when you're a nurse or a midwife you can claim certain tax allowances for say your professional registration so your union membership, if you subscribe to journals, for uniform although most people get given their uniform free. Or ways they can reduce their tax. And yes, the menopause because there's a lot of midwives that are in that age range (*Steward, RCM, midwife, band 7, female, white, 26-35, teaching hospital, urban England*)

RCM survey respondents displayed great confidence in their ability to organize branch events (Table 11) and use a variety of activities to engage their members (Table 12).

Table 11: How confident are you in performing the following RCM/RCN activities? Organising branch events

	RCM	
	%	N
not at all confident	1.47%	2
not confident	5.15%	7

neutral	21.32%	29
confident	35.29%	48
very confident	33.82%	46
Not relevant to RCM/RCN role	2.94%	4
Total	100%	136

Table 12: What events/activities does your branch regularly (at least once a year) hold? Tick as appropriate.

	RCM	
	%	N
Member briefing meetings	14.10%	64
Union learning events	10.35%	47
Recruitment events	5.51%	25
Focused working groups / workshops	1.98%	9
MSW week events (RCM)	16.30%	74
International Day of the Midwife/International Nurses' Day events	21.59%	98
AGM	22.47%	102
Festive events	6.39%	29
Other	1.32%	6

The RCM organizers encourage this approach to organising, which focuses on supporting branch activity through the promotion of national campaigns and learning and development opportunities/events:

> In terms of the work that we [organisers] do in RCM, it's more about local activity rather than collectively organising members around issues. Obviously, there will be an element of collective organising around issues where changes are happening with the Trust. But generally in the main what we do is we support and encourage local workplace activity, visibility. Making sure that our local branches are communicating what's happening in RCM, both trade union and professional side to members and of course encouraging people to join RCM. It's more campaign-based organising. A good example of that is our Caring for You campaign, which picks up on a number of different issues that are particularly prevalent in maternity and probably in the health service in general. So staffing numbers, fatigue at work, people working over their hours, not getting their breaks, undermining behaviours. Also, a big part of the organising work that we do is around development, CPD. We've got a lot of very active

> learning reps who we encourage to put on local learning events, study days, lunchtime workshops which are helping to develop people which is a way of drawing new members into the union. (*Organiser, RCM*)

Some branch meetings have higher attendance than do others, notably when they deal with work organisation problems such as shifts and rotas, but there is still work to do to make branches places of professional socialization, as more seem to have been in the past. A fact that in itself can weaken the occupational magnet that draws people to unions and, in turn, reduces their role in the making of professional identities (Ackers, 2015):

> I think, as you know, the trade union situation has changed so much in recent years. In the old days when I first joined the RCM when I was first a midwife, a lot of branches were very much like the old fashioned branches model where you had coffee mornings and bring and buy sales and cake sales and you raised money and you had quiz nights. You did things almost like a club. But those branches are few and far between nowadays. (*Senior officer, RCM*)

Besides, some aspects of the professional culture may explain members' low tendency to seek collective solutions to the work problems encountered. For example, midwives were often described as very independent, individualistic even, and reluctant to seek help when faced with a problem:

> I think union wise I see work closely with other unions and the one thing that I don't see in the culture of midwifery is collective bargaining. Because people will do things individually, so they won't get you involved at all. Or they won't group together, they will all moan at the same thing but they will never do anything collectively which other unions' membership do and that's so much more powerful. Things like collective grievances and stuff people just don't want to do it. It's the culture in midwifery. The midwives are very independent and they're used to just dealing with things themselves so they don't feel the need for several of them to get together (*Focus group participant, RCM*)

On the contrary, the deterioration of the working environment and the sometimes lack of fairness in the organisation of shifts, rotas and flexible working discussed earlier, lead to numerous dissensions and resentment between colleagues, fuelling traditional stereotypes about the lack of solidarity in feminised professions:

> I have this theory that because it's a female predominated profession that we often take this passive role, so sometimes we can be quite vociferous in advocating for our patients or our women or looking after them perhaps on a one-to-one basis but collectively, women collectively just don't seem to get together. I don't know what it is. It's like you put women together and they're quite bitchy. It's very weird trying to unpick all of that. Certainly when I came into midwifery as an adult who'd had four children, my vision or my perception of midwifery, particularly one of the reasons I was drawn to it, was that I thought women together. Anything but! Complete, I had to change my whole worldview or mind-set to actually get my head around it. I think there might be some elements of that the same, individually women are very strong, we have to deal with, but as a collective, I don't think that always follows through. (*Steward, RCM, midwife, band 6, female, white, 46-55, district hospital, urban England*)

Because of the fear of repercussions and the diffusion of a "blame culture" within the NHS, many midwives seem to display a very high level of consent, but underlying that is a reluctance to assume the burden of any grievances:

> The thing with the staff is they can only challenge these things so far because it's just such a hard chore for them to keep pushing and to the point where you're taking out a grievance against your management. They are very reluctant. Even the most recent situations where people come to me and complain about various issues, you say to them well, there's not really much I can do other than making a complaint known to the management … but they're going to have their reasons why they want to do it that way. But if you want to pursue it, the only thing we can suggest is that you take out a grievance against management. But they don't want to take that up. It's not always they're afraid of management but it's such a long hard trawl to push back, as it involves meetings and statement writing and all sorts, and hearings in front of HR as to why we've taken out a grievance. (*Steward, RCM, midwife, band 7, female, BAME, 46-55, clinic, urban England*)

As in other care professions, including nursing, members' attachment to their profession may ultimately lead them not to take on union responsibilities in order not to affect the quality of service in workplaces where any additional absence is likely to add to the lack of resources and the pressures put on colleagues (Cunningham & James, 2010):

> I think there's an element of also not wanting to let people down. So if you stand up for your rights, you can say I'm entitled for a break, I'm going to take a break but if you do that to the detriment of one of your colleagues on the ward, it doesn't sit well whereas, perhaps that's not quite such the case in other professions. (*Focus group participant, RCM*)

Nevertheless, most RCM interviewees reported having adequate time off to carry out their union activity, but these are hours negotiated by mutual agreement with the management hierarchy, so they vary greatly from one Trust to another:

> I think I've been quite lucky really. Although it took a while to get there, I've got five hours per week for staff side and it gets put to twelve hours for other matters, so it's basically one long clinical shift a week that I can then use to attend staff side meetings, attend all the staff side stuff and meet with members and go to these things. And how I use that twelve hours, although it's one set day a week, I can then break that up if I need to, so if a meeting is on a Wednesday I can be flexible and do it on a Tuesday. But I think we really had to push for that and it took a while, it took months and months and months being told well, let's see what other Trusts are doing. (*Focus group participant, RCM*)

The number of union hours and the ability to claim them therefore depends very much on the quality of the relationship between management and reps, and reps may also have difficulty quantifying the workload involved in their trade union role:

> It's peaks and troughs, you might not have any case for months and then all of a sudden everything will come together, particularly maybe if there's been things happening in the Trust where there's a flavour of the month, like we had some data protection breaches so we had a flurry of several cases going on then. But mainly the day-to-day

> stuff is the bread and butter stuff that might be on capability or it might be sickness absence, those sorts of things. But the other things tend to come in as a cluster, those can be very demanding and very, very draining. And again some of the other reps were saying, having to do your homework and get prepared and it's a really big ask … you are trying to juggle between your own working as well, you have to fit that in around that and you do get your time back eventually but you have to file for that time. I had to put an exceptional request in to my Head of Midwifery to say look, I've been supporting these couple of members here and it's been ongoing for several months, this is the hours that I've put in on this, can I actually get this back (*Steward, RCM, midwife, band 6, female, white, 46-55, general hospital, urban England*)

Even when they have an amenable manager who understands the value of their union role, a number of stewards or reps struggle to make use of their facility time (see Table x) because the schedules are so busy and the staffing level is insufficient, and they do not want to let down their already over-stretched colleagues:

> I think there's another problem that on the one hand, you could be active in the union and there's good reasons to be, but then there's the guilt, the guilt that you're saying I need time off or you're given time off but that will leave your colleagues short. So there's again this tussle between the theory and the practice. I don't think we can ignore that because I think that is why people aren't active, why people don't do things. (*Focus group participant, RCM*)

Tellingly, many RCM stewards interviewed held senior positions (band 7, sometimes 8), had a specialist or community role that allowed them not to work shifts and to somewhat control their diaries, as well as access to phones and computers:

> It's a very sad state of affairs but if anybody has been suggested as being a steward, one of my first questions is not what grade are they or what their name is, but where do they work. If I get told they work on delivery suite as a labour ward coordinator my heart drops because they're not going to be able to be spared time off to go to meetings. Because they just are not going to be supernumerary, they're not going to be surplus. Whereas if someone is a community midwife or they're a specialist role midwife they've got slight control over their diaries. I think that's where you can then jiggle things in the workplace to do things. Whereas if you're working on the postnatal ward or the delivery suite, that is when you struggle. I'm sure that the Royal College of Nursing and other unions have this problem as well, if you work on the face-to-face aspect of patient care then it is really, really difficult. (*Senior officer, RCM*)

The challenges unions generally face in organising at workplace level even in the relatively high-density public sector are well known and to this extent, it is hardly surprising to find both RCN and RCM experiencing challenges. While there are pockets of active workplace unionism in public services (Guillaume and Kirton, 2017), in general previous research highlights the gap between high union density and uneven and sporadic activism sustained by a few experienced and typically older workplace representatives (Carter 2004). On the latter point, the age profile of RCN and RCM reps was noted earlier in this report (RCN = 56% 50 plus; RCM = 39% 50 plus). While not a problem in itself, it does indicate a need to be vigilant about succession planning for the near future to ensure the sustainability of the workplace rep network as well as workplace unionism.

Workplace union activity

This section discusses workplace union activity within the Trust/work environment. When exploring workplace union activity, the study highlights how in both unions workplace reps engage in intense management-facing activity (Kessler & Heron 2001), particularly of the individual kind (representing members in cases involving bullying and harassment, sickness absence management, disciplinary hearings, drug errors, professional misconduct, implementation of terms and conditions). From an RCN rep perspective:

> I think you can divide into thirds, so probably a third is bullying and harassment cases, a third is actual hearings, disciplinary processes, and another third is probably more general stuff that can be contractual or lots of other minor issues that affect them and that are usually fairly simple to sort out. (Focus group participant, RCN)

This division of work is confirmed by the survey respondents who, however, put sickness absence issues first (Table 13).

Table 13: Thinking back over the last year, what are the three main casework issues you have dealt with? Tick as appropriate.

	RCM		RCN	
	%	N	%	N
Capability	17.56%	49	11.11%	8
Clinical errors	11.47%	32	12.50%	9
Sickness absence	28.67%	80	30.56%	2
Bullying and harassment	12.19%	34	22.22%	16
Discrimination	6.45%	18	4.17%	3
Health and safety	5.38%	15	8.33%	6
NMC revalidation	4.66%	13	4.17%	3
Other	8.96%	25	2.78%	2
I haven't had any casework in the last 12-18 months	4.66%	13	4.17%	3

Member-facing activities (Kessler & Heron 2001) are clearly time-consuming and cover "proto-legal" advice (Willemez, 2017), which consists of informing members about their rights vis-à-vis existing policies. Both unions find that casework has become demanding and complex notably because employers are more aware of professional standards, more defensive and also driven by results in terms of sickness management, but also because individual cases are more complicated:

> I think employers are much more conscious of professional standards and the majority of casework for disciplinaries now tends to be around whether someone as a nurse behaved professionally and whether their standards were appropriate, more than was

there an error. Sickness absence management has increased a lot in terms of casework. Partly again there's a national drive to reduce sickness absence stats so the length of time someone is on absence, so employers are trying to move people through casework more, through sickness absence processes more, get people back to work if they can. But we're also seeing our members living or working more with long-term health conditions themselves and so more cases requiring greater input and greater thought around reasonable adjustments at work, managing disabilities in the workplace, physical disability and sort of learning disabilities around dyslexia, dyspraxia we see regularly now where I think it was uncommon in the past. (*Senior officer, RCN*)

However, as soon as the case becomes legal, whether it is a referral to the NMC or a complaint to the employment tribunal, in RCM the regional level typically handles it:

> People come to you first of all before even going through the formal routes of checking the local policies and actually invoking the policies that are there in the first instance. Nine times out of ten they don't need a rep, they just need signposting to what's there and they come to you as a sticking plaster to go and talk to their manager. Well, I'm not there to talk to your manager. You can talk to your manager. All the procedures and policies are in place to support you to do that. It's only once you've exhausted those and that you're hitting a brick wall then you can come to your rep. But you get a lot of those with all the nit picking stuff of I just need to talk to you about this and sometimes maybe a little bit of a counselling thing as well as a sounding board before anything actually goes formal. (*Focus group participant, RCM*)

Interestingly, employers and NMC panel members seem to have switched from a narrow legalistic approach to a more comprehensive and supportive attitude, aiming at developing and training staff rather than blaming/penalizing them. The difficulties of recruiting and retaining nursing staff in particular probably explain this change.

> We've seen a drop in disciplinary and conduct management, largely because I think employers have become much more conscious of the need to support staff through conduct issues rather than take a big stick approach, partly it's a better way of managing staff and partly I think maybe they're conscious of how fluid the workforce in London can be so if you get a reputation as a punitive employer … you know you can work in [another hospital] which are ten minutes apart there is a bit of risk there for employers in their reputation. I think although there is a drop off in disciplinary work certainly around medication errors, for example, there's a much more supportive performance management element now. (*Senior officer, RCN*)

Apart from this individual representation role, for both unions stewards' and some safety reps' management-facing activity is also of the collective type including sitting on various committees for example the Trust's Joint Consultative Negotiating Committee (JCNC) or Health and safety Committee where trade unions and management meet for formal discussions before decisions affecting employees are taken. As shown in the table below, this activity is second in the most time-consuming activities, after dealing with members' professional concerns.

Table 14: Which three activities do you spend most time on in your RCM/RCN role? Tick the three most important

	RCM		RCN	
	%	N	%	N
Dealing with members' professional concerns/queries	20.38%	85	21.15%	33
Casework related to disciplinary and capability procedures	11.51%	48	8.97%	14
Casework related to NMC referrals	0.72%	3	0.00%	0
Joint employer/union committee meetings	16.07%	67	20.51%	32
Meetings with individual managers	5.52%	23	1.92%	3
Meetings with HR advisers	0.24%	1	1.28%	2
Union meetings	11.27%	47	12.18%	19
Attending union training days	8.87%	37	10.90%	17
Member recruitment	6.47%	27	8.33%	13
Disseminating information to members	15.35%	64	13.46%	21
Other	3.60%	15	1.28%	2

Following the decentralisation of employment relations in the 1990s in the NHS, local union reps can actually influence many decisions, individual or collective, through formal or informal channels. Apart from pay issues that are still negotiated nationally under Agenda for Change, many topics such as recruitment and staffing levels, as well as health and safety issues are discussed locally:

> Recruitment, retention can be negotiated. We negotiate all our own policies. If you'd come in here yesterday we had a table of policies like that. We were going through and saying they're not getting away with putting that in there. And trying to keep the terms and conditions we've got that are better for our members than the national terms and conditions because if we can negotiate something better then we can use it. (*Steward, RCN nurse, female, white, 56-65, general hospital, non-urban England*)

However, the composition and frequency of these consultative meetings are not imposed by law and depend on the robustness of local arrangements. For example, in some Trusts, health and safety reps are allowed to participate while in others they are not, which does not help their union influence:

> So there is no laid down mandate as to who should attend. Our broad recommendations are it should be the chief exec, director of HR, or equivalent, director of nursing, and the director of finance to either attend for the whole meeting or certainly to attend and give an update on the financial position of the Trust. That would be the core component, core constituents from the management side that we would hope would attend. They range from monthly to quarterly. It's up to local bodies from both sides to decide how

> they operate and how frequently they meet. There has to be mandated in law a mechanism for the unions and the employers to have a dialogue and there are certain things that we can mandate an employer has to tell us. But it isn't mandated as to how often those meetings should be held. I guess given how busy Trusts are, the activity they're facing and the workload on union reps, bi-monthly is probably the norm now (*Senior officer, RCN*)

Overall, most reps seemed rather satisfied with the relationship with management and their ability to influence decisions during joint meetings. The survey showed that participating in staff side and joint consultation committees is seen as effective or rather effective by at least 70% of survey respondents, both RCM and RCN (Table 15).

Table 15: What do you see as the most effective RCM/RCN employer-facing strategies for defending/improving members' terms and conditions in your workplace/Trust/Health Board? *Participating in staff side and joint consultation committees*

	RCM		RCN	
	%	N	%	N
not at all effective	0.00%	0	0.00%	0
not effective	7.50%	9	4.65%	2
neutral	25.00%	30	23.26%	10
effective	49.17%	59	37.21%	16
extremely effective	18.33%	22	34.88%	15
Total	100%	120	100%	43

However, some deplored the absence of some managers and HR people at these meetings. Such non-attendance can be linked to the constant restructuring of HR departments and the shortage of staff in support services:

> We have a lot of lack of engagement from the managers and that's the problem. I have a good working relationship with the head of HR and now he's attending every single month, which is good but we didn't have that before. We've had a lot of change in HR management and directors and that's not been easy because you're constantly working with an interim and an interim only wants to do so much because they know they're going so they're not going to start any big projects. To be fair there aren't many of them but we even set up a rolling rota so we said OK, if you can't all come from finance and from communications, what we'll do is we'll put you on a rolling cycle so one of you comes to represent (*Steward, RCM, midwife, band 6, female, white, 26-35, teaching hospital, non-urban England*)

Moreover, linked to the chronic lack of resources in NHS Trusts, many criticisms were also made about the length of the processes for handling individual cases, the high number of consultations to be dealt with during joint committees (which does not allow other issues to be discussed) and the somewhat bureaucratic nature of formal industrial relations:

> [My Trust] is the worst proponent of taking years to do a disciplinary, taking 18 months to hear a grievance, just horrific. I've got three midwives at the moment who had an investigation meeting in January and we're now 27th of September. Completely ridiculous. But at [another Trust] I supported someone there and I thought [my Trust] got the prize for being the most inefficient but [the other Trust] came very close (*Focus group participant, RCM*)

Some interviewees also felt that the consultation exercise was rather a matter of box ticking, where all the important decisions had already been made:

> Although the employers tend to make all the right noises about being pro-partnership working and promoting their JCNCs, in reality there's an awful lot of examples of when there isn't partnership working and decisions are made and it is a bit of a tick box exercise, it's on the agenda of the JCNC and it's already been decided at executive level. (*Focus group participant, RCM*)

At an individual or collective level, the effectiveness of union representation clearly depends on the attitude of management, middle or senior, which is mainly composed of professionals who know the health service, but are not always receptive to union input (even though sometimes they themselves belong to the same trade union):

> We have a JCNC … every other month and so we meet with HR, management of change should be discussed there and that's been reviewed at the moment because we don't think it's relevant in lots of ways. And we don't get enough managers to come. Some managers see us as a block on what they want to do. We're not a block. It's a cultural thing. Again, NHS culture is embedded and it's part of the culture, they're not trained to see the benefits. (*Steward, RCN, nurse, band 7, female, white, 56-65, specialist unit, non-urban England*)

The other equally important factor concerns the quality of the relationships between the different unions sitting on the various committees including staff-side (Lloyd 1997). While in most cases, these relations were described as positive and constructive, which gives the unions some credibility *vis-à-vis* their employers, they can sometimes be strained and competitive (Table 16).

Table 16: How would you describe your relationship with other unions represented at your workplace/Trust/Health Board? Select one.

	RCM		RCN	
	%	N	%	N
Supportive and productive	67.46%	85	57.78%	26
Other	2.38%	3	8.89%	4
Non-existent	22.22%	28	11.11%	5
Conflictual	2.38%	3	4.44%	2
Competitive	5.56%	7	17.78%	8

Total	100%	126	100%	45

Besides, as a smaller union, RCM could feel less considered than other larger unions:

> Now that we've been taken over by [a large hospital] that Trust convenor role is going because although we're RCM we're now part of this much larger organisation where UNISON is the dominant union. That hospital doesn't have any midwifery or obstetric profile so they don't have that understanding of midwives and the RCM. We're probably one of the smallest unions there. So that's difficult. Also finding our voice and the way that they structure their JCNC or their joint negotiation committee, they almost have like an executive because they've got so many members and branch officers within UNISON that they have an executive that then goes on to meet with the management side. I haven't even been to one of these joint meetings yet, I don't even think we've even got a voice or a seat on that board. So again, I think us being a small union our voice will get lost in all of that. (*Steward, RCM, midwife, band 6, female, white, 46-55, district hospital, urban England*)

RCN and RCM interviewees mostly described their union approach as "sensible", "not heated or obstructive" and "civil" in terms of relations with management. While they "carefully choose their battles" and avoid the "banging and shouting" style that they perceive other unions may adopt, they usually gain the trust of management and try to diffuse problems before they become formal:

> I think they appreciate you when you listen. I think some people view trade unionists as people who are obstructive. I think we have to be more clever than that. I think we have to work with the managers so that if you do that you get so much back. They will come to me now and ask what do you think of such which I don't think that ever happened before in our local Trust. I think you have to work with them and once you get a good working relationship, it's much smoother. And we can sort problems out very early. There are other reps who are very obstructive and I think that if I was a manager and if I was working with this trade unionist, I would feel that they're not listening to my perspective, I would feel that there isn't a joint working relationship and then you'd lose the benefit (*Steward, RCM, midwife, band 6, female, white, 26-35, teaching hospital, non-urban England*)

Survey respondents from both unions saw building partnership relationship with managers as an effective strategy (Table 17).

Table 17: What do you see as the most effective RCM/RCN employer-facing strategies for defending/improving members' terms and conditions in your workplace/Trust/Health Board? *Building partnership relationships with managers*

	RCM		RCN	
	%	N	%	N
not at all effective	0.82%	1	0.00%	0
not effective	13.11%	16	4.55%	2

neutral	27.05%	33	29.55%	13
effective	43.44%	53	43.18%	19
extremely effective	15.57%	19	22.73%	10
Total	100%	122	100%	44

Most of the reps interviewed chose to adopt a "small steps" approach, sometimes contenting themselves with small improvements for their members, but above all keeping in mind the dual objective of improving working and service conditions. A professional perspective that may surprise trade unionists with experience of other unions:

> I've had some tensions in the way that I approached things. A really good example is the work that we did with [one] branch, galvanising our members around responding to a change proposal. A colleague was hang on a minute, you don't automatically want to send the message that an RCM branch should straightaway object to something and then get its members active around preventing it happening because you're missing out the step of considering whether that change is actually positive in terms of the care that the service can provide. We are a professional organisation, we do represent midwives and support workers, but we also want to positively influence maternity services and the experience of childbirth. (*Organiser, RCM*)

This double stance can on occasion lead to some sort of confusion of roles, when union funds are used to improve service conditions that should be funded by Trusts. The fact that many stewards are part of management, being band 7 or 8, might tip the balance to the professional side at the expense of a more union approach:

> Every year we do a cake sale and we try and collect the money and the last couple of years we bought a cup chair so like birthing inflatable chairs. So it's something for our department. Last year from the money we raised and had in the pot, they bought special lights for each room. Right. So this year I become the RCM rep, I said that's enough, no more. We raise the money and we've got good money in our pot, we need to then spend that money on us. And the suggestions from the RCM chairman, she's Band 7, was we spend it again on the department. I think that's very unfair actually. (*Steward, RCM, midwife, band 6, female, white, 36-45, teaching hospital, non-urban England*)

The professional side of the RCN and RCM role can sometimes appear to be a double-edged sword. It allows a positive recognition of the contribution of the two unions by management (and government), but at the same time encourages a more moderate stance, in comparison with other more vocal (and more masculine) unions, which may not always prove effective:

> Interviewer: Do you think being a professional body as well as union means that the employers and managers engage with RCM more constructively than with UNISON?
>
> Participant: They're more respectful. But is that from a paternalistic point of view as well because it's a nice little … In our Trust UNISON have grown a huge voice on the staff side. When I go to the meeting to be honest, I feel very small when I go to the staff side meeting because predominantly it's UNISON. I can only speak for my Trust but they have a forceful voice and there are quite a few of them who have been militant and

> they've been in UNISON for a very long time. They're extremely experienced. They are very much listened to because I just sit there and just observe and they would pick and pick if they wanted a process to be addressed properly, they would not go ahead until there's an answer. (*Focus group participant, RCM*)

Most officers interviewed were of the opinion that the union dual role was well balanced and that the two aspects were complementary:

> For me, I very much see it as being massively complementary and only very rarely conflictory if that's a word. So most of what we do is what's best for patients is most of the time best for nurses and vice versa if I'm honest. You do not get very good patient outcomes if you have a deeply unhappy, mistreated workforce and not enough of them. So for example, a conversation about staffing levels is that a trade union conversation or is that a professional conversation? It's both. And both of them come to the same conclusion. So for me we absolutely benefit from having the two things with the evidence based on the professional Royal College evidence and our wider remit to promote both nursing but the patients and public. But also to fight for nursing and nurses and we do both I think. (*Senior officer, RCN*)

Overall, the recognised professionalism of the two unions and their "moderate" approach tends to facilitate the recognition of the role of individuals who take up a union role, even if stepping up is always risky. While 50% of survey respondents feel that their management is supportive of RCM/RCN involvement, around 15% find management not (or not at all) supportive (Table 18).

Table 18: How supportive is management in your workplace/Trust/Health Board of RCM/RCN involvement in workplace employment relations?

	RCM		RCN	
	%	N	%	N
not at all supportive	6.82%	9	4.55%	2
not supportive	10.61%	14	9.09%	4
neutral	30.30%	40	36.36%	16
supportive	40.15%	53	40.91%	18
very supportive	12.12%	16	9.09%	4
Total	100%	132	100%	44

Managers' appreciation of the unions' contribution is gradual and built on a daily basis:

> Interviewer: Do you feel that your role is valued by managers?
>
> Participant: I think it's a gradual thing. So it's not instant but after a while when they realise that you perhaps can resolve situations and help ease the situation which could become quite toxic, then I find more people are coming my way now via advice from

their manager to go and have a word with the union but it's gradual, it is not instant. The more that you interact with them and the more they see that you can resolve things or come to an agreement, then they slowly come around to value your presence. (*Focus group participant, RCM*)

Survey respondents were of the opinion that they managed to contribute positively to solve problems that are important to their members (Table 19)

Table 19: What workplace/Trust/Health Board policies has RCM/RCN contributed to/positively influenced? Tick as appropriate.

	RCM		RCN	
	%	N	%	N
Health, safety and wellbeing	25.32%	79	20.63%	26
Flexible work arrangements	19.87%	62	18.25%	23
Work-life-balance	16.99%	53	13.49%	17
Bullying and harassment	15.71%	49	19.84%	25
Dignity and respect	12.18%	38	17.46%	22
None	7.05%	22	7.94%	10
Other	2.88%	9	2.38%	3

The steward experience is often described as a mix of "a lot of effort not always greeted by colleagues", a feeling of isolation tinged with fears of being ostracized and as emotionally draining:

> It is a very lonely place indeed. Apart from your other reps, and days like these where you get to share that, but it's a very lonely place in the Trust because you will be singled out by everybody, you will be labelled. When we had the industrial action a few years ago, you're out on the picket line, with your staff and you are actually singling yourself out. You are throwing your colours out there so anybody who knows you for the wrong reasons, management just see you as an agitator. And staff only come to you when they've got a problem and then there's an onus on you to be seen to sort out their problems for whatever reason they're in that problem, but there's an onus that oh, we pay our subs, you've got to sort it out now. So we're stuck between a rock and a hard place really. It's not fully appreciated. (*Focus group participant, RCM*)

While very few cases of union victimization were mentioned, taking on a union role requires courage, a real desire to "give back to community" because you have been helped yourself in the past or because of personal convictions. It is obviously easier at the end of a career than at the beginning, both because family constraints are less severe, but also because professional options are more open. Many interviewees spoke of their choice to retire at age 55, while continuing to work bank shifts and keeping their union role:

> At this stage of my career now because I feel I am very fortunate, I have options. So I can take early retirement, I could get myself retrained, I am not under the same sort of pressure that a lot of people are which is, they've got to pay their mortgage and all that, they've got children to look after. I'm not so worried about career progression at this point. And if I can help my colleagues by doing representation work then that's even greater, that's just the icing on the cake I suppose. But I'd like to be just left alone and I don't want them to put any hurdles in my way. (*Steward, RCM, midwife, band 7, female, BAME, 46-55, clinic, urban England*)

As previous research on women's union participation has shown, the ability to set boundaries and have the support of the partner/family is crucial in taking union roles, especially in workplaces confronted with multiple problems and constant changes where demands placed on stewards are incessant:

> I think the organisation relies on a few hundred passionately committed [reps]. My phone never stops going. My husband gets quite cross at times because I'm not the sort of person to switch my phone off and if I've got a distressed member I will be there to support them whatever time of day or night it is. It does get the family down and I'm very fortunate that I've got a really good family that supports me and knows that I am passionate in what I do and what I believe in because without their support I couldn't do what I do. I mean, I'm here today, I have an RCN day tomorrow doing job matching, then Wednesday I'll be travelling up to Newcastle for three nights for the RCN joint reps conference. And then back on nights at the weekend (*Steward, RCN, nurse, band 7, female, white, 46-55, general hospital, urban England*)

BAME interviewees and focus group participants expressed the additional difficulties they encountered as BAME reps in their relations with management as well as within the union, with the feeling of having more to prove in order to be elected/selected and recognised as legitimate in their union and professional role. While both unions have developed equality and diversity policies, as have the employers, a situation of "institutionalised discrimination", in particular against BAME workers, was frequently mentioned (and partially documented by RCN/RCM, in particular with regards to the frequency of disciplinary actions and lack of promotion), especially in London hospitals, which are very diverse:

> I try to encourage people to become a rep, it's very difficult. Because they will say you're all right because you can talk, you've got the support. But I say all you've got to do is just knock on the door and say I'd like to talk to you about this. And that's what I've done really, I've gone to HR and like I said with a lot of disciplinary, and I say can we just sit and look at this, does this have to be a disciplinary, could we not sit, get the manager and sit and talk with the manager and ask what is going on or why this went on. But it's just something as a black person, I've got to put my head above the parapet. (*Steward, RCM, maternity support worker, female, BAME, 56-65, general hospital, urban England*)

PART 4: CONCLUSION

The findings discussed five major dimensions that define working lives in nursing and midwifery identified by this and previous research: staffing shortages; working hours; low pay and undervaluing; bullying and harassment; equality and inclusion for BAME staff. As we have shown through direct accounts from nurses and midwives, these dimensions interact and combine to create an extremely testing environment. In general, research participants' accounts painted a picture of two professions experiencing poor morale, low levels of job satisfaction; widespread stress-related ill-health in particular mental health problems; excessive and potentially dangerous workloads; a culture of blame that has to some extent destabilised collegial staff relations; high levels of burnout and intention to quit. These conditions have many implications for RCN and RCM with regard to how the two professional organisations/unions can work to address the issues and improve the working lives of nurses and midwives.

The literature on industrial relations in the public sector, and in particular in the NHS, has raised a number of questions about the effects of the decentralisation initiated in the 1990s (Bach & Givan 2001; Lloyd 1997) on trade unions' organisation and activity in the workplace. This study confirms some of the difficulties encountered in setting up and maintaining an active network of reps and shop stewards, despite some growth in their number in the two unions (around 250 for RCM and 1,330 for RCN in England). As observed by previous work (Bach & Givan 2008), in an ever-pressurized work environment, members seem reluctant to participate in the activities of union branches, let alone taking on additional union responsibilities. As a result, just as in some other public service unions, the union representation workload is shifted to a small number of "key" stewards and full-time officers who are under heavy pressure due to crisis conditions in the service (Guillaume & Kirton, 2017).

This study also confirms the absorption of reps' time in problem solving on behalf of individual members, more than meeting and socializing with members collectively (Saundry & McKeown, 2013), which, despite a strong, shared professional identity, tends to weaken any form of workplace unionism. The institutionalisation of industrial relations, in particular through the establishment of numerous joint negotiation and consultative committees, reinforces this form of professionalization of trade union activity (Guillaume and Pochic, 2009) in the workplace but also at the regional/national level. While the weakening of inter-union rivalries (Lloyd, 1997) has helped sustain a good social partnership at the workplace level, this study highlights certain difficulties, in some workplaces/Trusts, in making consultative and negotiation bodies function properly, particularly due to a lack of staff and resources on both the union and management sides. As previous research has shown (Lloyd 1997), the variable quality of social partnership, depending on the workplaces, is also linked to the existence or not of a managerial approach, which encourages union contribution. However, this study underlines that austerity measures imposed on public services not only have deleterious effects on working and employment conditions, but also on the quality of industrial relations and union representation (Guillaume & Kirton, 2018).

In terms of issues addressed, the activity of reps covers concerns already identified by previous research (Kessler & Heron, 2001), which were already severe two decades ago but are now even more pronounced such as staffing and retention issues, and newer ones such as endemic harassment and bullying, and race discrimination as we have highlighted earlier. Interestingly, we found that the professional and educational dimensions are not very prominent in the activity of local stewards, with the exception of a few learning reps, and finally not very well

identified by new members. As research in the French context has shown, nurses do not necessarily favour professional unions, and may prefer general unions (Sainsaulieu 2012) to fight the many reforms imposed on public hospitals. This tension around professional unionism may be more prevalent for nurses than midwives and can be interpreted as the sign of an unfinished process of professionalization, both objectively and subjectively. The search for legal protection seems therefore quite prevalent in the desire to join RCN and RCM, as shown in other studies on teaching unions, for example (Moreau, 2014). The two unions are also identified as a source of information on individual rights. This "legal" focus can be explained both by the broader legalization of employment relations, but also the diversification and individualization of employment conditions (albeit certainly less strong in the UK than in other countries (Kealey 2008). The relationship with the union can then be described as "protectionist instrumentalism" (Moreau 2014) in a context, in the case of RCN and RCM, of constant threats against public sector professionals.

Finally, this study emphasizes workplace reps' attachment to the dual profession-union roles of RCN and RCM. Bergene & Egeland (2016) contend that "there is a vexed relationship between union militancy and professionalism" which conveys the risk of conflicting identities between being "good nurses/midwifes" and "good union members standing for themselves". As Sainsaulieu (2008) puts it, "the difficulty for nurses is to know when to stop caring and to start striking". This tension between the ethics of care and union action highlights the difficult relationship between two types of engagement, one "consensual" as professional and the other one possibly "conflictual" as trade unionist. However, this opposition between the figure of the activist and that of the professional can be mitigated by threats to the professional and service domains, which have led nurses to mobilize in certain circumstances (Kealey, 2008; Briskin, 2011) including the RCM strike in 2014 and the RCN action that members in Northern Ireland voted for in 2019. This observation highlights the complex intertwining of the professional, educational and union dimensions for RCM and RCN. If being perceived as professional unions remains a strength in their ability to recruit members and to be recognized as legitimate by employers and governments, the balance between these different aspects may become increasingly difficult to find in the current context of the restructuring and underfunding of public services and the many associated pressures.

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