Healthcare Assistants and compassionate care: Perceptions of 12-hour shifts

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The views expressed are those of the authors and not those of NHS England.
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Summary

Aims
NHS England is committed to including the perspectives of healthcare assistants (HCAs) and support workers in its review of the impact of 12-hour shifts on patients and staff and the delivery of compassionate care.

The aim of this study was to facilitate wider engagement with the findings from earlier research stages (a literature review and depth interviews with HCAs about 12-hour shifts undertaken by the Institute of Mental Health on behalf of NHS England¹) with healthcare assistants and stakeholders such as managers and other healthcare professionals; and seek suggestions about how to manage 12-hour shifts, to inform NHS England’s future work.

Methods
A qualitative consultation methodology was employed, consisting of four listening events involving focus group discussions, and an online consultation consisting of 9 open-ended questions. In total 126 participants took part; 86 healthcare assistants and 34 stakeholders (including managers and other healthcare professionals).

Key findings
The findings of the listening events with HCAs and stakeholders further support the issues around 12-hour shifts already identified in the earlier stages of the research programme.

A key message was that preferred shift length and patterns varied across HCAs, depending on individual factors such as: age, health status, work environment and out-of-work commitments. HCAs called for more control and involvement in decisions around the allocation of short and long shifts.

Benefits of 12-hour shifts
The perceived benefits of 12-hour shifts were primarily related to patient care. Longer shifts could increase contact time between patients and HCAs resulting in greater continuity and consistency of care. HCAs could also benefit from having more time to plan and complete their workload; allowing them to offer patients more flexible and personalised care. These benefits were important elements of HCA job satisfaction, but could only be realised with adequate staffing levels and supportive colleagues and managers.

Improved work-life balance due to compressed working hours and an increased number of rest days was a benefit specific to HCAs. Compacted working hours had related benefits such as reduced commuting time, travel costs, and more time for out of work commitments, such as childcare responsibilities.

¹The findings from the literature review and interview studies undertaken by the Institute of Mental Health can be found at: http://www.england.nhs.uk/6cs/groups/safe-staffing/
**Drawbacks of 12-hour shifts**
The main drawback of 12-hour shifts was staff fatigue. HCAs reported higher levels of tiredness during and after long shifts which had multiple implications for personal and patient wellbeing; increasing the risk of staff sickness, and concerns for performance errors and patient incidents.

**Making 12-hour shifts work**
Considerate management and teamwork were key themes identified in making 12-hour shifts work for HCAs and patients. This encompassed a number of issues for consideration, including:

- Involvement of HCAs in decisions about preferred shift length and patterns;
- Capping the number of consecutive long shifts and having minimum requirements for the number of rest days;
- Ensuring adequate staffing levels both in terms of overall numbers and skill mix to support HCAs deliver quality patient care;
- Allocation of breaks to provide opportunities to toilet, eat and hydrate to tackle fatigue; and managerial encouragement to take breaks;
- Mechanisms for managers to pick up on work-related stress of HCAs, with a view to reducing long term sickness;
- Measures to encourage staff cohesion between nurses and HCAs; for other staff to work with HCAs in an inclusive way, and make HCAs feel valued.

**Participant suggestions to inform NHS England’s work on 12-hour shifts**
HCAs and other stakeholders made suggestions to help inform NHS England’s future work. These centre around 6 key areas:

- Offering HCAs flexibility and choice in shift length;
- Taking measures to reduce staff fatigue;
- Developing a strategy to review sickness levels, and provide cover for sickness at short notice;
- Creating work environments where HCAs feel valued by other staff;
- Creating work environments that support HCAs to deliver compassionate care; and
- A research framework to evaluate the success and implications of 12-hour shifts for HCAs and patients.
1 Introduction

1.1 Background
Compassion in Practice² (launched in December 2012) is the three year vision and strategy for nursing, midwifery and care staff led by NHS England. The aim of the strategy is to set out the shared purposes of nurses, midwives and care staff to deliver high quality, compassionate care, and to achieve excellent health and wellbeing outcomes. It builds on the values of the 6Cs: care, compassion, competence, communication, courage and commitment. The strategy is underpinned by six Action Areas, each of which constitutes a separate work stream and aim to address the 6Cs.

The 6 Action Areas underpinning the Compassion in Practice strategy

1. Helping people to stay independent, maximising wellbeing and improving health outcomes
2. Working with people to provide a positive experience of care
3. Delivering high quality care and measuring impact
4. Building and strengthening leadership
5. Ensuring we have the right staff, with the right skills, in the right place
6. Supporting positive staff experience

As part of the delivery plan for Action Area 5, the National Nursing Research Unit undertook research to provide an overview of nursing and midwifery shift patterns with particular focus on the impact of 12-hour shifts on patients and staff³. The focus of which is, in the main, specifically on registered nurses within the acute care setting.

This research report also sits under Action Area 5, under the leadership of SRO Ruth May, NHS England Regional Chief Nurse (Midlands and East).

The Government Hard Truths commitments⁴ (January 2014) and the Cavendish Review (July 2013)⁵ recommended and accepted a commitment for NHS England to

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lead on the development of a body of evidence about the impact of 12-hour shifts on Healthcare Assistants (HCAs), nurses and patients.

As part of this, NHS England committed to including the perspectives of HCAs and support workers in its review of the impact of 12-hour shifts on patients and staff and the delivery of compassionate care.

It is within this context that three stages of research were grant funded.

**Stage 1 – Review of existing literature**
A scoping review to develop theory and synthesize existing evidence. This piece of work was led by Dr Louise Thomas, of the Institute of Mental Health, University of Nottingham. This literature review has been published separately, and can be accessed here: [http://www.england.nhs.uk/6cs/groups/safe-staffing/](http://www.england.nhs.uk/6cs/groups/safe-staffing/)

**Stage 2 – Depth interviews with healthcare assistants**
The second stage of this study comprised depth interviews with HCAs to understand their perspectives on shift lengths. This piece of work was also led by Dr Louise Thomas of the Institute of Mental Health, University of Nottingham.

Early findings from this work supported the development of the listening events. This initial study has been published separately, and can be accessed here: [http://www.england.nhs.uk/6cs/groups/safe-staffing/](http://www.england.nhs.uk/6cs/groups/safe-staffing/)

**Stage 3 – Wider consultation with HCAs and other stakeholders**
NHS England wanted to facilitate stakeholder engagement with the findings from Stages 1 and 2 more widely. The overall aim of this third stage was to provide a chance for the earlier research findings to be aired widely, discussed and responded to, and for this engagement to be captured, analysed and reported on. This was done through four listening events held with healthcare assistants and other stakeholders, such as other health professionals. This piece of research was conducted by NatCen Social Research, and is the focus of this report.

### 1.2 Purpose of the overall research programme

NHS England funded these three research stages to address the government commitment to build evidence to support decisions about shift patterns of nursing and midwifery staff, including non-registered nursing staff (i.e. healthcare assistants and support workers); and provide evidence to inform national policy on staffing and shift patterns.

### 1.3 Aims of this consultation

The aim of this stage of the research was to build on earlier research stages by exploring HCA and stakeholder perceptions of 12-hour shifts more widely, with
particular emphasis on exploring the impact of the delivery of compassionate patient care. Specifically this stage aimed to:

- Provide an opportunity to engage with, and hear the views of HCAs and stakeholders (e.g. registered nurses, ward managerial staff) from a range of care provider settings on the impact of 12-hour shifts on HCAs.
- To better understand the areas of divergence and convergence on perspectives of the impact of 12-hour shifts.
- To outline stakeholder suggestions around the future of 12-hour shifts to feed into NHS England’s future work.

### 1.4 Consultation methods

A qualitative approach was adopted to address the research aims: through listening events and an online consultation survey. The project was carried out in accordance with data security standards as set out by ISO 202526.

**Listening events**

A series of listening events were undertaken. Listening events are a participatory approach that actively involves stakeholders in decision-making processes, or in this case in the formulation of suggestions for the management of 12-hour shifts.

A total of four events were held in London, Bristol, Leicester and Manchester, in March 2015. The format of the workshops was designed to facilitate engagement with the wider literature around 12-hour shifts and to generate a set of suggestions to effective management of them. Each event lasted 3 hours and was chaired by a member of the NatCen research team.

Events started with a presentation of early findings from Stages 1 and 2 on 12-hour shifts for nursing staff. This was followed by two separate focused discussions about the emerging issues, in smaller breakout groups (of up to 10 delegates). Each breakout group was facilitated by a member of the research team.

The first discussion group at each event focused on understanding views and experiences of the benefits and drawbacks of 12-hour shifts for HCAs and patient care. This group lasted up to 90 minutes. The second discussion group provided an opportunity to suggest recommendations for the future of 12-hour shifts, with a specific focus on addressing the drawbacks identified in the prior discussion group.

This group lasted up to 30 minutes. Representatives from each breakout group fed back a summary of their group discussion to all delegates within plenary sessions. Topic guides were used for the breakout sessions to ensure consistency of coverage across the listening events, see Appendix A.

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6 A quality management system which establishes the terms and definitions as well as the service requirements for organisations and professionals conducting market, opinion and social research.
Online consultation
Following the events, a short online consultation survey was set up. The topics mirrored those covered in the listening events. The survey comprised 9 open free-text questions. The questions were informed by the emerging findings from the listening events. The online survey was an opportunity to include people who were unable to attend the events, or delegates who wanted to further contribute to the research including any issues that they did not want or feel able to raise in a group setting.

The survey was hosted on SurveyMonkey, an online survey platform, for a 2 week period in April 2015. A copy of the survey questions can be found in Appendix B.

1.5 Ethical considerations
Ethical approval for the research was sought from NatCen’s Research Ethics Committee and granted. Informed consent was obtained from all participants who took part in the research. Information was provided to participants prior to recruitment (in the form of an information leaflet) and prior to the groups (via the moderator) and it was made clear to respondents that they could withdraw from the research at any time. Focus groups and interviews were audio recorded so that an accurate record of the discussions was made; permission to audio record the groups was obtained prior to the group discussion.

All participants received a certificate of attendance and a contribution towards costs they may have incurred by taking part in the research.

1.6 Recruitment
Recruitment for the listening events was carried out using a variety of methods. The events were promoted widely, at both a national and local level. Invitation emails were circulated by NHS England and partner organisations. Hospitals and Trust communications teams promoted the events at a local level through emails, newsletter bulletins and email communications targeted at Heads of nursing staff. Furthermore, the Nursing Times (a large nursing information website) posted information about the events on their website, as well as sending a direct email to HCA subscribers.

Participants could register an interest to participate by contacting the research team, by email, freephone, or text. Key participant characteristics such as job role, work setting and area of specialism, were carefully monitored throughout the recruitment process to ensure that a broad range of participants and experiences were included at the events.

In each of the four cities where the listening events took place, they were held in central locations which were convenient for participants to access.

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7 http://www.nursingtimes.net/
Recruitment to participate in the online consultation differed. An invitation email was sent to everyone who registered an interest in participating in the events, regardless of attendance. This was followed by a reminder email sent to those who had not opened the first email.

### 1.7 Sample

A total of four listening events, comprising 30 focus groups sessions with HCAs and stakeholders were conducted for the research. This qualitative fieldwork was carried out in four cities in England: London, Bristol, Leicester and Manchester – to capture localism of views and diversity of research participants.

The events were followed by an online consultation about 12-hour shifts. This online survey was targeted at HCAs and stakeholders. A total of 29 participants completed this online survey.

The research aimed to include a range of stakeholders. The populations of interest included in this research were:

- Healthcare assistants – working in a range of settings (including NHS and private providers, acute, community and mental health), contracted and bank staff, as well as variation in term of the number of years in the role.
- Stakeholders – senior and ward level managerial staff, registered nurses, other health professionals who work alongside HCAs and patients.
- The sample captured a diversity of views, experiences and circumstances among the population of interest. It is important to point out that the views of the participants were not intended to be representative wider populations. Nevertheless, the key themes across participants and listening events were resoundingly similar, providing a measure of confidence that findings would resonate across the wider population.

Table 1 shows the profile of participants who took part in the research.
## Table 1  Profile of participants

<table>
<thead>
<tr>
<th>Job role</th>
<th>Listening events</th>
<th>Online consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare/nursing assistant or support worker</td>
<td>70</td>
<td>16</td>
</tr>
<tr>
<td>A registered nurse</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Another healthcare professional</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Working in HR, management or elsewhere</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Patient / Other</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>

### Area of work

<table>
<thead>
<tr>
<th>Area of work</th>
<th>Listening events</th>
<th>Online consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute hospital</td>
<td>60</td>
<td>16</td>
</tr>
<tr>
<td>Community setting</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>Mental health services</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Learning disability services</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Children’s services</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Maternity services</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Care home</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other or unknown</td>
<td>17</td>
<td>3</td>
</tr>
</tbody>
</table>

### Sector

<table>
<thead>
<tr>
<th>Sector</th>
<th>Listening events</th>
<th>Online consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS</td>
<td>79</td>
<td>22</td>
</tr>
<tr>
<td>Private</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Bank / agency</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Third sector</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>

**Total number of participants**                                            **97**      **29**
1.8 Analysis
Framework, a thematic approach to analysing qualitative data was used for this research. This involved developing an analytical matrix framework following familiarisation of the focus group recordings, with different column headings for the key themes identified and a row for each discussion group. Data from each group was then summarised into the appropriate column heading to allow for the systematic comparison of themes between groups. This approach helped to reduce the large volumes of data obtained whilst ensuring comprehensive analysis. It also facilitates systematic between case (looking at what different groups said on the same issue) and within case (looking at how a group’s opinions on one topic relate to their views on another) investigation of the data.

Through reviewing the summarised data the full range of attitudes and behaviour described by participants was systematically analysed, and the accounts of different participants, or groups of participants, was compared and contrasted. The use of the Framework approach ensured that analysis was fully documented and conclusions could be clearly linked back to the original source data.

As noted earlier, the different populations included in this study, whilst sharing some characteristics, resulted in very varied group composition. Therefore the level of analysis possible for the research was at a relatively high level. Due to the diversity of participants and their experiences within groups it was not possible to drill down to deeper levels of analysis, for example, in terms of similarities within one particular healthcare setting or geographical area. However, strong patterns did emerge of the potential impacts of 12-hour shifts as well as implications within some settings.

1.9 Structure of the report
The report is separated broadly into four key sections. Chapter 2 looks at the participants’ experiences and views of 12-hour shifts, both for HCA wellbeing and on the delivery of compassionate patient care. Chapter 3 outlines participant’s views on the barriers and facilitators to making 12-hour shifts work. Chapter 4 outlines participant suggestions for 12-hour shifts. Chapter 5 concludes with a discussion of the overall findings.
2 Experiences and views of 12-hour shifts: implications for patients and healthcare assistants

This chapter covers consultation participants’ experiences and views of 12-hour shifts, including the benefits and drawbacks. Initially, the chapter provides an overview of the key implications of long shifts, as identified by consultation participants. The chapter then sets out the details of each theme of 12-hour shifts for the delivery of compassionate patient care and then moves on to detail the implications for HCAs and their wellbeing.

2.1 Implications of 12-hour shifts: an overview

The four overarching implications of 12-hour shifts, as identified by HCAs and stakeholders, are illustrated in the table below; detailed information on each of these themes is presented in the body of this chapter.

Many of the issues raised during this consultation with HCAs and stakeholders were not exclusive to 12-hour shifts. The implications of 12-hour shifts listed may also be experienced on shorter shifts. However, there was a concern that these issues may be exacerbated on longer shifts.
2.2 Perceived implications of 12-hour shifts on delivering compassionate patient care

2.2.1 Continuity of care

A benefit of 12-hour shifts raised by consultation participations was the increased level of contact and familiarity between HCAs, patients and relatives. Longer shifts allowed more time to build relationships with patients and relatives. Continuity of care was seen as especially positive for patients within particular settings. For example, in long-term stay settings (e.g. care homes, older people’s care settings), surgical admissions and dialysis wards, where one HCA could follow the patient journey over the course of a long shift. Participants believed that consistency of staff was reassuring to patients and relatives; and could, in turn, lead to increased trust and patient co-operation.

Fewer handovers between staff on long day shift patterns was linked to an improved patient experience as this reduced the risk of information being missed. Furthermore, fewer handovers were considered efficient, and linked to provision of more consistent care.
Although 12-hour shifts increased consistency of staff during individual days, it failed to provide consistency over a week – a stated benefit of short shift patterns. Furthermore, longer shift patterns alone were not considered to be a measure of the quality of care provided. It was also highlighted that increased contact time between staff and patients may be detrimental to the patient experience, in cases where the patient and a HCA did not have a good relationship.

2.2.2 Time for compassionate care

Lack of time and large workloads due to insufficient staffing and poor teamwork were barriers experienced by HCAs working across a range of settings, in delivering compassionate and holistic care.

“Holistic care on a conveyor belt, that’s what it feels like. Get them in, get them done, get them out.”

(Healthcare assistant)

12-hour shifts with adequate staffing levels and being part of a supportive team enabled HCAs time to deliver patient care. Longer shifts gave HCAs time to plan their workload, and build in time for personalised patient care; which contributed to job satisfaction.

Personal care activities such as taking patients off the ward, helping with hair-care or doing a patient’s make-up, were reported to be possible on longer shifts. Furthermore, longer shifts enabled HCAs to offer more person centred care; an example given, illustrated in the below quote, was washing a patient at a time they preferred.

“If they don’t wanna shower early in the morning [the patient]’ll say, ‘Oh you’re here all day though ain’t you?’ You know, ‘Well yeah, shout me, I’m here all day.’ If they say, ‘I don’t want it now, can I wait a few hours.’ ‘Well I’m here ’til eight, so yeah’.”

(Healthcare assistant)

Staff on short shifts explained that working over their set hours to complete tasks such as paperwork was a common occurrence, leaving little time for personalised care activities.

Reduced overlap time, between staff changeover was observed on 12-hour shift patterns. Staff on shorter shifts reported this overlap time being invaluable for task completion; such as ward cleaning.

2.2.3 Staff fatigue

A concern about 12-hour shifts was the resulting tiredness experienced by HCAs (discussed in more detail at section 2.3.3). HCAs felt they maintained a level of professionalism with patients, even when they were tired; however, they described
the ways in which tiredness could affect care delivery. **Safety concerns for patients** were raised as potential issues for staff and patients alike. For example, in settings, such as mental health wards, staff who are less alert may miss warning signs or changes in mood of a patient, which may place staff and patients at risk of harm.

HCAs reported fatigue could cause staff to become confused when documenting patient information, which they worried **could lead to errors** due to false or inaccurate information being provided. Managerial stakeholders also held concerns about the link between fatigue and patient incidents, but did not discuss personal experience of this.

Despite efforts to maintain a professional image in front of patients, HCAs reported that **patients recognised tiredness in staff**. Patients expressed sympathy for staff who looked tired, they may offer to help HCAs, or take a decision not to request help in an effort to avoid further burden on HCA workloads. Experiences such as these worried HCAs, and made them feel bad.

> ‘If I see that the workers are busy or stressed - I would hold back on going to the toilet as I didn’t want to bother them.’

(Patient, Stakeholder)

Whilst HCAs felt they did continue to perform all required tasks on 12 hour shifts, they described their **tiredness leading to increased irritability** which they felt may affect their levels and types of interactions with patients. For example they may be less talkative with patients, which may be viewed as unfriendly.

> "At the end of the day I don’t feel less compassionate to that patient, I still care about that patient… but I might not be as chatty, as chirpy, as happy to be there as I was at the start of the shift"

(Healthcare assistant)

Tiredness also affected levels of resilience. For example, HCAs described feeling more upset by distressing incidents or feeling less able to deal with difficult interactions and conversations with patients and relatives at the end of a long shift.

**2.3 Perceived implications of 12-hour shifts for healthcare assistants**

**2.3.1 Work-life balance**

An increased number of rest days were a positive aspect of working long shift patterns; enabling a good work-life balance. More consecutive days off gave HCAs **time to rest and recover** from physically demanding long shifts; as well as more **time for personal commitments**, such as caring responsibilities and study.
Although, more days off work were initially an incentive for switching to longer shift patterns, HCAs experienced downsides to this extra time off. The first day off was spent sleeping and recovering in order to recuperate from exhaustion as a result of working long days. Limited social contact during days off, due to friends and family being at work, for example, was reported by some to result in them feeling isolated and ‘down’ on days off. However, others described enjoying the peace and quiet and the advantages, for example, of being able to do shopping at off peak times. HCAs could also experience a feeling of reluctance to go back to work after having a number of days off.

When working long shifts, HCAs experienced restrictions in participating in social activities on work days, due to a longer working day and resulting tiredness. They also reported limited or no contact with friends and family on long working days. Work-life balance during long shift days was therefore hindered. Furthermore, due to irregular and changeable shift patterns, individuals felt unable to join clubs and groups and other social activities; an issue of shorter shifts too.

### 2.3.2 Reduced commuting time and financial savings

Working longer shifts and therefore fewer work days in total resulted in less overall commuting time and reduced travel costs. Some HCAs with child care responsibilities benefited from reduced childcare costs when working longer shifts, but fewer days; whilst others experienced no reduction in childcare costs due to unpredictable rotas, and having to pay a regular weekly cost.

### 2.3.3 Tiredness and fatigue

Levels of tiredness and fatigue were concerns and drawbacks of 12 (or longer) hour shifts. Tiredness was reported to increase towards the end of long shifts, and with each consecutive working day. HCAs recounted feeling tired at the start of their second and third consecutive shift.

Levels of tiredness were attributed to the physical demands and nature of the HCA role. HCAs also reported feeling mentally and emotionally drained after long days, especially if they experienced a distressing incident during their shift. Staff shortages were reported to have resulted in a larger workload for those on shift; which, in turn, was linked to increased levels of staff exhaustion. Limited opportunities to hydrate, eat and take a break off the ward were also said to contribute to levels of tiredness.

The consequences of tiredness during a shift included a lack of concentration and feeling less alert, which may lead to less efficient working, concerns about increased errors or safety concerns for staff and patients, particularly when working in challenging patient settings. Managerial stakeholders had concerns about increased safety incidents on 12-hour shifts, due to staff fatigue.

“Your brain just starts going after about 12 hours”

(Healthcare assistant)
When feeling tired, HCAs said they completed required tasks, but did not feel able to ‘give their best’. HCAs reported a noticeable lack of productivity amongst colleagues working long shifts towards the end of a shift; which was a source of tension between staff working short and long shifts. HCAs working short shifts reported an increased workload due to the tiredness, and resulting lower productivity, of colleagues on long shifts. These participants highlighted that having tired staff on shift may satisfy required staffing levels on a ward, but did not equate to provision of quality care.

“By the second or third long day, they’re no good to nobody, so they are there in number but they’re not actually doing anything”

(Healthcare assistant)

A further downside to tiredness was that it affected people’s mood. Tiredness was said to increase levels of irritability, reduce patience and affect attitudes and communication with other staff. Although HCAs reported maintaining a level of professionalism with patients and relatives when feeling tired and irritable, they did feel they had lower levels of tolerance with patients and relatives. It is therefore likely that staff tiredness may have some impact on patient care.

Tiredness also affected HCAs after their shift in a number of ways. Safety concerns when travelling home when tired were raised, particularly in out of London areas, where there is limited public transport and greater reliance on driving. HCAs described driving home on ‘auto pilot’ and not being able to recall their journey home, which worried them. HCAs felt unable to ‘switch off’ after a shift, which affected their sleep. Tiredness also affected appetite; being too tired to eat after a long shift. Fatigue and feeling irritable was also reported to affect relationships at home, in their personal life.

2.3.4 Health implications and sickness

Some staff with long term health conditions such as back pain and fasciitis, reported that 12-hour shifts exacerbated these conditions compared with shorter shifts; though consecutive rest days provide opportunity to rest and recover.

HCAs highlighted that it can be harder for managers to arrange sickness cover for longer shifts at short notice than for 8 hour shifts. There was recognition that staff shortages, due to sickness, increased work pressures for colleagues. With this in mind, some HCAs reported a pressure to work when feeling unwell.
3 Making 12-hour shifts work

This chapter outlines participants’ views on the barriers and facilitators to making 12-hour shifts work as well as possible for HCAs and patients in relation to delivering compassionate care. The chapter largely focusses on the management of 12-hour shifts. Broadly speaking, the issues discussed address the concerns of longer shifts outlined in Chapter 2.

3.1 Making 12-hour shifts work: an overview

The key areas to the management of 12-hour shifts, as identified by HCAs and stakeholders, are illustrated in the diagram below; detailed information on each area is presented in the body of this chapter.

3.2 Staffing levels

Staffing levels were felt to impact staff wellbeing, job satisfaction and delivery of compassionate care. Having an adequate number and skill mix of staff at all levels, on short and long shifts, was felt to benefit patients and staff. Sufficient staffing levels were described to have a number of benefits including a manageable workload, being able to take breaks, reduced tiredness, and feeling supported.
Reduced overlap time, when incoming staff work alongside the outgoing, was observed on 12-hour shift patterns. Staff on shorter shifts reported this overlap time being invaluable for task completion. Ward managers may need to consider the implications of a reduced overlap time for HCA workloads, task completion as well as sufficient time for handovers.

Working with agency staff could be a source of contention, as working alongside non-permanent staff, unfamiliar with local policies and procedures could increase workload for HCAs.

“If staffing is right, the skill mix is right, you’re allowed to work within your role, they [12-hour shifts] work, they work well”

(Healthcare assistant)

From a managerial perspective, recruitment and retention of HCAs was problematic; particularly amongst London-based stakeholders. Managers reported difficulties in recruiting HCAs to work short shift patterns and retaining HCAs working both short and long shifts. Managerial stakeholders attributed these challenges to low pay, and a lack of training opportunities and investment in HCAs. These issues resulted in a reliance on bank staff.

Managerial staff felt equipped to work with HCAs to manage the transition from 8 to 12-hour shifts in the short term but feedback included concerns about managing the longer term accumulative impacts, such as burnout, maintaining motivation and staff retention.

3.3 Management of 12-hour shift allocations

3.3.1 Rostering - choice and control over shift patterns

Preferred shift patterns varied across HCAs, depending on individual factors, such as age, health status and out-of-work commitments. HCAs wanted the opportunity to have greater control over their shift patterns. HCAs not currently working long days were generally open to trialing 12-hour shifts, but wanted the option to revert back to short shifts if they found long shifts to be unsuitable.

Input on shift patterns was not limited just to the length of shift, but also to more general issues, for example, HCAs might prefer working exclusively nights, or days. It was felt that greater efforts could be made to offer flexibility to meet the needs of staff. Furthermore, HCAs advocated being able to swap shifts amongst colleagues, to increase HCAs feeling of choice and control over shift patterns, and support efforts to achieve a work-life balance.

Those who had an e-rostering system suggested a need for shift allocations to be sense checked prior to being released, due to system glitches they had observed. A highlighted problem was the high number of consecutive shifts allocated at the end
of one week and the start of the next without any rest days in between. Managerial staff explained that the new e-rostering systems had some teething issues. Much like any other new system, it requires require monitoring and management and time to imbed.

In addition HCAs, believed that notification of rosters in advance and outcome of annual leave requests would enable personal planning and improved work-life balance.

3.3.2 Limiting the number of consecutive long shifts

There was support from HCAs and managerial stakeholders alike to limit the number of consecutive long days worked by HCAs. Study participants advocated working no more than 2 consecutive long days, followed by a minimum of 2 rest days. Whilst there was some support from HCAs to work 3 consecutive long days; managerial stakeholders felt that day shifts should be capped at a maximum of 2.

There was less certainty about the number of consecutive long night shifts a HCA can safely do. Dependent on the care setting, night time shifts could be less busy, however there were also HCAs who felt this was a false perception, and that night shifts could be just as busy as day shifts, particularly if fewer staff are on-shift.

Participants stressed the need to monitor adherence to policies related to the number of consecutive long shift working days. Study participants working 12-hour shifts, explained that caps on the number of consecutive working days were in place, but due to staff shortages HCAs would often work more than the recommended number of consecutive shifts to help provide cover for staff sickness or other absences. Having an adequate number of rest days to support the transition from night to daytime shifts for recovery and body-clock adjustment was considered to be of particular importance.

There was also concern about HCAs working additional shifts or hours, as bank staff, during rest days. HCA participants recommended a need to monitor such practices to safeguard staff and patient safety; and believed that HCAs themselves had a duty to make responsible choices about the number the shifts and total hours they work.

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Please note that this report represents the views of research participants on shift patterns. NHS shift allocations should adhere to European Working Time Directive.
3.4 Management of 12-hour shifts: during shifts

3.4.1 Protecting break times

HCAs described how they often do not get to take their breaks or are interrupted when on a break. Missing breaks further limited already sparse opportunities to hydrate, eat and toilet; contributing to feelings of fatigue. Not being able to take breaks was linked to inadequate staffing, but there was also some evidence of a general stigma amongst ward staff to taking breaks. HCAs recounted experiences of colleagues, including registered nurses and ward managers directly challenging them for taking breaks, or making their feelings clear by more subtle means, such as passing sarcastic remarks.

HCAs stressed a greater need to protect break times during 12-hour shifts; and challenge the stigma of taking breaks. There was also support for facilitating structures to take breaks away from the ward setting, allowing for a sufficient break period to get fresh air, toilet, and access water and affordable and healthy food. Breaks can support HCAs having respite and feeling refreshed for the latter part of their shift.

Managerial stakeholders emphasised a need for ward managers to ensure breaks are allocated and taken by all staff. There was an appreciation that coordinating and staggering break times for staff on long shifts presented challenges. They felt that HCAs too, had a responsibility to protect their break time by taking it, rather than working through them.

3.4.2 Teamwork and feeling valued

Feeling supported and valued by other staff was identified as a key facilitator to job satisfaction. Staff cohesion was a central issue of concern when working longer shifts and having increased contact with colleagues, especially in the context of potential staff fatigue. Some HCAs reported feeling undervalued by senior colleagues, including by registered nurses and doctors. There were some examples where this manifested in staff speaking down to HCAs and the delegation of additional tasks exclusively to HCAs despite them already having a large workload.

A negative attitude towards HCAs was demotivating and felt to hinder teamwork, staff cohesion and delivering quality care. A suggestion to promote the role of HCAs amongst wider staff was to include HCAs in ward rounds and patient handovers, where appropriate. HCAs have high levels of patient contact, and felt they could therefore support information sharing about patients.

HCAs wanted to feel respected by other staff, and suggested this could be improved by simply being spoken to politely or other staff offering help during busy periods. A cited example was that HCAs and nurses should be involved with feeding at meal times which would lighten the load for HCAs, and ensure patients receive warm meals and the feeding support they need. Some participants believed that
professional registration, subject to training, may also improve the position of HCAs within the workforce.

HCAs had noticed that some patients become attuned to negative attitudes towards HCAs, and sometimes also speak down to HCAs.

There were also HCAs who reported working in wards with strong management, where teamwork across staff levels was observed and a general positive attitude towards HCAs. Feeling valued by colleagues and ward managers was important to staff morale. Furthermore, positive staff working relationships, particularly between registered nurses and HCAs, were considered to improve patient experiences.

“If you make the staff happy it means that the patients are also happy.”

(Healthcare assistant)

Managers echoed a need to take time to get to know their teams, in order to be able to provide them with the required support and get the best out of them.

3.4.3 Workloads – managing conflicting demands

Having a high workload was difficult on all shifts and a potential source of stress. HCAs also reported feeling constantly ‘put on’. There was a view that some doctors and nurses expected HCAs to pick up any additional and excess roles, and a perception that experienced HCAs in particular are requested to perform tasks outside their scope or remit; or being requested to complete two or more different tasks at the same time without question or recognition of HCAs' existing workloads.

3.4.4 The role of managers

Considerate, supportive and inclusive management were themes running throughout discussions about 12-hour shifts. Managerial support and intervention to address potential issues related to long shifts were identified as key facilitators to ensuring staff and patient wellbeing.

Ward managers within hospital settings, and direct line managers within community settings, were seen as responsible for supervising safe working practices at a local level. HCAs felt that managers were responsible for dealing with a number of the aforementioned concerns raised by HCAs regarding 12-hour shifts. These included:

- Monitoring working hours of HCAs and rostering
- Noticing signs of work related stress/sickness, and raising these with individual HCAs;
- A strategy and policy in place to ensure adequate staffing levels and cover for staff sickness at short notice;
- Ensuring breaks are allocated and taken;

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10 This fits with the a need to ensure shifts and hours worked are in line with the European working time directive.
• Monitoring and addressing potential tensions between staff working short and long shifts, such as fair workload allocation;
• Providing opportunities for support and debrief, particularly if HCAs had experienced a distressing incident; and
• Fostering and promoting positive staff relationships and teamwork.

HCAs also raised a number of wider managerial issues that may require input at a strategic level. These included:

• Safeguarding health and safety: a need for assurance of adherence to statutory requirements for manual handling training due to the physical nature of the HCA role in some settings.
• Training opportunities: greater encouragement and support from management in HCAs taking up training opportunities to increase skillsets but also to demonstrate that they are valued team members was suggested; as well as more face-to-face training. Managerial stakeholders supported a need to formalise training structures for HCAs in order to develop, reward and retain staff.
• Promotion of HCA views: in addition to day-to-day supervision, a forum for HCA representatives to air work related views, ideas and concerns.
• Ongoing monitoring of 12-hour shifts: managerial stakeholders had reservations about the overall value of 12-hour shifts. There was particular concern about an increase in incidents due to fatigue, patient satisfaction as well as the overall cost benefit of longer shifts. These stakeholders advocated a need to collect and monitor data on 12-hour shifts to assess its wider implications.
4 Participant suggestions for the management of 12-hour shifts

This chapter presents participant suggestions on 12-hour shifts for HCAs, to inform NHS England’s future work. It is paramount that shift allocations are planned to meet service and patient needs when considering the suggestions for the management of 12-hour shifts put forward by HCAs and other stakeholders.

The suggestions put forward can be summarised into 7 key areas and are outlined in the below table.

<table>
<thead>
<tr>
<th>Areas of concern</th>
<th>Suggestions</th>
</tr>
</thead>
</table>
| **Involving HCAs in decisions about shift length and patterns** | • Subject to the service and patient needs, offering flexibility and choice of shift length taking into account individual circumstances  
• Reviewing changes to shift length with HCAs  
• Offering flexibility to switch back to shorter shifts |
| **Staff fatigue**                        | • Limiting the number of consecutive long days. No more than 2 consecutive 12-hour days, followed by 2 rest days. This could increase to 4 consecutive long nights  
• Adequate staffing levels; both the number and skill mix and staff experience  
• Ensure breaks are allocated and taken  
• Access to water on wards |
| **Staff sickness**                       | • A strategy to ensure adequate staffing levels and cover for staff sickness at short notice |
| **Shift allocations**                    | • Increasing choice and control over shift patterns; accounting for personal preferences, as far as possible  
• The possibility to trial and evaluate implementation of 12-hour shifts, with an opportunity to move back to short shifts  
• Releasing rotas in advance – for greater work life balance |
| **Making HCAs feel valued**              | • Promoting positive attitudes towards HCAs  
• Promoting team work between registered nurses and HCAs  
• Formalised training opportunities |
| Supporting delivery of compassionate patient care | Adequate staffing levels\(^\text{11}\)  
| Ensuring handovers and involvement of HCAs |
| Monitoring data to measure the success of 12-hour shifts | A research framework to understand the impact data on 12-hour shifts, which should include:  
| Patient satisfaction linking to shift patterns  
| Review of safety incidents by shift patterns  
| Individual reviews for HCAs after a 3 month period of 12-hour shifts  
| Assess overall cost saving of 12-hour shifts |

\(^\text{11}\) Please note that staffing levels must be in line with national guidance and workforce tools.
5 Discussion of findings

Healthcare assistants and stakeholders identified a range of positive and negative implications of 12-hour shifts for the delivery of compassionate patient care and staff wellbeing. Participants also put forward strategies for managing long shifts to ensure they work for patients and staff. The findings of the listening events with HCAs and stakeholders, further support and strengthen the issues and considerations identified within research Stage 1, depth interviews with HCAs.

A key message was that 12-hour shifts are not suitable for all HCAs. A range of personal and work factors, such as age, health status, work environment, out-of-work commitments and care setting were linked to whether or not longer shifts patterns were suitable for individual HCAs.

The possible benefits of 12-hour shifts included greater continuity of care for patients, due to fewer staff handovers and numbers of HCAs involved in their care. In addition, HCAs could plan their daily work over a longer timeframe, and importantly, build in time for the delivery of person-centred patient care. HCAs reported 12-hour shifts facilitating greater work-life balance; however, it should be noted that there were also HCAs who preferred working shorter shifts and felt better able to provide quality patient care on 8-hour shifts.

The key concern of 12-hour shifts was staff fatigue and health implications, due to longer working hours over a number of consecutive days, which was linked to multiple potential risk factors for patients and staff.

Factors such as staffing levels, protection of staff break times, promotion of teamwork between nurses and HCAs and supportive managers were identified as important in making 12-hour shifts work. Although these factors are also important for short shifts they were considered key to enabling the potential benefits of 12-hour shifts and mitigating the possible negative consequences. For example, ensuring shifts have adequate number and skill mix in line with national guidance on safe staffing from the National Quality Board and NICE guidelines, safeguarding time for HCAs to provide personalised patient care.

HCAs and other stakeholders made suggestions to inform NHS England’s future work on 12-hour shifts for HCAs. Broadly, these included: offering HCAs flexibility and choice of shift length; capping the number of consecutive long working days and setting a minimum requirement for the number of rest days; taking measures to reduce staff fatigue such as protecting break times and providing facilities for staff to stay hydrated; developing a strategy to review staff sickness levels and provide cover for sickness at short notice; creating work environments that make HCAs feel valued and supported to deliver compassionate care; and a research framework to evaluate the success and implications of 12-hour shifts for HCAs and patients.
Appendix A.

Listening events - Topic guides

P11824 Healthcare Assistants and 12-hour shifts

Discussion group 1 topic guide:
Views and experiences of 12-hour shifts

Aims of the research
- Understand the impacts of 12-hour shifts for Healthcare Assistants (HCAs) and patients; with a specific focus on delivering compassionate care
- Map views and experiences of HCAs and other stakeholders on 12-hour shifts
- To feedback suggested recommendations which will inform NHS England’s action plan on 12-hour shifts for HCAs, to ensure delivery of compassionate care

Objectives of the discussion group
- Explore views and experiences of 12-hour shifts
- Explore how 12-hour shifts affect delivery of compassionate patient care
- Explore how 12-hour shifts affect job satisfaction for HCAs + their wellbeing
- Explore positive and negative impacts of 12-hour shifts

Introduction – covered in the plenary
- Details about the discussion (given by workshop leader before participants break into groups)
  - Voluntary – participants do not have to answer questions if they do not want to
  - Confidentiality – there will be a research report, information will be used for research purposes only
  - Anonymity – individuals will not be named in the report, anonymity also depends on participants so don’t use names outside the room
  - Nature of discussion – please contribute, no right or wrong answers, don’t interrupt, respect other people’s views including religious or ethical beliefs
  - Length of discussion – 60 minutes
  - Permission to record?

WORKSHOP LEADER:
- Check whether participants have understood project / what participation involves
- Check whether there are any questions
- Seek permission to record

START RECORDING

1. Background (5mins)
Researcher to introduce self and invite participants to introduce themselves, including:
- Name
- Job role, specialism, length of time as HCA/job role

FOR HCA GROUP ONLY:
- Out of work commitments
  - Family / caring commitments - children, parents
  - Other jobs, hobbies, responsibilities

FOR STAKEHOLDERS:
- How their job role relates to working with HCAs

2. Wider issues for HCA (5mins)
Aim: to provide participants an opportunity to raise burning issues in relation to HCAs; moderator to refer back to relevant issues raised during discussion

What are the key issues for HCAs where you currently work
- Flavour of wider issues; not just limited to 12-hour shifts
- Differences by specialism

3. Shift patterns for HCAs (20mins)
Aim: To understand typical shift patterns. Views and impacts of 12-hour shifts

Describe shift patterns for HCAs where you currently work
[General discussion; not a round robin; but do check for differences across participant experience]
- Shift lengths – 12-hours, more or less
- Breaks
- Staff to patient ratio
- Days / nights
- Consecutive shifts
- Number frequency of rest days
- CHECK: Is this typical – check for differences by wards / specialism

Views of 12-hour shifts
- Positive – what do you like
- Negative – what do you dislike
- 12-hour shifts vs other types of shifts

Impact of 12-hour shifts for HCAs
- Wellbeing / job satisfaction
- Work-life balance
- Tiredness – during and after shifts
- Safety – staff, patients
- Transport / cost of travel
4. Impact of 12-hour shifts on patients (15mins)

Impact HCAs doing 12-hour shifts on patients
- Impact on quality of care – meeting needs
  - Safety
- Impact on companionate care:
  - Relationships with patients, family
  - Empathy / Respect / Dignity
- Continuity of care
- 12-hour shifts vs other types of shifts
- Differences by ward / specialism

5. Positive and drawbacks of HCAs and 12-hour shifts (5mins)

Materials: post it notes, pens, A3 paper

Ask the group, in pairs or as individuals to suggest – on post it notes:
- At least one positive aspect of 12-hour shifts + for who (i.e. HCAs; staff; patients)
- At least one draw-back / issue with 12-hour shifts + for who

(Ask for a volunteer to feedback in the group feedback session)

Close
- Stop recorder
- Thank the participants
- Explain – tea break; everyone back the main room for feedback as a whole group, and then back to break out room to discuss recommendations.
P11824 Healthcare Assistants and 12-hour shifts

Discussion group 2 Topic Guide:
Recommendations for HCAs and 12 hour shifts

Aims of the research
- Understand the impacts of 12-hour shifts for Healthcare Assistants and patients; with a specific focus on delivering compassionate care
- Map views and experiences of HCAs and other stakeholders on 12-hour shifts
- To feedback suggested recommendations which will inform NHS England’s action plan on 12 hour shifts for HCAs, to ensure delivery of compassionate care

Objectives of the discussion group
- Identify recommendations for the future of HCAs and 12-hour shifts
- Short term and longer term recommendations
- Recommendations for delivery of quality patient care; compassionate care and ensuring HCA safety and wellbeing

WORKSHOP LEADER:
- Materials required / may be helpful during this discussion
  o Pros and cons list from discussion group 1
  o Flip chart
- Remind participants: project aims to understand the impacts of 12-hour shifts for HCAs delivering compassionate care. This discussion to focus on short and long term recommendations for HCAs and 12-hour shifts to inform NHS England’s action plan.
- Length: approx. 30mins
- Check whether there are any questions
- Seek permission to record

START RECORDING
1. Blue Sky (20mins)

Aim: To hear range recommendations for HCAs and 12-hour shifts
Materials: Flip chart to map out recommendations
Moderator: Quality care and compassionate care may have common features for HCAs. It’s o.k. for participants to tell us about delivery of good quality care; but please do cover delivery of compassionate care too as this is the focus of this research.

If there were no constraints, what would help HCAs deliver compassionate care during 12-hour shifts

[Compassionate care covers…]
- Relationships – patients / family carers
- Empathy / dignity / respect

What helps/hinders HCAs deliver compassionate care now

Recommendations
- to help ensure HCAs can deliver compassionate care on 12-hour shifts
- to ensure 12-hours are safe for HCAs, staff and patients
If necessary: moderator to refer to points raised in earlier discussion group

- CHECK: differences by ward specialism
- CHECK: 12-hour shifts vs other types of shifts - recommendations specific to 12-hour shifts (i.e. would these recommendations be the same or different for another other type of shift pattern)

2. Prioritising recommendations (10mins)

Group recommendations into:
- Short term
- Longer term

Explore reasons for prioritisation
- Reasons some for more of a priority than others

Close
- Stop recorder
- Thank the participants
- Explain – everyone back to the main room for final words
Appendix B.

Online consultation - questions

We are preparing a report for NHS England on Healthcare Assistants and 12-hour shifts. We want to know what Healthcare Assistants, people who work with HCAs and patients think about 12-hour shifts. Please feedback your views and experiences via this short survey. You do not need to respond to every question. The survey is entirely confidential.

[Questions 1-9: freetext response questions]

1. What do you feel are the benefits of 12-hour shifts for health care assistants?
2. What do you feel are the drawbacks of 12-hour shifts for health care assistants?
3. What do you feel are the benefits for patients?
4. What do you feel are the drawbacks for patients?
5. What needs to be place if 12-hour shifts are to work for HCAs?
6. What needs to be place if 12-hour shifts are to work for employers?
7. What needs to be place if 12-hour shifts are to work for patients?
8. What would you like NHS England to consider when making recommends on 12-hour shifts?
9. Anything else?

[Questions 10-12: pre-coded response questions]

10. **Are you a…** [single code]
    - Healthcare or support worker
    - A registered nurse
    - Another healthcare professional
    - Working in HR, management or elsewhere
    - A patient
    - Other (ENTER)

11. **Which of the following best describes where you work** [single code]
    - Acute hospital
    - Community setting
    - Mental health services
    - Learning disability services
    - Children’s services
    - Maternity services
    - Care home
    - Other (ENTER)
12. **What sector do you work in...** [Tick all that apply]
   - NHS
   - Private
   - Bank / agency
   - Third sector (e.g. Marie Curie)

Thank you for your feedback.